CHAPTER FOUR: RESULTS AND DISCUSSION

4.0 INTRODUCTION

This chapter will focus on the approach used for analysis of research data and findings of the study will be presented. Data were obtained from personal interviews conducted with 94 mobile clinic users' from nine mobile clinic points in the Muldersdrift area over a period of four months. Figure 4.1 illustrates mobile points and the number of service users' interviewed.

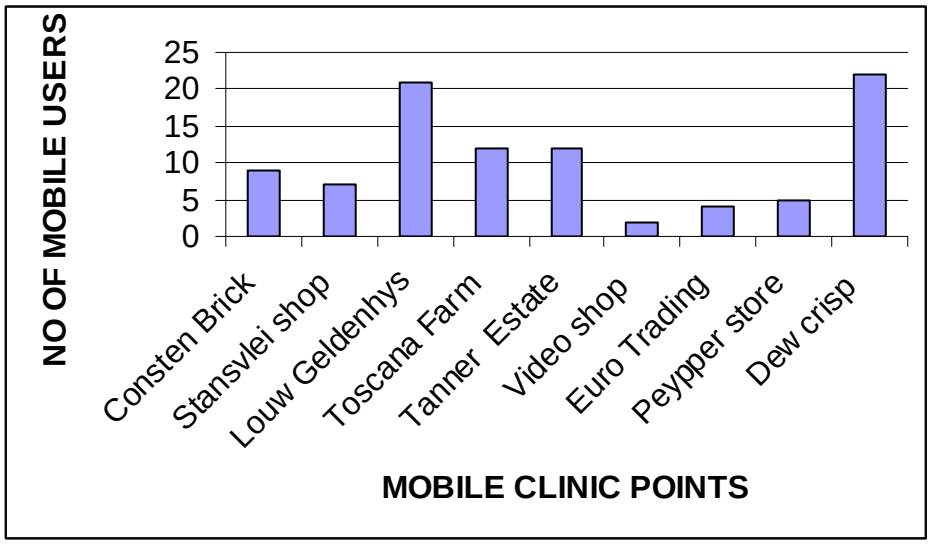

Figure 4.1 Muldersdrift mobile clinic points and the number of service users interviewed.

4.1 Data Analysis Approach

Descriptive statistics were used to summarize, organize and present data. The collected interview schedules were categorized according to the mobile clinic points numbered. Interview schedules were then checked that all the questions were answered and that the responses were filled in the appropriate places. The interview schedules were then coded, data entered on Microsoft excel software and analysed using the Statistical Package Stata 7.0 in consultation with a statistician. Findings of this study relate to the research objectives, which guided the research process.

4.2 Discussion of Findings

The findings are presented in four sections according to those on the interview schedule.

4.2.1 Section A: Demographic data

Section A presents demographic information of the respondents. Demographic data consisting of the following variables: list of all the mobile points, age, gender, employment status and level of education of participants were collected and analysed to determine the characteristics of the community under study.

4.2.1.1 Age and sex distribution

Table 4.1 illustrates age and sex distribution of the respondents. The mean age of the respondents was 36.6 years. Most of the respondents (42.5%) were between the ages 19 and 30 years and twenty-one respondents (22.3%) were between 31 and 40 years. Eighteen respondents (19.1%) were between 41 and 50 years. Respondents whose ages were between 51 and 60 were fifteen in number (15.9%). The majority of the respondents interviewed (80.8%, n = 76) were females while only 18% (n = 19) were males.

Table 4.1 Age and sex distribution of the respondents (n = 94)

Gender	**Age distribution**				
Females 76	30 years or less	31 – 40 years	41 – 50 years	51 – 60 years	Total
Males 18	40	21	18	15	94

The findings from the study are a true reflection of the situation in majority of the rural areas. Women are the ones who are easily accessible as most of them are the one who head the family. They are also employable as domestic workers and farm labourers as men migrate to urban areas in search of work.

4.2.1.2 Employment status

Respondents were asked to state their employment status. The majority of the respondents (87.2.1%, n = 82) were employed, while only 13% (n = 12) were unemployed. Results on employment status are only representative of the mobile clinic users. Table 4.2 illustrates the categories of workers interviewed. The majority of the workers 76.8% (n = 63) are farm workers. Only one respondent was found to be self-employed. Of the six respondents classified as “other”: four were waitresses at a hotel and two were security guards.

Table 4.2 Categories of workers interviewed (n = 82)

Categories	Frequency	Percentage
Farm Workers	63	77%
Domestic workers	5	6%
Self employed	1	1%
Factory workers	5	6%
Road works	0	0
Catering	2	2%
Other	6	7%
Total	82	87%

4.2.1.3 Level of education

Respondents were asked about their level of education. Respondents were assisted in interpreting their level of education according to the new South African system of

classifying the level of education “Grades”. Findings indicate that 22.3% (n = 21) had never attended any type of schooling. Sixteen percent (n = 15) attended school up to grade 4. A further 27 (28.7%) respondents attended school up to grade 8. A greater percentage of the sample interviewed (31.9%) (n = 30) school attendance ranged between grade 9-12 and one respondent had a certificate in catering.

The findings indicate that accessing education in some rural areas of South Africa is still a problem, since almost a third of the mobile users’ in Mulderdrift did not have any form of schooling. The results are congruent with results of the Population census (2001), which determined that a third of the population in Limpopo had received no education. However, there are positive signs compared with the 1996 Population census figures, whereby almost 20% of adults had received no education at all.

Table 4.3 illustrates the level of education of the respondents in the study.

Table 4.3 Education level of the respondents (n = 94)

Level of education	Frequency	Percentage
Never attended school	21	22%
Grade 1-4	15	16%
Grade5-8	27	29%
Grade 9-12	30	32.%
Certificate	1	1.%
Total	94	100

The results of the demographic data analysed are a true reflections of a typical rural area were majority of the people are farm workers and mainly women. Due to lack employment opportunity even people who had 12 years of schooling work as farm labourers.

4.2.2 Section B: Utilization of the mobile clinic service and other resources

In this section five questions were asked to assess the level of service utilization of the mobile clinic and other resources available in the community by respondents in the quest for having their health needs met.

4.2.2.1 Frequency of clinic visits

Respondents who have attended the mobile clinic within the last six months were asked to state the number of times they had utilized the mobile clinic service. Out of the 94 respondents interviewed over half of the respondents 59% (n = 55) stated that they had utilized the mobile services more than three times. Seventeen percent (n = 16) utilized the mobile services thrice and 24% (n = 23) twice over the past six months. Figure 4.2 illustrates the frequency of utilization of the mobile clinic over the past six months.

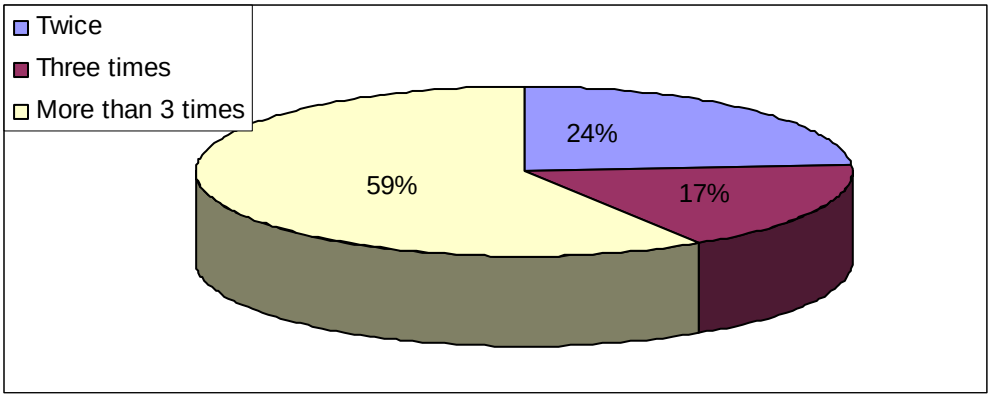

Figure 4.2: Level of mobile clinic services utilization

Further analysis of the clinic attendance results was done to establish relationship between service utilization and gender. The results from Table 4.4 revealed 61.8% females had utilized the mobile clinic service thrice as compared to the 44.4% males. The results are consistent with fact that in the farm labour setting, more females are employed as compared to the males. Females are the one's who are likely to consult for early development of a health care problem, bringing a child to the well baby clinic and utilization of services such as the family planning programme. The results are also congruent with Pindani (2001) findings, the majority of females (58%) had utilized the health service. However the relationship between gender and utilization of health care services cannot be confirmed as more males (33.3%) used the service twice as compared to 13.1% of the females in the study.

Table 4.4: Description of relationship between sex and clinic visits

Sex	Twice	Thrice	More than Thrice
Females (n76)	25% (n=)19	13.1% (n=10)	61.8 (n=47)
Males (n=18)	22.2% (n=4)	33.3% (n = 6)	44.4% (n=8)

4.2.2.2 Reasons for not using the mobile clinic service

A follow up question asked the respondents if there was a time during the last six months that the respondent or member of the family got ill and could not attend the mobile clinic. Seventy-seven percent (77%, n =72) stated that it has never happened that the mobile services were not utilized despite the fact that there was an indication for using it. Of the 22 respondents who did not use the mobile service, two respondents (11.7%) stated that they were too sick to come. Four respondents (23.5%) stated that the services that they needed were not available on the mobile. One respondent (5.8%) stated that the reasons for not utilizing the service was to avoid being shouted at by nurses as earlier on he had been drinking alcohol and was intoxicated. The extent of alcohol use in this community is not yet established. The possibility could be that it is high. This could be related to the fact that in rural areas, community member brew their own alcohol. Kishchuk, Peters, Towers, Sylvestre, Bourgault and Richards (1994) conducted a formative and effectiveness evaluation of a worksite programme promoting health alcohol consumption in Montreal, Canada. The findings were that despite the fact that there was lack of interest in the topic, the programme was effective in promoting socially responsible attitudes and reducing self-reported weekly consumption among participants. The conclusion was that worksite alcohol health promotion programs could be effective.

Other reasons for not utilizing the mobile clinic are as follow: Four respondents (23.5%) stated that they did not go to the mobile clinic because they did not need the services of the mobile clinic for their health problem. Other reasons recorded from

each of the five respondents were that, they preferred to go to the clinic, to the hospital or utilize services of general practitioners. Two respondents said they had forgotten the date of when the mobile clinic service will be rendered in their area. Five respondents did not give reasons for not utilizing the mobile clinic service.

4.2.2.3 Alternate sources of treatment

To establish the preferred method of managing their health problems, the respondents were asked to choose from a list of alternate source of treatment. In Table 4.5, the left column illustrates resources utilized on the day that the mobile services were not regarded as being necessary. On the right side of the column is resources utilized on the day that the mobile was scheduled to arrive but failed to do so.

Table 4.5: Alternate sources of treatment

Management of health problem	Mobile clinic came but service not utilized (n=14)	Mobile clinic not scheduled to come and health service needed (n=63)
Self treatment	7.1% (n = 1)	7.9% (n = 5
Used medication at home	28.5% (n = 4)	3.2% (n = 2)
Bought medication	7.1% (n = 1)	4.8% (n = 3)
Muldersdrift Health Care Centre	14.2% (n = 2)	41.2% (n = 26)
Traditional healer	7.1% (n = 1)	0% (n = 0)
Community health worker advice.	0% (n= 0)	0% (n = 0)
General Practitioner	14.2% (n = 2)	17.4% (n= 11)
Private nurse practitioner	0% (n= 0)	4.8% (n = 3)
Other	21.4% (n = 3)	20.6 (n =13)

The findings indicate that 42.7% (n = 6) respondents who did not use the mobile service, preferred to treat themselves at home with medication that they already had, or had bought from the chemist. Fourteen percent (14%, n = 2) preferred to go to the general practitioner. The results are congruent with the results of a study conducted by Khe et al (2002). Their findings indicate that the use of self treatment was common practice and that private providers were regarded as an important source of health service not only for those who are better of, also for poor households.

Twenty-six respondents (41.2%) who needed health care when the mobile was not scheduled to come to the area preferred to go to the MHCC. Niger (2001) conducted a study investigating factors responsible for poor utilisation of the PHC services in a rural community in Nigeria. The findings from the results were that the cause of non-attendance of the available services included the high easy access to traditional healers (39%). However, the findings from the above table indicate that only seven percent from the group that the mobile clinic was not the preferred service, admitted to the fact that they consult traditional healers for their health problems. From the researcher's observations in rural areas traditional healer's services are available and easily accessible. In a study conducted by Pindani (2001) more than half of the respondents (52%, n = 51) stated that they went to the traditional healers for treatment. Respondents stated that they preferred traditional healers as they were nearer to their homes. Traditional healers always informed them about what was wrong and the treatment options available. In both groups (21.4%, n = 3), and 13% (n =13) respectively respondents indicated that they used other sources. All three participants in the group who did not use the mobile clinic service said they decided to

go to the hospital. In the other group, seven respondents out of thirteen decide to go to hospital and five respondents never gave information on how they dealt with the health problem.

It can be concluded that the mobile clinic is a well utilized PHC service as more that 50% of the respondents had utilized the service more than three times within a period of six months. It was also noted that only a quarter of the total number of respondents (n = 22) admitted to not using the service despite the fact that there was a health need. Self-treatment and utilization of the MHCC were the preferred means of having the health problem addressed.

4.2.3 Section C: Mobile clinic users' knowledge of available services

Section C presents data on the respondents' knowledge of the range of PHC services available on the mobile clinic and additional services needed. Six questions were asked. Data yielded the following findings:

4.2.3.1 Knowledge of mobile clinic services

Respondents (n = 94) were asked if they had the knowledge of the services offered at the mobile clinic. Eighty-four respondents (89.3%) stated that they knew all the services offered on the mobile clinic and ten respondents (10.6%) knew some of the services offered.

4.2.3.2 Knowledge of the types of services

Respondents were requested to name the services that they knew were available on the mobile clinic. Table 4.6 presents the types of services and the frequency of the responses in relation to knowledge of such services.

Table 4.6: Knowledge of type of services

NAME OF SERVICE	FREQUENCY	PERCENTAGE
Well baby clinic	86	91.4
Family planning service	89	94.6
Treatment of common ailments	92	97.8
TB Treatment	45	47.8
Antenatal Clinic	51	54.2
Chronic diseases care	74	78.7
HIV & Aids Counseling and testing	18	19.5

It was noted that almost all respondents (97.8%) were aware of the availability of treatment of minor ailment service. Other services that the respondents were well aware of are the well baby clinic and the family planning service which were known by 86 (91.4%) and 89 (91.4%) respectively. Services that the respondents were less aware of included the management of Tuberculosis and HIV and AIDS testing and counseling services. Lack of knowledge of these services is of concern as the Government of South Africa has massively increased the budget for its 2000 -2005

plan in controlling the diseases through early detection, providing treatment and care and support for those infected and affected.

The findings of this study are congruent to those obtained by Pindani (2001). The results from Pindani's (2001) study indicated that the treatment of minor ailments service was well known to majority of the respondents and the less known service is a service that has a health education component which is the HIV/AIDS counseling service. According to Holloway (1996), people need to know about the health care services offered in their areas in order to make use of them and assume responsibility for their own health. Lack of knowledge of available services on the mobile clinic can result in under-utilization of the services. Table 4.7 is a description of service utilization levels among the respondents who knew all the services and those who knew some of the services. It was noted that high levels of services utilization were associated with knowledge of all the services offered on the mobile clinic.

Table 4.7: Relationship between knowledge of service and clinic utilization

Utilization of service	**Knowledge of all (n=84)**	**Knowledge of some (n=10)**
Thwice	22.6% (n=19	40% (n=4)
Thrice	17.8% (n=15)	10% (n =1)
More than thrice	59.6% (n=50	50% (n=5)
Total	100 % (n=84	100% (n=10)

The findings from a study by Swaddiwudhipong et al (1995) were that the increased proportion of women who knew about the Pap smear test led to an increase in the proportions of women screened for cervical cancer from 19.9% in the first survey to 58.1% in the second survey sample. Well baby service was well known as compared to findings obtained in Columbia by Galwan, Wolff and Sturgis (in Pindani, 2001). The findings indicated that a large gap of knowledge in women concerning the under five-health care services. The results from Pindani's study (2001) also indicated that there was no relationship between respondents' knowledge of the services and utilization of such services. In this study knowledge of the availability of the services did have an influence on utilization of the services. Four respondents (23.5%) did not utilize the mobile services because they knew that the services that they needed were not available.

Findings from a study on women's views of a breast cancer-screening programme were that women demonstrated altruistic concern for other women who are currently excluded from the screening programme because of lack of knowledge of the available services. Women interviewed suggested that the services should be advertised more widely and that more detailed information before and after screening should be made available (Hamilton et al, 2003).

From the above it can be concluded that majority of the mobile clinic user's knew all the services provided and the well known is the treatment of minor aliments service. The other two well known services are services utilized mainly by women. The two services are the family planning clinic and the well baby clinic. It was also discovered

that knowledge of all the provided services has a positive influence on the frequency of utilization of the service.

4.2.3.3 Additional services needed

Respondents where further asked if they thought all these services offered by the mobile clinic are needed by in their community. All the respondents (n=94) 100%) indicated that all the services mentioned were needed. A follow up question was posed to elicit whether there were additional services needed by the community but not offered on the mobile. Twenty-seven respondents (28.7%) expressed the need for additional services. Two respondents mentioned the need for of elderly service and home visits for those who cannot come to the mobile clinic. From three respondents each mentioned a need for, X-ray facilities, eye care and a service for the people with mental health problems. Eight respondents (29.6%) mentioned the need for HIV/AIDS testing and counseling service. Eight more respondents (29.6%) suggested there should be health information talks given from the mobile clinic especially information related to the availability of TB treatment on the mobile clinic. Six respondents (22.2%) did not give the specifics of the services to be added. What was expressed is a need to provide more services, including having all the medications needed by the community.

It can be concluded that the range of services offered are well known and appropriate and suggestions were given on the services to be added to the mobile clinic.

4.2.4 Section D: Satisfaction with the services

This section consisted of mostly open-ended questions. Twelve questions were asked to determine the level of satisfaction with the services and management of health problems presented. Satisfaction with the service times, frequency of the mobile clinic visit and the attitude of the staff were also explored.

4.2.4.1 Level of satisfaction with the services

Respondents were asked if they were satisfied with the range of services provided on the mobile clinic. All most all respondents (98.9%, n = 93) were satisfied with the range of services offered on the mobile clinic. The respondent who expressed dissatisfaction with the range of services stated that nurses prescribed “Disprin” tablets for treatment of all health problems. A follow up question was asked to determine which services respondents were most satisfied with and the reason(s) for their satisfaction. Table 4.8 illustrates the services that the respondents were most satisfied with. The respondents were most satisfied with the following services: treatment of minor ailments (22.6%, n = 21). Respondents stated that appropriate and effective medications were given for their health problems. The chronic care service was also rated as most satisfactory by 22.5% (n = 21). The availability of these services was rated as being most useful as respondents did not have to request time off from the employers to go to the clinic for monitoring and control of chronic health problems.

Table 4.8: Services most satisfied with (n = 94)

Name of service	Frequency	Percent
Well baby clinic	18	19.1%
Family planning	15	15,95%
Treatment of minor ailments	21	22.3%
TB treatment	2	2.1%
Antenatal service	1	1.0%
Chronic disease service	21	22.3%
HIV/AIDS Counselling and Testing	2	2.1%
All	10	10.6%
None	4	4.3%

Ten respondents (10.7%) were most satisfied with all the services that are offered on the mobile clinic as compared to 3.2% (n = 4) that indicated that there were no services that they were most satisfied with. They stated that the quality of all the services were the same and acceptable to them.

A follow-up question was asked to determine services the mobile clinic user's were least satisfied with. Respondents were requested to tick all the relevant answers. Seventy-seven respondents (81.9%) stated that there are no services that they were least satisfied with. Of the services that 17 respondents stated that they were least satisfied with treatment of minor ailments had the highest rating (5.3%, n= 5). Prescriptions were based on the history taking only. Physical examination and diagnostic tests especially urine testing and measuring of blood pressure was seldom

done. Unavailability of medications is one of the reasons given for dissatisfaction. Table 4.9 illustrates services that respondents were less satisfied with.

Table 4.9: Services least satisfied with (n = 17)

Name of service	Frequency	Percent
Well baby clinic	1	1%
Family planning	3	3.1%
Treatment of minor ailments	5	5.3%
TB treatment	1	1%
Antenatal service	2	2.1%
Chronic disease service	4	4.2%
HIV/AIDS Counselling and Testing	1	1%
None	77	81.1%

4.2.4.2 Level of satisfaction with the service times

Respondents were asked to state if they find the day and times of offering the mobile clinic service convenient. Eighty-nine respondents (n = 94.7) and 93.6% (n = 88) expressed convenience of service with reference to time and day of service delivery. Six respondents (6.38%) who were dissatisfied with the day and time of service delivery mentioned that, the mobile clinic comes during lunch time. Time available time is insufficient for proper consultation and for their meal time and rest. A follow up question was asked on satisfaction with the mobile clinic service rendered once a month. More than fifty respondents (57.4%) were satisfied that the once a month mobile clinic as the service was mostly needed for once a month health needs. Forty-

six respondents (48.9%) indicated that they were not satisfied with the mobile service offered once a month. Thirty-seven respondents (77%) indicated that they preferred that the mobile service be rendered at least twice a month, 16.7% (n = 8) suggested that the service be available at least three times a month. Two respondents (4.1%) suggested once a week. Only one respondent stated that he would like to see the mobile clinic service offered at least three times a week. Figure 4.3 illustrates preferences on frequency of mobile clinic visits.

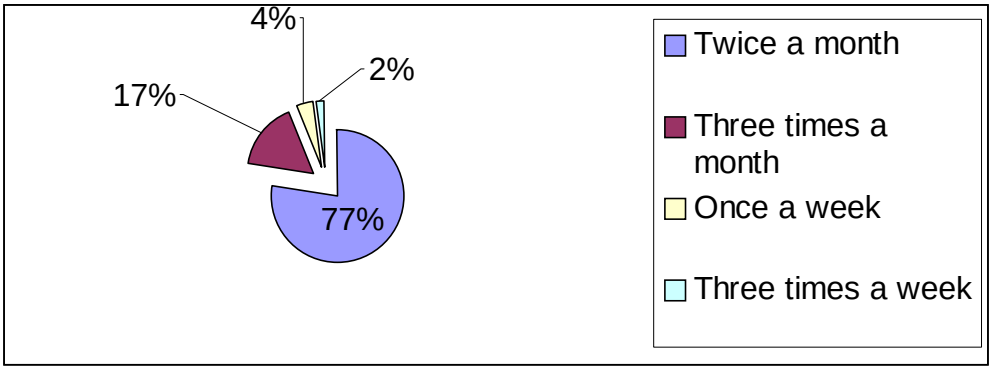

Figure 4.3: Number of clinic visits preferred by mobile users

4.2.4.3 Attitude of the staff

Mobile clinic users were asked to state their opinions with regards to the attitude of the mobile clinic staff toward them. They were required to choose from a scale of bad, good and excellent. Figure 4.4 illustrates the responses given.

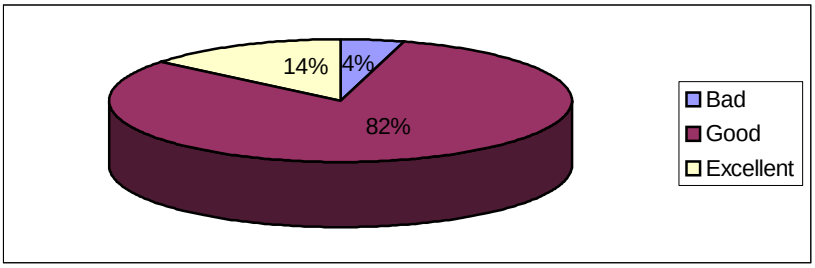

Figure 4.4: Attitude of staff to the community (n = 94)

Four percent of the respondents (n = 4) described it as excellent. Eighty one percent (n = 74) of the respondents indicated that the attitude of the staff was good and 4.4% described it as bad. Respondents were further asked to comment on whether they think everyone was treated equally at the mobile clinic. Eighty-five respondents (90.4%) stated that they think everyone was treated equally. Of the 9.6% (n = 9), five stated that it depends on the nurse on duty. Four respondents gave examples of staff members shouting at them, and people treated according to their status in the community.

4.2.4.4 Satisfaction with management of health problems

To establish satisfaction with management of health problems, respondents were requested to think about the last time that they utilized the service and comment on their opinions on how their health problem was managed. Eighty-nine respondents (94.6%) stated that they think they were satisfied as compared to 5.3% (n = 5) who

were dissatisfied. Respondents were asked if they had any problems with the mobile clinic service. Of the 94 respondents, 11.7% (n = 11) stated that they actually do have problems with the mobile clinic services. According to Gogorcena et al (1992) the quality of health services include logistic elements among others simplicity of paperwork. Four respondents stated that they were refused treatment due to failure to produce a family planning card. Other problem raised were the fact that most of the time there was a shortage of medications on the mobile clinic. Two respondents mentioned a concern related to privacy and that a mobile vehicle with bigger space should be used. Lack of shelter for patients waiting to be seen was also mentioned as one of the problems with the mobile clinic. Despite the fact that 11.7% (n = 11) of the respondents indicated that they have other problems with the mobile health care services, one respondent described the service as being excellent. Ninety three percent of the respondents (n = 87), overall opinion of the mobile clinic was that it provided a good service. The service was described as a useful and good quality service. Respondents stated that the mobile reaches out to where the people are. *"I used to have dizzy spells, now I am okay" "I am feeling much better since I started using medication from the mobile clinic" "My blood pressure is controlled now*" these were some of the responses from mobile clinic service users.

Gilleard and Reed (1998) state that satisfaction with care provided should be seen as a multidimensional phenomenon in which patients may be satisfied with some aspects of their care and be dissatisfied with other aspects. Findings from a study conducted by Hamiton et al (2003) on women's views on mobile clinic breast screening service, staff was reported to be efficient, caring and helpful. The findings from this study are congruent with results of a study conducted by Ramsey, Edwards,

Lenz, Odom and Brown (1993) on types of health problems and satisfaction with services in a rural nurse-managed clinic. The results suggested that family nurse practitioners were providing effective and satisfactory health care for this rural community. Client satisfaction rate with nurse practitioner-managed care was highly rated by 97% (n = 101) of the subjects in a random sample telephonic survey. According to Lombard's model (1992) in Jagananen and Kortenbout (1999) the community members themselves are in the possible position to identify their own needs and problems and to see to the satisfaction of their needs and to solve the problems.

4.3 CONCLUSION

This chapter described the analysis of the research data and the findings of the study. The last chapter summarizes the study and describes the main findings of the study. Recommendations for improvement of provision of the mobile service are presented.