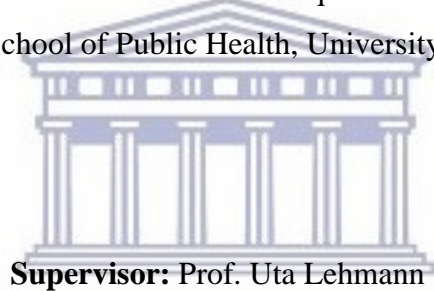


# **Exploring the clients' experience of Primary Health Care services prior to and post the implementation of appointment systems in City Health Clinics, Western Cape, South Africa**

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A mini-thesis submitted in partial fulfilment of the requirements for the degree of Masters in Public Health at the School of Public Health, University of the Western Cape



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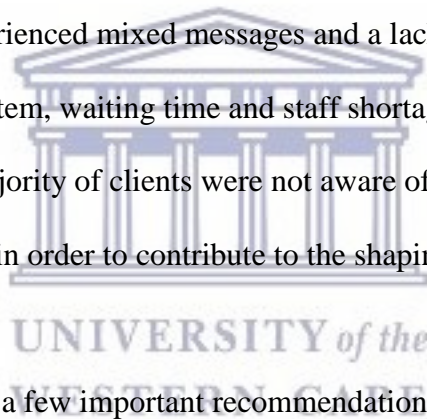
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## **Abstract**

Long waiting times have, for many years, been synonymous with primary health care in South Africa, and this is evident by the long queues and consistent client dissatisfaction. There are multiple contributing factors that exacerbate waiting time in Primary Health Care (PHC) facilities such as shortage of health care providers, increase in the uninsured population and South Africa's quadruple burden of diseases. Health establishments have initiated numerous strategies to reduce long waiting times with varying degrees of success. These strategies have mostly been quantified and linked to indicators to measure their level of success in relation to quality healthcare. This research explores the clients' perception of one such intervention, which is the implementation of an appointment system in primary care facilities in the City of Cape Town.

Qualitative, exploratory descriptive methods were used to gain understanding of the impact the appointment system has had on the clients' experience of attending health care services. The researcher also explored how clients perceive their role with regard to the shaping of their clinic's appointment system. Semi-structured in-depth interviews were conducted with fifteen purposively sampled clients from five City Health clinics, who have implemented an appointment system through the guidance of the Appointment System Learning Initiative (ASLI). Maximum variation in sampling ensured the inclusion of small, medium and larger facilities within different geographical settings. Data analysis was done using a thematic coding approach, the themes were derived from the emerging data and were used to guide the researcher in gaining a rich picture of the clients' experiences within the clinics. Ethical approval was requested and received from both the University of the Western Cape (UWC) and City Health prior to engaging any participants.

The results of the study confirmed some of the anecdotal information available in this arena. The study found that facilities were differing in context, populations they served, staffing and appointment modalities implemented, and in line with the intent of the Appointment System Learning Initiative (ASLI) different appointment modalities were used across and even within facilities. Facilities in this study appeared to have adapted various appointment system modalities across programmes or services, which caused confusion and dissatisfaction. Furthermore, the research highlights a link between waiting time, client satisfaction and quality of care when considering an appointment system. Just over half of the clients interviewed felt there was no value and benefit in an appointment system. Clients attending smaller facilities noted that the service they received prior to the ASLI was satisfactory, and clients in larger facilities experienced mixed messages and a lack of communication regarding the appointment system, waiting time and staff shortages by facility staff. In terms of advocacy platforms, the majority of clients were not aware of any health committees or fora they could participate in, in order to contribute to the shaping their appointment system.



The findings have highlighted a few important recommendations from the clients for the health care services which pertains to the quality of an appointment system and an improved communication strategy. Clients have to form part of the discussions when conceptualizing and implementing the system, either by way of health committee or a community dialogue process in the absence of an operational health committee.

## DECLARATION

I declare that, *Exploring the clients' experience of Primary Health Care services prior to and post the implementation of appointment systems in City Health Clinics, Western Cape, South Africa*, is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full name: René Liezel Sparks

Date: 08 November 2018

Signed: 



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## ACKNOWLEDGEMENT

Firstly, I have to give thanks to the Lord, God Almighty, who has truly carried me and given me the strength, patience, endurance to complete my MPH despite all the challenges over the period of this course.

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A huge vote of thanks to the City of Cape Town, City Health facilities and the community members who participated in the study. I could not have pursued this study without support from City Health and participation from community members. I hope that these findings will act as a voice of the community and aid City Health in reshaping their appointment system to improve quality of care.

I would like to acknowledge my husband, Clarence and my daughter, Bethyn for their support and sacrifice of quality time as a family, in order for me to envisage my goal of completing my course. This acknowledgement extends to my Sparks/Smidt and Kearns Families – thank you for all your support, love and understanding.

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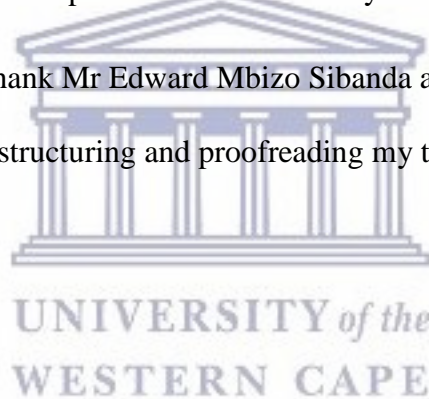
enough, may you be blessed for your sacrifice, love and patience. Your input was so valuable, without it I would have been lost.

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Furthermore, I would like to thank Mr Edward Mbizo Sibanda and Mr Efraim Oppelt for their valuable input into the restructuring and proofreading my thesis. Thank you for your time and attention to detail.



## **DEDICATION**

I would like to dedicate this work to my late Dad, who passed away April 2016. This dark period was made lighter by knowing that you supported me 100%. The learnings and principles you embedded bear fruit daily from both Morné and myself. You are missed daily as you were my rock, my strength and my true sounding board. Blessed to have you in eternity.



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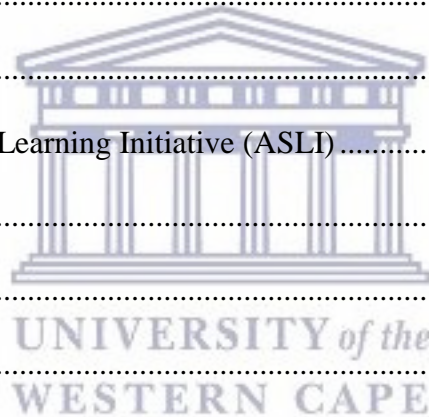
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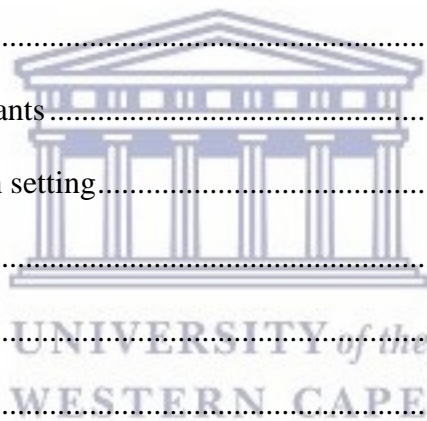
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## **Glossary of Acronyms and Abbreviations**

ART	Anti-retroviral Therapy
ASLI	Appointment System Learning Initiative
BANC	Basic Antenatal Care
CCT	City of Cape Town
DoH	Department of Health
FMs	Facility Managers
FP	Family Planning
HAST	HIV/AIDS, STIs and TB
HCP	Health Care Providers
ICRM	Ideal Clinic Realisation and Maintenance
IDP	Integrated Development Plan
LMIC	Low-middle income countries
MDHS	Metro District Health Services
MHS	Metro Health Services
NCS	National Core Standards
NDoH	National Department of Health
NHI	National Health Insurance
ODTP	Organisational Development Transformation Project
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PPHC	Personal Primary Health Care
QA	Quality Assurance
SMS	Short Message Service

SRH	Sexual Reproductive Health
SOPH	School of Public Health
TB	Tuberculosis
UWC	University of the Western Cape
WC	Western Cape
WCG	Western Cape Government
WHO	World Health Organisation



## **Chapter 1**

### **1.1 Introduction**

This chapter describes the background to the study, the setting, the problem statement, the purpose and outline of the thesis. This allows the researcher to introduce the study and for the reader to join the journey exploring the clients' perceptions of the Appointment System Learning Initiative (ASLI) within the City of Cape Town.

### **1.2 Background**

The City of Cape Town is a municipality within the Western Cape, which among its responsibilities has a caring component or pillar. This caring component is operationalized by 'City Health', who is mandated to render primary health care (PHC) services to the uninsured population within the Cape Metro.

World Health Organisation (WHO) (1978) defines Primary Health Care in the Alma Ata Declaration, as “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 forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community”.

Historically, City Health was associated with health promotion and preventative services, but due to growing needs and burden of disease, the health services have since evolved to include selected curative services. The nature of services and the population City Health originally served, meant it could initially render a 'first come, first serve' service. The increase in uninsured population, migration in search of employment opportunities, increased co-



morbidity within disease profiles and compliance regulations has forced City Health to reconsider the implementation of waiting time reduction strategies, which included fast lane for wellness and ‘one stop shop’. Fast lane refers to separating Family planning or immunization clients, who are seen as “non-complex” clients and dedicating a staff member to providing their services to them in a more streamlined and effective approach. Whereas the “one-stop-shop” method refers to all nursing staff seeing a variation of clients and having the ability to provide all the care they require within the same room. Various City Health facilities have over two decades attempted to implement appointment systems with the aim of decreasing bottlenecks, long waiting times and client dissatisfaction with clinic services and allowing staff to manage consultation times more effectively in order to render quality PHC services. None of these attempts generated sustained success (Lembani & Lehmann, 2017).

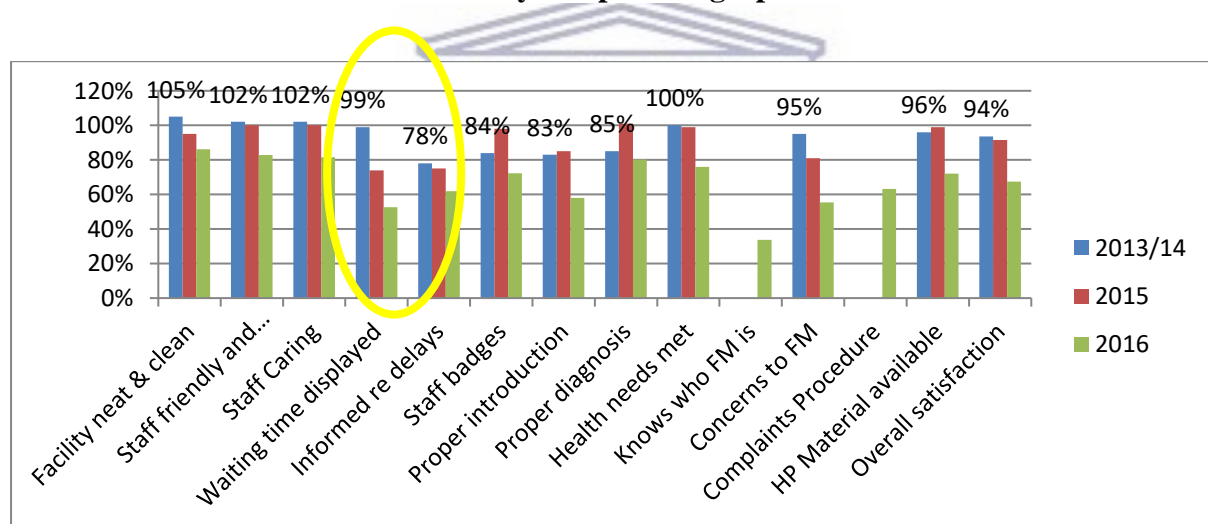
Long waiting times have been associated with public health service in South Africa for many years. Eilers, et al. (2004) and Fomundam, et al. (2007) highlight that waiting time is a significant aspect and predictor of client satisfaction, thus corroborating the link between the waiting times and client satisfaction, and illustrating its connection to quality of care. This link can be noted in Figure 1, which illustrates client satisfaction being monitored by determining satisfaction with waiting time and communication among the elements for quality of care.

PHC services are governed by National, Provincial and local health policy and as a result, City Health has to comply with the quality assurance requirements and legislative framework. The Health system of South Africa has more recently implemented two quality assurance programmes, both of which, amongst other things, require PHC facilities to implement an effective appointment system to meet the needs of the community as part of quality assurance assessments: National Core Standards (NCS) and Ideal Clinic Realisation and Maintenance (ICRM) (South African Government (2011); National Department of Health (2013)). Health

Facilities are rated according to their level of compliance to the minimal health standards, and if no appointment system is noted, a negative score is allocated to the facility. The programmes dictate that six-monthly client satisfaction and waiting time surveys are required to meet the standards, linked to quality of care.

City Health facilities are not immune to long waiting times and have as a result of NCS and ICRM commenced six monthly waiting time surveys<sup>1</sup>. City Health has benchmarked a standard waiting time of 90 minutes. However, this was not met according to the discussions with two Primary Health Care Programme Managers, which can be viewed in Table 1, page 9 of this document.

### Sub District Client Satisfaction survey comparison graphs 2013/14 - 2016



**Figure 1: City Health Client Satisfaction survey 2013/2014**

Figure 1 illustrates that the waiting times displayed and clients informed regarding delays, steadily declining over the 3 years. This graph is shown here to visually depict the

<sup>1</sup> City Health have attempted to determine the level of client satisfaction over the years, but this was not always measured in a uniform manner and thus results are difficult to compare. The graph in figure 1 is presented here solely for illustrative purposes.

relationship between waiting times and client satisfaction surveys within one Sub District within City Health.

### **1.3 The Appointment System Learning Initiative (ASLI)**

City Health facilities have attempted to implement an appointment system on numerous occasions in the past 10 years (Lembani & Lehmann, 2017). Success remained limited and systems not sustained until 2 years ago (2015), when one clinic managed to successfully establish an appointment system (Lembani & Lehmann, 2017). This had a catalytic effect, which sparked the interest of other PHC facilities to implement appointment systems in their clinics. The City Health Department, through the HIV/AIDS, STIs and TB (HAST) unit in collaboration with the School of Public Health (SOPH) at the University of the Western Cape (UWC), in 2015 initiated an appointment systems learning initiative (ASLI). The aim was to support interested health facilities with the implementation of appointment systems, in order to reduce client waiting times and improve both the clients' and staff experiences. Two interested health facilities were selected from each of the eight sub-districts in the City of Cape Town to participate in this initiative (Appointment System Steering Committee, 04/2016).

This initiative took a different approach from previous interventions, rather than providing detailed instructions, the aim of this initiative was to create a space for participating facilities to innovate and learn through the process, by sharing knowledge among the facility team members. ASLI sessions were a learning platform, which allowed peer support, engagement and sharing of experiences of appointment system implementation from a Health Care Provider (HCP) perspective. One facility manager went as far as interviewing a young mother (client) regarding her experience of the appointment system and shared it with all ASLI sites during one of the workshops (2<sup>nd</sup> ASLI Workshop, collated notes, 2016).

Two workshops were convened with City Health staff from the interested health facilities which included two facilities per sub district (management and facility level staff) and a UWC SOPH research team. The first workshop took place in May 2016, which served to introduce ASLI and create an environment for initial sharing of previous experiences of appointment system implementation and plan their respective appointment systems. Each participating facility was given the chance to strategize for the implementation of the appointment system, as it suited their operational needs and local contexts. This workshop created a unique opportunity for facility managers, support staff and management of City Health to engage and explore the barriers and enablers to implementing an effective appointment system (Lembani, M. & Lehmann, U., 2018).

The second workshop was conducted in November 2016. The aim was to enable facility teams to share their experiences of the implementation successes, challenges and lessons to assist them to improve on the design of their appointment systems. Through the guidance and facilitation by the SOPH and the HAST unit, it was noted that facility staff have been able to voice their concerns and best practices in order to shape their appointment systems and adapt variations of the system to suit their operational and community's needs (Appointment System Steering committee, 04/2016). The second workshop also allowed health facilities that did not form part of the initial ASLI to present their experiences since they learnt about the initiative. Observations by the researcher from the first workshop, highlighted the increased interest generated by ASLI, and health facility staff appeared motivated to overcome their challenges with regard to the implementation of the appointment system. PHC staff looked at innovative ways to realize their collective vision of reducing client waiting times within their respective facilities. The workshops allowed different cadre of HCPs to engage and share their views on implementation, their experiences since they

established their appointment systems, their challenges and their successes (Lembani, M. & Lehmann, U., 2016 & 2018).

The ASLI project was not limited to two workshops, but was further supported by monthly Steering Committee meetings, which drafted a conceptual framework for the project and allowed for very real, operational issues to be addressed and guided by HCPs and their management. Additional mobilization and motivation was generated by means of newsletters, created by the HAST unit, which highlighted PHC facilities and staff, who made significant strides in the implementation and establishment of their appointment system. These elements served as a form of social mobilization amongst PHC facility staff and fostered an iterative, learning process as it gathered momentum.

The ASLI was piloted to form a more supportive foundation to scaling up of the appointment system throughout all City Health facilities as per ICRM, NCS and subsequently. Its early focus on iterative learning and local ownership (which the ASLI Steering committee had estimated to take up to 3 years) was superseded in early 2017 by a shift to rapid scale-up as part of the City of Cape Town's Organisational Development and Transformation Project (ODTP). The City's ODTP is focused on quality service delivery, standardization and governance.

#### **1.4 Problem statement**

Appointment systems are a requirement for quality Primary Health Care services in South Africa (National Health Act 61 of 2003, amended 2010, Section 11). Therefore, the implementation of ASLI in City of Cape Town, City Health facilities, is a step forward towards achieving quality PHC services, especially reduction of client waiting times. Health facilities participating in the initiative have expressed some success in the implementation of

the appointment system during the second workshop. The ASLI allowed the City Health staff to express their views and experiences of appointment systems, either from their previous exposure to implementation or of current implementation to the greater workshop participants, UWC researchers and City Health management. However, the missing element throughout all these interactions, has been exploring of the perceptions of the end-users in these PHC facilities. There is no existing qualitative information regarding clients' experience of the appointment system and their perceived role in designing and implementing the appointment system.

### **1.5 Purpose**

This research study, which formed part of a pilot initiative, is focused on understanding how the appointment system has impacted on the clients' experience at five City Health clinics, across five sub-districts. The research explored aspects of the clients' perceived value added or any unintended consequences created by the ASLI, since its commencement. This research allowed clients accessing PHC services to voice their experiences of the appointment system in the City Health Clinics. This information will indirectly allow City Health to determine whether their appointment system addresses the client and community needs adequately.

### **1.6 The setting of the study**

The study was conducted in five Primary Health Care (PHC) facilities within the Cape Metro, Western Cape, South Africa. The Western Cape is unique in that it has two entities responsible for rendering PHC services to uninsured populations, namely: The City of Cape Town (CCT), a municipal entity and Metro Health Services (MHS) (previously known as Metro District Health Services, MDHS) which is a Western Cape Government (WCG) entity. CCT is mandated by WCG to render PHC services to predominantly women and children,

TB services and HIV services whereas the MHS has historically been more focused on curative services. This study was conducted in CCT PHC facilities, which implemented the ASLI project. The researcher has sampled small, medium and large facilities and included informal, peri-urban and urban settings within the Cape Metro.

The table below was derived from the discussions with two Personal Primary Health Care (PPHC) Programme Managers and presentation from two Sub Districts within City Health, which performed workload studies in 2016. The table illustrates the average headcount and minimum and maximum waiting times.

The information was taken from a discussion with Facility Manager of a small facility, a Primary Health Care Manager and the documentation of a Sub District Strategic plan for 2014 and 2016 respectively. The information varies from Sub District to Sub District, facility to facility as well as geographic area, but the averages for the two sub-districts within the City are depicted in the table below.

<b>Facilities</b>	<b>Headcount</b>	<b>Average Waiting time</b>
<b>Small</b>	3000	Minimum 10 mins – Maximum 180 mins
<b>Medium</b>	3001 – 5000	More 180 mins
<b>Large</b>	More than 5000	Minimum 40 mins to Maximum 311 mins

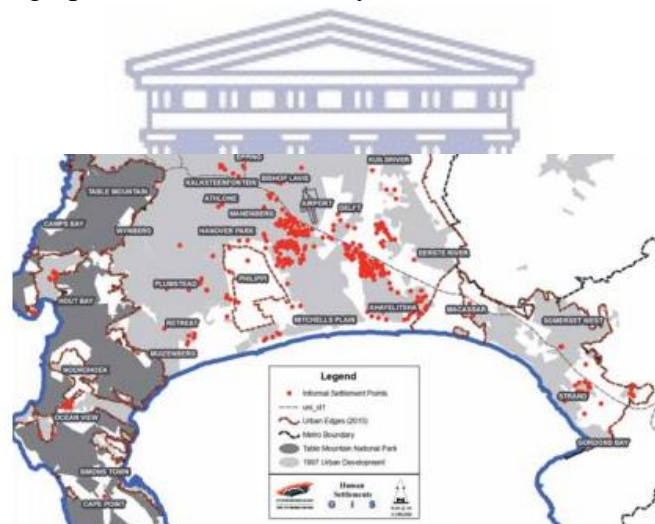
**Table 1: Depicting variation in size, headcount, staffing and waiting time provided by PPHC Managers of two sub-districts.**

The table above has provided information regarding the size estimation and waiting times experienced in each categorized health facility that was taken into consideration during this study. All participating PHC facilities were part of the ASLI and their input was reviewed via the workshop notes.



All the health facilities who participated in the study are located in areas of low social economic settings with high levels of unemployment, substance abuse, violence, poor housing and sanitation. The communities mainly consist of residents who were classified coloured and black African under Apartheid, and the PHC facilities are all part of the group areas act within the Apartheid regime, which enforced the geographical segregation of South Africans due to race and to this day, perpetuates inequity in access to quality health services and care.

The picture below has been included to visually illustrate the number of informal settlements within the Cape Metro, which highlights the inequities and contributes to the social determinants of this geographic area. Illustrated by the red dots (●)



● **Figure 2: Informal settlements within the geographical area City of Cape Town, IDP (2012 – 2017: 97)**

It is important to highlight that the appointment system may only be applicable to certain services (e.g. Family Planning, immunization, Anti-retroviral Therapy or TB) rendered within the facilities or all, depending on implementation strategy and operational support.



## **1.7 Outline of thesis**

Chapter 1 serves as an introduction to the study, followed by Chapter 2: Literature review which describes the research globally and locally with regard to appointment systems: waiting times, client satisfaction and quality of care. Chapter 3: Methodology, describes the qualitative method used, the sampling, collection and rigour used during the research. Whilst Chapter 4: Results unpacks the findings from the interviews with the clients. Chapter 5: Discussion, limitation and recommendations, is the final chapter of this thesis. It discusses the findings of the research, highlights the limitations and provides recommendations, which emerged from the clients and the researcher as a result of the interviews.



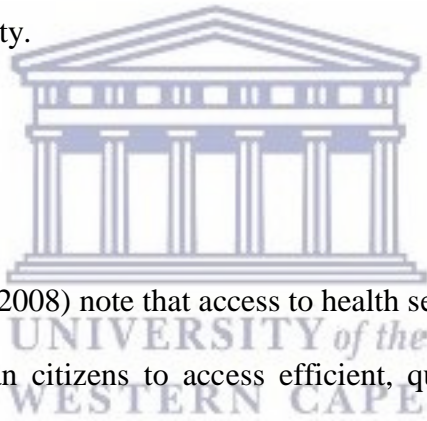
## CHAPTER 2

### Literature Review

#### 2.1 Introduction

This chapter covers the various appointment system modalities in relation to their impact on client satisfaction and waiting times, as well as highlighting the appointment system as an aspect of health care quality improvement, as part of quality assurance programmes in South Africa. It further describes the clients' perception of waiting times as explored through research. Lastly, it explores the improvement strategies linked to appointment systems and the role of community participation in the decision making of health services and how it relates to improved health outcomes, ownership of services and the transitions within the health sector and the community.

#### *Client-centred approach*



Batho Pele (1997) and WHO (2008) note that access to health services is a basic human right. The right of all South African citizens to access efficient, quality health care services is further stipulated in the Constitution of the Republic of South Africa (1996:13). The democratic right of citizens to participate in issues which have impact on their lives are expressed by Dennil, et al. (2003).

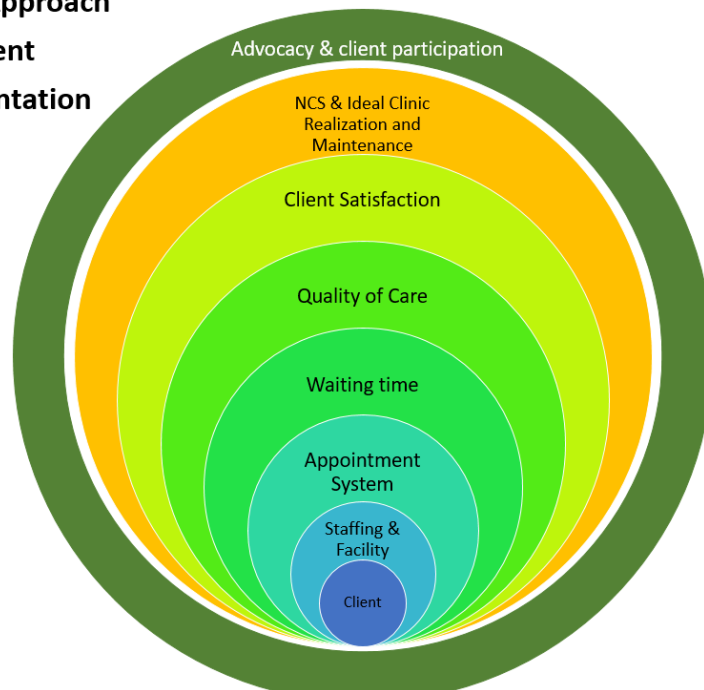
Globally there is a strong focus on client-centric approaches to health and integration of services, in order to streamline service delivery, decrease client waiting time and address bottle necks within the health facility. These approaches are envisaged to improve not only the quality of health services to the communities, but to improve the use of health resources to ultimately improve health outcomes. The researcher intentionally focused on research from low income settings, but notes that most of the literature available was from the high

income countries, highlighting a need for further studies regarding appointment systems within the developing world in order to contextualize and assert relevance in a unique South African context.

The diagram below aids the discussion points listed below and aims to keep the client at the centre of service delivery. It illustrates the dynamic or link between the client and the facility and staff, the appointment system facilitates waiting times, the perception of quality of care and the impact of quality of care experienced by the client. Lastly, it highlights how all those noted aspects link to National Core Standards and Ideal Clinic Realisation and Maintenance. Importantly the role of advocacy and participation from the community and the client in shaping their ideal appointment system, which reduces waiting time, increases quality of care and client satisfaction are highlighted.



**Client- Centred Approach  
to the appointment  
System implementation**



**Figure 3: Conceptual framework of study**

## **2.2 Appointment systems as a quality assurance measure**

There are numerous definitions of quality assurance (QA) linked to health care, but Donabedian (1980) describes quality of care as demonstrated by the balance between implementation of biomedical strategies and technology and its increase in benefit to the client with mitigation of risk. He further notes the high standards of quality equate to a positive equilibrium between the expected risks and benefits to the client. Simply put, the expectation of clients could be met with a monitored, balanced primary health care service, in which standards are measured and both community and staff actively participate in a quality improvement strategy to enhance care in the context required.

### *Appointment systems as a quality measure in the National legislation*

The National Health ACT 61 of 2003, amended in 2010, states in Section 11 (1:10) that a health facility must provide services to clients booked within “agreed timeframes” to promote access to treatment, thereby reducing delays to treatment and aiding in the prevention of any morbidity and mortality (South African Government, 2010). This basically legislated the need for health establishments to implement an appointment system to improve access and quality of health services.

The NDoH and Parliament of South Africa, have promulgated one quality assurance programme, National Core Standards (NCS) and adopted another parallel programme, Ideal Clinic Realisation and Maintenance (ICRM), which both address patients’ rights and access to health services (NDoH, 2011; NDoH, 2013). Among the strategies to improve quality and access to health facilities, these programmes advocate for the implementation and maintenance of an appointment system.

NCS has been promulgated and legislated as a national QA programme via the National Health Act, whereas ICRM is a National Department of Health (NDoH) initiative instituted by the former President, Jacob Zuma, based on Operation Phakisa. Operation Phakisa was introduced into broader industries such as fisheries, agriculture and health, to name but a few, to focus on a more streamlined approach to improving quality within the respective industry. The ICRM programme is described by NDoH as a step-wise strategy to improve and address the gaps noted in the South African public sector Primary Health Care (PHC) clinics (NDoH, 2018).

The QA programmes, as well as the Health Act, promote the implementation of an effective appointment system. Vissers (1979) describes appointment scheduling as a mathematical system implemented to manage the client load within a health facility, within a set timeframe and staffing capacity. Her study describes the complexity of finding the correct appointment system within the outpatient context, which benefits both HCP and clients. Vissers (1979), therefore, appears to be highlighting the need for a tailored approach to appointment scheduling and not a 'one size fits all' approach. Arbers (1982), Al-Dogaither, et al. (2000) and Engels, et al. (2005) similarly acknowledge that an efficient appointment system encourages more organized attendance and can be considered a good indicator of quality of care by both providers and consumers.

The ICRM manual, version 18, states that all PHC facilities should not only have a functioning appointment system but that all staff must be trained on how the appointment system operates. Each client must be given both a date and time and all folders must be retrieved a day before the appointment is scheduled (NDoH, 2018). This corresponds with the legislated QA programme, National Core Standards, which advocates in section 11 of the National Health Act 61 of 2003, amended 2010, that each client is entitled to an appointment when accessing a Primary Health Care (PHC) service. Both QA programmes appear to be

noting the appointment system as a client's right to accessing appropriate, quality health care (South African Government, 2010).

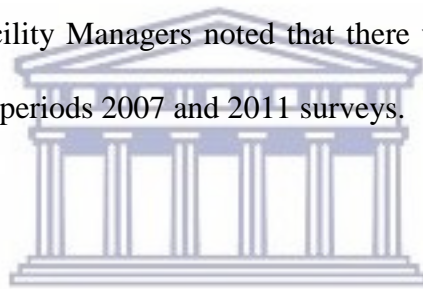
The NDoH released a National policy on patient waiting times in out-patient departments (2014), which serves as a guideline to PHC and clearly articulates the need for facilities to implement an appointment system, which allows for client and practitioner participation. It states that the appointment time should be agreed upon by both parties and should be staggered throughout the day and lastly, it should match the demand of communities.

The strong recommendation to implement and maintain an effective, quality appointment system requires regular evaluation of its efficiency and its applicability to the communities it services. This perpetuates the need for PHC staff to evaluate the client experience of the facility and the service rendered on a regular basis, which then links back to NCS and ICRM programmes, which both highlight the six-monthly assessments, the outcome of which serves, amongst other measures, to monitor and evaluate the quality of care.

Additionally, NCS and ICRM programmes both advocate for six-monthly client satisfaction and waiting time surveys to determine the quality of care and level of service delivery satisfaction from the end-user, the client (NDoH, 2011; NDoH 2013). The outcome of the two surveys, along with facility specific workload studies, depict a mainly quantitative picture of the situation within the health facilities at the time of assessment. Once all these quantitative assessments have been analysed, the health facility is then able to collectively work to improve the services based on the gaps noted from these surveys. It is recommended that the surveys be done independently, analysed and then discussed or conveyed to the community. Ideally, community members, facility staff (inclusive of civil society organisations) and clinic committees are envisioned, by the NCS and ICRM initiatives, to collaborate to draft an action plan to address shortcomings and then monitor performance until the next surveys occur (NDoH 2011; NDoH 2013).

It should be noted that not only quantitative results are of value in improving health care and that qualitative input can add huge value in understanding why some initiatives fail or succeed. Hart, (1995) discourages HCPs from only monitoring statistical data related to client satisfaction surveys and highlights the critical value and importance of including qualitative aspects to the survey to find richer information which could support quality improvement of the health system.

Daniels (2015) notes that when City Health instructed Facility Managers (FMs) to reduce waiting time, they were not prescriptive in this instruction, and FMs could therefore implement reduction strategies based on their experience and settings. Some of these reduction strategies included the introduction of appointment systems to specific services e.g. Family planning services. Facility Managers noted that there was a significant reduction in the waiting times between the periods 2007 and 2011 surveys.



### **2.3 Impact of waiting time on client satisfaction**

The previous section highlighted the link between clients waiting time, client satisfaction and the appointment system as a quality assurance measure. Cuevas et al. (2010) and Cayirli et al. (2006), concur that the clients' waiting time has a direct association with their level of satisfaction with clinical services, adherence to treatment and attitude towards both HCPs and health facilities. Dansky (1997) states that client satisfaction is an integral measurement of quality health care within a clinical setting; and Ramsaran-Fowdar (2008) further corroborates that client satisfaction and quality health care delivery is a key component in the strategic planning process and has been attributed to more well informed clients, which highlights the importance of communication and community empowerment. Dabale et al. (2015), states that quality health care and client satisfaction is integral to the relationship



between HCP and client.

Conversely, Deyo et al. (1980) note that patient dissatisfaction with health services may lead to patient drop out and missed appointments, which could have an impact on morbidity on the client side, but also add to inefficient workload and provision of services from the facility aspect. Deyo et al. (1980) further stated that patient belief, patient-provider interaction and organizational structure contributed to missed appointments and drop out but that this was less researched.

Dexter (1999) through his research within a High Income Country (HIC), links patient satisfaction to their perception of quality of care rendered by the HCP and that health services are evaluated not only by the actual HCP service delivery but by the time taken to render these health services. Bailey (1952) conducted his research in a HIC, noted that long waiting times create congestion in PHC facilities, negative client engagement and further, have the ability to culminate in poor job satisfaction of the HCP. Similarly, Huang's (1994) research in HIC setting, emphasizes that long waiting time in clinics is often the major reason for clients' complaints and dissatisfaction about their experiences of clinic visits and that it plays a vital role in the quality assurance of health services. In a study that looks at waiting times in eThekweni district, South Africa, where Sokhela et al. (2013), noted that participants associated long waiting times with poor services and conversely, shorter waiting times with quality health care. They further recommended the health care users be encouraged to attend the facility throughout the day rather than arriving all at once, thus recommending the implementation and maintenance of appointment systems (Sokhela et al., 2013).

In a client satisfaction survey conducted by Hill et al. (1992), in a specialized outpatient setting in a High Income Country (HIC), they noted that although clients indicated satisfaction with care provided, the long waiting time, barriers to accessing care without an appointment and continuity of care from same provider were major contenders for



dissatisfaction with health care services. Similarly, McMullen et al. (2013) through their cross sectional study within a HIC, in a specialized outpatient setting, noted that negative client satisfaction scores from client satisfaction surveys were linked to long waiting times, irrespective of the fact that health services were free of charge.

Davis et al., (1998) highlight the importance of waiting times even further, showing in their research that a client's perception of waiting time is a more critical indicator of quality of care than the measurement of actual waiting time. Research in a Low to Middle Income Country (LMICs), by Jooste et al. (2011) and Benjamin et al. (2011) highlight that the clients' perception of long waiting time are affected by the fact that health facilities appear overcrowded from very early in the morning, and further reinforced by the queues forming outside the facilities. Maister, (2005) argues waiting time becomes more acceptable if patients know how long they have to wait and waiting time is 'occupied'. This is echoed by Dansky (1997), who suggests that HCPs should fill the waiting time with health talks or updating the client regarding waiting times, shortage of staff or delays as this could reduce anxiety related to long waiting times and could still culminate in high client satisfaction rates within a health setting.

Thomas et al. (1997) noted during their research in a specialized oncology outpatient setting in a High Income Country (HIC), that HCP with a positive attitude made long client waiting time a secondary factor, they deduced that if clients considered the HCP service valuable they acknowledged extensive waiting time as a problem but were prepared to wait and their feedback related to high patient satisfaction despite the waiting time.

This is contradicted by Bleustein et al., (2014), by raising the findings from an outpatient setting with ambulatory beneficiaries, these findings highlight that client perception of quality of care when linked to longer waiting times are negatively associated with HCP services and that this negative perception then spills over into every aspect of the

consultation, it leads to poor rapport with HCP, decreased uptake of health information and poor communication between client and HCP from the start.

Limited information was available on which clients were engaged about the relevance of an appointment system in PHC settings, and even less was available on the perceived benefits or unintended negative consequences to the end-user. This study in a way will address the gaps identified in literature and contribute to the critical mass of literature about quality of care, waiting time and client satisfaction from a clients' perspective.

This study will be evaluating whether clients have noted an improvement in waiting time and are experiencing satisfaction with the health services within City Health since the implementation of the appointment system.

#### **2.4 Appointment system modalities**

Appointment scheduling systems are described by Harper et al. (2003) as an effective control mechanism to manage client waiting time. Clients are provided a specific date and time for consultation and HCPs are able to manage their workload and time more efficiently. There are many different models of appointment system implementation described throughout literature, mostly from a more high income country perspective. These include the queuing system which ranges from a one stop shop or fast lane approach; single block appointments; mixed method appointment and multiple-blocked appointments.

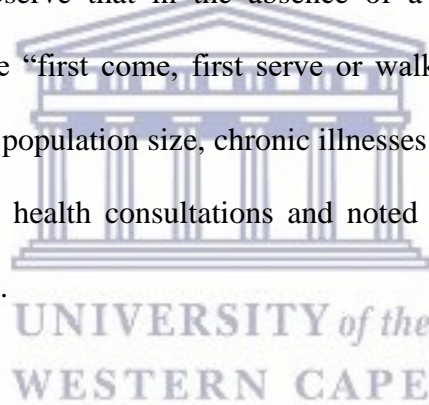
##### *Advantages or disadvantages of appointment systems*

Gupta et al. (2008), noted that multiple factors contribute to the performance of appointment systems, including arrival and variation in service time, preferences of the client and provider, and the level of experience of the staff.

### *Queuing system*

Palvannan et al. (2012) note that long client queues are evident in health care settings. They argue that the queuing system might work in some contexts but has limitations. These limitations can be linked to capacity, resources and arrival times of clients to the facilities (Palvannan et al. 2012). Bailey (1952) highlighted in his research regarding queuing systems in health facilities, that long waiting times are undesirable for both client and HCPs as the client may face loss of income due to the waiting for hours and may only have very short consultations.

Gillam et al. (1998) also observe that in the absence of a formal booking system, the unpredictable workload of the “first come, first serve or walk-in” model, as well as other factors such as the increase in population size, chronic illnesses and the ever-increasing client expectations, result in rushed health consultations and noted negative experiences of both health care provider and client.



### *Appointment system modalities*

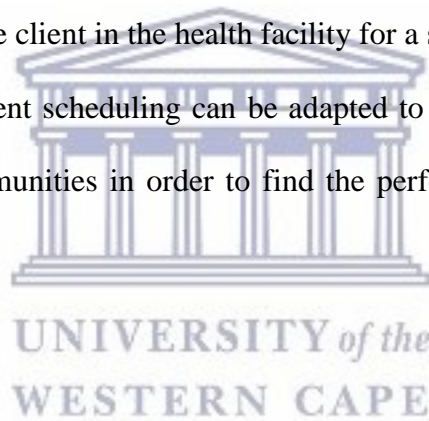
An array of appointment scheduling variation has been described by researchers. Vissers, (1979) and Daniels (2015) description is used in this chapter, as outlined below:

- i) Single block appointment refers to the “first come, first serve” method (Daniels, 2015). Daniels, (2015) refers to this type of appointment system as the most primitive of its kind. The “first come, first serve” modality, as described earlier, allows HCPs to see clients in the order they arrived at the facility, irrespective of needs. This requires only providing the client with a date to return.
- ii) Mixed method appointments refers to clients with appointments and those without

appointments being seen in a particular sequence. As an example, the HCP could see five clients with appointments and then see a few without appointments. This strategy, if not managed correctly, could incite dissatisfaction from the clients with appointments as it could impact negatively on their time to consultation.

- iii) Individual appointments allow each client to receiving their own personal timeslot which includes a date and time (Vissers, 1979).
- iv) Multiple- blocked appointments refer to a time allocation to a group of people, as an example, a HCP could give ten to fifteen clients a timeslot of approximately 2 – 4 hours on a specific date (Vissers, 1979; Daniels, 2015). This allows variability in consultation per client and allows the HCP some flexibility but could potentially keep the client in the health facility for a significant amount of time.

These variations in appointment scheduling can be adapted to suit the context of the health facility, its staff and its communities in order to find the perfect appointment system for a community.



#### *Characteristics and design of an appointment system*


Dexter (1999) researched appointment systems in outpatient settings, noting that the design of the appointment system is critical to its success, and factors such as unbooked clients, HCP idle time, folder searching and absenteeism should be factored in when designing an appointment system. He further describes the impact of client ‘no shows’ and late arrivals, which supports the inclusion of clients and communities in the shaping or designing of their clinic appointment system.

In a survey done by Salisbury et al. (2007) in England, they surveyed 10 821 clients to determine whether appointment systems improved access to care. One of their

recommendations stated that appointment systems need to be flexible to accommodate the different needs of different clients accessing care from the health establishment.

Notably, the literature has not described one system as superior to the other, it depicts the implementation of simple to complex appointment scheduling systems, in line with the requirement from the health facility and its end-users, the community.

In addition to all the evidence that an appointment system should be implemented in all health facilities in South Africa, the ICRM programme requires evidence of staff training related to the appointment system, to ensure that staff have the skills and motivation to implement a more sustainable, user-friendly appointment system if supported and managed appropriately (NDoH, 2018).



*The appointment system as a perceived barrier to quality care*

George et al. (2003); Neal et al. (2001) and Taylor (1984) unanimously describe an appointment system as a barrier to communities within low socioeconomic status and notoriously difficult to access due to the nature of their lifestyles. This viewpoint cannot be ignored as it suggests that a more tailored, participatory approach is needed to address the needs of communities. Bailey (1952) and Maister (2005) highlighted that a barrier to the acceptance of an appointment system by clients can be linked to their perception of financial impact and whether they received the care they were seeking. They note that if clients perceive the appointment system as ineffective, it may stem from their possible financial losses due to long waiting times in clinics and not being able to return to work on the same day. They further note that the possible financial impact is exacerbated by not necessarily getting the care they envisioned from the PHC facility. Limited consultation time in relation to waiting time can be a constraint and may lead to further client dissatisfaction

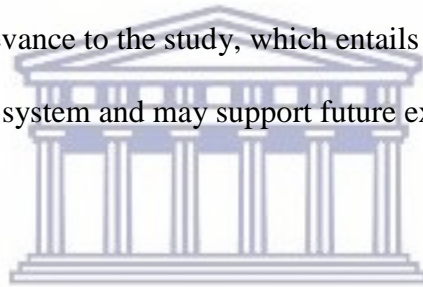
(Wijewickrama et al., 2005).

The study will discuss the various methods of appointment system implementation currently utilized in various City Health settings and how they impact on the daily lives of the clients within their communities.

The study will further emphasize differences or similarities in the clients' perception of appointment system implementation in small, medium and large health facilities.

## **2.5 Innovative strategies to improve the appointment systems**

Although not the focus of this study, the researcher has noted that there is a large body of research, which may be of relevance to the study, which entails technological advances or innovation in the appointment system and may support future expansion of the appointment system.



*Technological innovation to improve the appointment system*  
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The use of mHealth and eHealth innovation strategies has been researched at length, of particular interest is the innovation strategies for appointment systems within low resource settings in the developing world. The use of mobile applications, sms reminders, clinic navigators and the tracking of missed appointments are focused on as strategies to link clients to health and promote positive health seeking behavior.

Aranda-Jan et al. (2014) noted in their systematic review that there is insufficient data to support mHealth as ideal for low resource settings but noted that mHealth is dependent on infrastructure, efficient management, and stability in funding and requires government and political support in order to be sustainable. This technology is dependent on end-users

having access to mobile phones, data and PHC facilities having dedicated staff to maintain mHealth appointment reminders and WiFi to provide the service.

Zhang et al. (2015), in their Australian study noted that, while e-appointment scheduling could be useful in promoting access to clients, it was negatively impacted by ‘no shows’ to booked appointments which led to reduced productivity of HCPs and increased waiting times of those clients in the facility. They further noted that e-health innovations were not as accepted by communities as initially thought by implementers and acceptability by the end-user impacts on its efficiency of the strategy. Labrique et al. (2013) however, concurs that mHealth technology is able to improve health outcomes.

Apart from concerns about technical appropriateness an emerging literature raises other concerns with technology-driven solutions:

Sharp et al. (2001) notes that an appointment system with flexibility which allows a client to select their timeslot would be ideal, but she highlights that the more complicated the appointment system the more it could disempower underprivileged clients as an unintended consequence, as they are more likely to not have the resources to access or understand complex systems. Attention to appropriateness and to careful education are therefore paramount.

A larger emerging concern is around the confidentiality and risk of unintentionally disclosing clients’ health information to others in cases of theft of mobile phones or messages read by unintended recipients (Aranda- Jan et al. (2014) and Labrique et al. (2013).

## **2.6 The importance of community participation, community development and advocacy in shaping health service delivery and the appointment system**



The World Health Organisation (WHO) (1978) stated that community participation is widely acknowledged as critical to achieving sustainability. This should encompass all aspects of planning and delivery, and include input into the monitoring of health programmes and services in order to achieve positive outcomes. Patro et al. (2008) as well as Chaka (2005) describe community participation as one of the key principles on which primary health care was founded with the Alma Ata Declaration in 1978.

The significance of community participation in shaping health service delivery is linked to all aspects of the service as noted by WHO, 1978. The researcher therefore intends to highlight how community participation, engagement and development needs to form part of the implementation and management of an appointment system within a PHC facility in order to create a sense of ownership and support to the system.



*Stakeholder engagement and communication*

Rogers et al. (1998) notes that communication between all HCPs, appropriate stakeholders and communities is the integral step to transforming the health system and introducing an appointment system into a health facility.

Sharp et al. (2001) advocate for community participation in shaping the health facilities appointment system in order to improve attendance in marginalized, in need communities.

Dabale et al. (2015), through their research, advocate for improved quality of health care services and highlight that continued, regular client satisfaction surveys and information sharing campaigns promotes community awareness and improve the understanding of health services, in order to foster and sustain a sense of ownership, and motivate communities to actively participate in shaping their health service.

It is therefore undisputed that the role and value of the client is absolutely essential in understanding how the health system can improve their overall wellness. In relation to the



study, understanding how communities' input could be integral to knowing how the PHC appointment system impacts on their lives and how they view their input into transforming the appointment system to suit their needs as well as improving health services to their communities. Kols et al. (1998) discusses how research can accentuate the advantages of addressing client perspectives on quality of health care. They emphasize that understanding the community dynamics and engagement with the community, directly contributes in improved client satisfaction; loyal, appropriate use of health services, and evidently, to positive health outcomes.

## **2.7 Conclusion**

The findings of the literature review illustrate the need for more in-depth understanding of the waiting times impact on client satisfaction and quality of care. It further highlights that appointment systems can vary in complexity and that it is impacted by multiple factors. It therefore requires the consideration and engagement with HCPs and the community in order to shape an appointment system which is flexible yet rigorous and sustainable, which speaks to stakeholder engagement. It further illustrates that technology has the ability to enhance the appointment system but needs to be tailored to the needs of the clients and needs to be robust in order to mitigate unintended disclosure of client information. These technological innovative strategies further require the technological infrastructure, secure funding and client and health facility access to smart devices in order to implement and sustain them effectively. Though South Africa is a noted emerging country in the arena of technological innovation, the inequalities of its past still linger in its poor communities. This needs to be addressed before a public health sector can fully adopt the strategies.

The most striking element of this literature review is of the clients' perception of waiting time and its linkage to their perception of quality health care, which is further reflected in their

client satisfaction surveys. These waiting time surveys and client satisfaction surveys form part of quality assurance strategies, which all foster a collaborative, multisectoral, integrated approach to quality improvement of health care but importantly emphasizes the need for client-centricity. The literature corroborates the need for research to focus on client perspectives and for HCPs to engage on a deeper level to understand how the implementation of an appointment system impacts on clients' lives, health decisions and health outcomes.



## **Chapter 3**

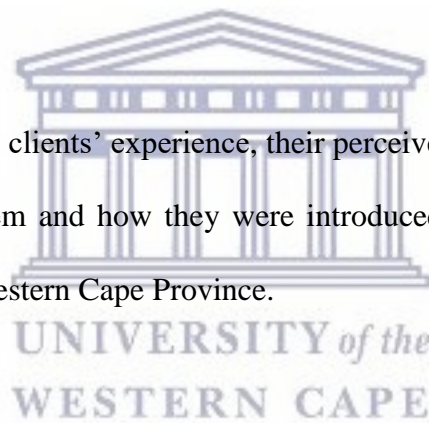
### **Methodology**

#### **3.1 Introduction**

This chapter describes the methodology used in this research study. It outlines the aims and objectives, the study design, the study population and sampling processes that were utilized. The methods and processes for collecting data inclusive of the research tools that were used are described at length in this section. This is followed by the data analysis process, the rigour and the limitations of the study. Lastly, the chapter explores the ethics that were considered in relation to this study.

#### **3.2 Aim**

To explore and understand the clients' experience, their perceived role in shaping the recently established appointment system and how they were introduced to the appointment system, within City Health Clinics, Western Cape Province.



#### **3.3 Objectives**

1. To investigate and understand the clients' experience of PHC services prior to the implementation of the appointment system
2. To explore the clients' experience of the PHC services since the implementation of the Appointment System Learning Initiative
3. To understand how clients view their role in shaping the appointment system in their clinics.
4. To explore the client's experience of how the health facility staff engaged with them regarding the introduction of the appointment system in PHC clinics

## **Methodology**

### **3.4 Study Design**

This is an exploratory, descriptive qualitative study. A qualitative approach is used and is best suited for this study as the researcher's aim was not to measure but to try to establish the relevance of the appointment system to the client, how it impacts and how the client experiences it. Black (1994) describes qualitative research as being able to go beyond the remit of quantitative research, as it is able to explore deeper meaning and deal with complex human behavior, emotions and interactions, which cannot be quantified, which is complemented by Flick (2018), who notes that goal of qualitative research is less focused on the known (inductive theories) but more focused on exploring and discovery new theories (deductive theories). Creswell (2013) states that a descriptive qualitative study design provides a rich picture of people's personal experiences of a phenomenon, which provides a unique view into their lived experiences.

With this research, the researcher wanted to gain a deeper understanding of the experiences of clients prior to, and since the implementation of the appointment system in City Health clinics. The research further explored the clients' perceived role on shaping the appointment system and strategies they are aware of, that informed them of the implemented appointment system at their local clinic.

The research was conducted using semi-structured interview tools with open-ended questions, which allowed the client to describe their experiences and share valuable information that culminated in a rich description of the appointment system from their view.

### **3.5 Population and sampling**

#### **i) Study population**

The study population consisted of all clients at facilities that participated in the Appointments System Learning Initiative (ASLI) in the City of Cape Town.

## **ii) Sampling of facilities**

A combination of purposive and random sampling was utilized in this study, which allowed for maximum variation in both facilities and clients sampled. Purposive sampling is described by Mays et al. (1995:2) as sampling “a deliberate choice of respondents, subjects or settings”.

The researcher purposively sampled five (5) PHC facilities that was comprised of two (2) small clinics, two (2) medium clinics and one (1) large clinic. The categorization of the clinics, as described by Table 1 (pg 23), were done by City Health taking into consideration, the workload, headcount and service package offered at each health facility.

The large clinics, also known as community day centers (CDCs), provide more comprehensive PHC services compared to small and medium clinics which only provide a selected range of services.

These clinics were purposively selected from facilities that have had continuity of a facility manager working in that clinic since the initiation of the appointment system, as part of the ASLI, until the time of the study.

## **iii) Sampling of the participants**

During the initial planning phase of the sampling methodology, the researcher arrived at facility on agreed date and requested a list of clients attending in order to commence the sampling process. The administration clerk was required to assess, with the electronic patient management system, whether clients had attended the facility prior to the implementation of

ASLI in May 2016. These prospective participants were either selected via random selection of their folder and information on the electronic patient recording system, in the reception area or on consultation in the weighing or waiting areas dependent on the facility layout and client flow. The researcher then purposively selected three prospective participants per clinic, from those who have the required experience of the appointment system as identified and verified by the electronic patient record system or verbatim during consultation in either the waiting area or weighing room. All clients were then approached by the researcher and informed of study. The prospective participants were given the opportunity to ask any questions and participate in the study. Only three participants per facility were required for interview process. The researcher interviewed three clients per facility, which equates to a total of fifteen client interviews. Rigour was ensured at this phase by having clear inclusion and exclusion criteria as noted below.

**The inclusion criteria:**

- City Health PHC facilities in the WC, which formed part of the appointment system learning initiative
- City Health PHC facilities, identified by sub district management, which showed a good level of interest or expressed that they have implemented this initiative successfully.
- Clients: with experience of attending clinic with and without an appointment system in place
- Clients of all genders, race and religious or cultural backgrounds
- Clients older than 14 years of age

**The exclusion criteria:**

- Clients: Children aged 14 and younger

- PHC facilities who have not implemented an appointment system
- PHC facilities who have undergone change in management and disruption in ASLI implementation

### **3.6 Data Collection**

#### **3.6.1 Individual interviews**

A semi-structured interview guide was used with probing questions in order to facilitate the interview process. The interview guide was drafted with deductive questioning but the researcher included some inductive questions during the interview sessions in order to gain a deeper understanding of the client's perspective. The interview was recorded using audio recording equipment and backed up with cellphone recording. When considering the sample population, culture and language, the researcher is required to communicate in English, Afrikaans and IsiXhosa languages. Interviews took place in English, IsiXhosa and Afrikaans, with respective interview guides, and the participant information sheet and consent form was available in English, IsiXhosa and Afrikaans. Therefore, the study information and consent were available in English, IsiXhosa and Afrikaans. The researcher was able to do both English and Afrikaans interviews herself, but required a translator for IsiXhosa interviews. This was done with a trained IsiXhosa individual and the researcher required translation directly into English at the point of interview. The researcher and or translator observed and made notes in a journal regarding any body language and other nuances that arose during the session. The researcher and or translator used unique identifiers in order to promote anonymity and confidentiality. All this information was transcribed by a transcriber (in English and Afrikaans interviews only), as the isiXhosa sessions were directly translated to English during the interview. Afrikaans interviews were directly transcribed into English by the transcriber. The researcher accompanied the translator during each of the isiXhosa interviews. Member checking was done by the

researcher by summarizing what the client verbalized. This summarization was done to verify with both client and translator that the correct interpretation of statements were recorded. The member checking was done to ensure clarity regarding the input during the interview to mitigate confusion or misinterpretation.

All these interviews took place at the respective health facilities, in a room allocated by the Facility Manager or Senior Professional Nurse. The researcher attempted to maintain privacy and confidentiality throughout the interviews. The use of a journal to capture all the different phases of the data collection process was used in order to ensure rigour throughout this phase.

### **3.6.2 Observations**

This method was initially not part of the protocol but during the facility visits the researcher had made some observations which, she believed, could add value to the study. These observations were documented in a journal and was not limited to observations of the physical site visit but included the communication processes. These communication processes commenced with initial and on-going communication with the sampled health facilities, facility managers regarding access to the health facilities to recruit participants for the study, identifying staff to support with recruitment of clients for the study and the availability of a private space for the interview processes. These observations were further shared with the supervisors during debriefing sessions.

### **3.7 Data Analysis**

Manual thematic coding was used to analyze the raw data obtained during the interviews. Braun & Clarke (2006:79), describe thematic coding analysis as “a method for identifying, analyzing and reporting patterns (themes) within data”. These fifteen (15) interviews were transcribed into English and then coded, by means of phrases and colour coding, in order to derive themes. These themes were then reduced, where an overlap of themes was identified



and then given a more comprehensive, all-encompassing theme. Notably, the themes emerged from the data and is therefore inductive in nature, but notably due to the nature of qualitative research, the researcher has interpreted the data based on her understanding and perceptions. The researcher has also worked within City Health, formed part of the first workshop and supported health facilities with NCS and ICRM. The researcher has done a great deal of reflection during the research processes to reduce inferring her opinions, thoughts or beliefs on the data, but formulated themes from information given by the participants.

### 3.8 Rigour

Rigour refers to the trustworthiness of the study. Mays & Pope (1995) states that a qualitative researcher should be able to develop a methodology that allows for the data which they collected to be displayed autonomously; can be replicated by another researcher and found to have relatively the same outcome (within a similar context). The tools below contributed to the rigour of this study.

- i) **Audit Trail:** The researcher commenced by studying the detailed notes from workshops held in 2016, this along with newsletters (produced by the Specialized Health unit at City Health, noting progress of ASLI), was used to determine noted successes and challenges in implementation of ASLI.
- ii) **Reflexivity:** accurate notes were kept by the researcher, which includes of every step of the research process as part of the iterative aspect of valid, qualitative research. Reflection was done after each facility visit, the researcher noted definitive contributors to the experiences at each site from the entry point to the exit. These contributors were identified upon entry into the health facility by means of signage, reception and support from health facility staff, waiting areas,

communication from HCPs during waiting periods, the ability of the client to wait to be seen and the support to the researcher. The contributors were identified throughout the day and was observed by the researcher.

- iii) **Debriefing:** Continuous quality assurance in qualitative research can be achieved by regular debriefing sessions with supervisors, provide a sounding board for the researcher to test their developing ideas and interpretations, and probing from others may help the researcher to recognize their own biases and preferences (Shenton, 2004). Ad hoc, scheduled sessions with supervisors was done throughout the study, additional debriefing was done telephonically where possible to allow brainstorming and maintain focus on objectives.
- iv) **Triangulation:** The interviews and interview notes written by the researcher, were used in conjunction with the notes of the ASLI workshops and newsletters as well as the waiting time and client satisfaction survey analysis for the sub districts, where available. This was further triangulated with outcomes from the Daniels (2015) study of City Health facilities in relation to waiting time and client satisfaction.
- v) **Member checking:** The researcher would summarise each response from the client to establish whether an accurate understanding of the client view was attained. This strategy was extremely beneficial to the isiXhosa interviews as the researcher required an understanding of the clients' response as the interview was conducted by a translator and the researcher followed the process from start to completion.

### 3.9 Limitations

Recall bias could have occurred as clients were requested to reflect on previous experiences at facility in order to understand differences or similarities in experiences pre- and post-

appointment system implementation. Clients could also have confused their different experiences based on historical knowledge or forgotten information.

To reduce this bias, the researcher continuously reminded participants of the experiences the research is trying to access and giving participants enough time to reflect and think about their understanding of the questions being asked in the course of the interview.

The exclusion of people who have subsequently left the health system as a result of a bad experience could be a limitation, as their views would not be reflected by this study.

A further limitation could be the lack of male participants in this study, as their view will not be represented, despite attempts to gain their interest in the study at various health facilities.

In some facilities there was difficulty in accessing potential participants using the electronic patient system, as reception staff were new and unable to assist.

The researcher only spent one day in each health facility, so some of the observations may then have been limited to that day. It is therefore difficult to generalize or speculate regarding the observations only.

Lastly, the researcher noted multiple disruptions in some of the interview processes at some sites, this included staff stepping into the interview room to stock their rooms or collect equipment. This could have intimidated some participants and led to them not freely sharing information for fear of discrimination.

### **3.10 Ethics considerations**

The researcher applied for the ethical approval from the University of the Western Cape and the City of Cape Town prior to data collection. The researcher completed the necessary documentation to seek approval from the City of Cape Town. The ethical approval from both

the University of the Western Cape and the City of Cape Town was received (Appendix 1 and 2).

The ethical approval from the City of Cape Town was required prior to accessing PHC facilities and clients to participate in this study. Participation was voluntary and obtained via documented informed consent. Participation information sheet was provided in English, Afrikaans and isiXhosa (Appendix 3; 4 and 5). A Consent form in either English, Afrikaans or isiXhosa (Appendix 6; 7; 8) was then provided as per client preference.

There was no anticipated harm to participants identified who consented to be part of the study. Referral could be made for psychological support, in the event of it being required as a result of their participation in this study.

### ***Informed consent***

Participant information sheet was provided to each potential participant before the start of interview, this is available in English, IsiXhosa and Afrikaans. The information in the participant information sheet was supported and reinforced verbally as well by the researcher and translator, where applicable. The participants' rights were addressed which informed them that they may choose to not participate or to stop participation at any stage of the process without any negative repercussion. Their anonymity and confidentiality was maintained throughout the process. The researcher endeavored to reduce risk of stigma (by self or others) and possible discrimination by using a unique identifier when documenting information provided. The participant information sheet allowed the participant to engage with the research requirements and ask any questions related to the process prior to providing consent. Informed consent was gained by way of signature on a consent form which is available in English, IsiXhosa and or Afrikaans. This consent form will be kept by the

researcher for safe-keeping. The participant was also informed that they could revoke consent at any stage of the research without any negative recourse.

### ***Privacy and confidentiality***

The anonymity of PHC facilities sampled will be upheld to promote confidentiality. This was relayed to participants to allow them to discuss their experiences freely without concern about victimization or stigma by the respective clinic. The interviews were all conducted on-site in a designated, private space which endeavored to allow for confidentiality and comfort of both the researcher and the participant. The interviews were audio recorded for transcription by the transcriber. The audio recordings were anonymized and kept by the researcher for storage and safe-keeping.

### ***Risks***

There was an assumed or anticipated minimal risk of victimization by HCP based on the perception of the clients' negative contribution to the study. HCPs did not and will not have any access to the participants' information shared during the course of the study. This risk of victimization was mitigated by the sampling of clients solely by the researcher and use of coding of the acquired information. Clients were treated with respect and discretion throughout the process.

### ***Referral***

The researcher was able to refer a TB client appropriately, where a social problem arose during the course of the interview with the TB client's mother. The TB client's mother attended the clinic with a referral letter from a hospital, stating that the client required TB treatment. The client was too weak to walk all the way to the clinic and he's mother feared that he collapsed along the way or turned back to go home. The situation was discussed with the Facility Manager. The researcher supported family by collecting the weak TB client from

he's residence as he was unable to walk to the facility. The TB client's mother was part of the interviewees and was able to attend a session with the client and the TB staff within the facility. The client was initiated on TB treatment in line with the TB referral letter he's mother presented during the interview.

If any participant shared negative experiences that is upsetting to them, the researcher would offer them time to reflect on their experience and together with the researcher determine a way forward. This did not occur during the interviews. Should any of the participants have wanted to address any negative experience with the facility manager, they would have been supported through the process, alternatively, they could have been referred to appropriate individuals as required. Any negative emotions expressed would have been managed by the researcher and where appropriate with a translator and linked to appropriate care. No other referrals or additional support was offered or made, except for the TB client requiring support to attend the clinic.



## **Chapter 4**

### **Research Findings**

#### **4.1 Introduction**

This chapter initially starts with a description of both the participants of the study and the research setting in order to contextualize the findings. The themes discussed in this chapter were all emerging from the data collected from the interview process. The researcher takes cognizance of the nuances within each health facility and geographic area as this could impact on the findings and attempts to illustrate the differences and similarities within the various unique settings.

#### **4.2 Description of the participants**

The participants in this research study were all female, aged between 21 – 65 years and of coloured or black African descent. Although the researcher attempted to include potential male participants in the study, those approached were not inclined to participate, citing they did not have the time, noted it was their first visit or they simply were not keen in participating.

The participants were all attending their respective, local clinics which were notably within walking distance of their homes. They further had the required experience of attendance to the clinics, both prior to the appointment system and post the appointment system implementation. There were a few employed women within the sample group but the majority comprised of unemployed women and pensioners. The participants visited the facilities for numerous reasons ranging from acute and chronic ailments inclusive of reproductive health services (contraceptives and cervical screening), ART services, TB services and Adult or Child curative services.



Fifteen clients were interviewed in total, this comprised of three interviews per clinic, with five, purposively selected clinics. Contextually the variation in language use within the Cape Metro and the selected sub districts were considered and the interviews were conducted in English, Afrikaans, mostly mixed and isiXhosa, based on the preference of the participant.

#### **4.3 Description of the research setting**

The research took place in the City of Cape Town, City Health facilities, within the Cape Metro District of the Western Cape. The settings varied and ranged from informal, peri-urban and urban settlements, which are predominantly inhabited by coloured, black and some migrant populations. The health facilities ranged from small, medium and large, categorized by City Health, based on workload, headcount and package of services rendered by the health facility. There are also noted differences in areas with few, sparse health facilities within dense populations; to areas saturated with access to health services within even more densely populated areas, thus highlighting inequitable resources within communities. It should also be noted that the health care staffing distribution, disease burden and headcounts differ significantly across sub districts and health facilities.

The interviews were all conducted on the premises of the respective clinics, with prior arrangement, with the Facility Managers and Primary Health Care Managers. The Facility Manager or Senior Professional Nurse provided a vacant room within the facility to conduct the interviews. The room was essentially a consulting room, furnished with an examination bed, lamp, trolley, desk, two chairs and a storage cupboard. All rooms were able to lock to ensure privacy but some were interlinked with other consulting rooms which led to increased access from staff.



## 4.4 Themes

The below table summarizes the themes that emerged from the interviews, which will be discussed in turn. It is important to note that clients did not neatly distinguish between issues related to the appointments system specifically and service issues more generally, thus signaling that the former is just one (albeit very important) experience and concern.

Theme	Sub theme
Service related	Operational issues Attitude of staff Staff shortages and rotation Lack of communication and inconsistency of services
Appointment related	Proximity No Value vs Value of appointment system to clients
ASLI process variation	Variation between services (Curative/Acute/Wellness), modalities and facilities
Advocacy platforms	Awareness of advocacy platforms

**Table 2: Themes derived from the interviews**

### 4.4.1 Service related

#### *i. Operational issues*

The research and interaction at facility level highlighted differentiated models of appointment systems implemented by City Health facilities which appeared to be influenced by geographic location, headcount, staffing, and context as well as staff experience of

appointment systems. Inconsistency in appointment system implementation was seen across all the sites. Some facilities implemented varying modalities based on the services rendered.

Clients of the smaller facilities appeared satisfied with the level of service prior to the implementation of the appointment system and appeared un-phased since its establishment. They felt they received the same standard of care before and after the appointment system and it did not appear to make any real difference to them. They did not highlight the appointment system as a benefit or of significant value to them as they felt satisfied with the level of care irrespective of the appointment system. They felt the staff attitude was positive and that they were able to engage on a more personal level and get appropriate health education. Additionally, the waiting areas in the smaller facilities appeared empty in comparison to the medium and larger facilities. All facilities were visited for one day within the same time slots. The satisfaction with services irrespective of an appointment system, was not echoed in medium and large facilities. On the contrary, in one facility, which had been redesigned and re-categorized from medium to large, in terms of staffing and services, the participants highlighted that when it was smaller, with less staff it was more efficient.

The medium facilities infrastructure, appeared unable to manage the influx of clients early in the morning, as they did not have space. The medium facilities offer a wider range of services than small facilities. These services include but are not limited to: Child Wellness and Curative services; Sexual Reproductive Health (SRH); Prevention of Mother to Child Transmission (PMTCT) services, TB treatment, basic wound care, HIV Testing services (HTS) and basic emergency services with minimal consultation space and staffing. Some medium facilities have also commences Anti-Retroviral Therapy (ART) services and Basic Antenatal (BANC) services. The impact of expansion of health services from small to medium facilities were notable. The medium facilities appeared overcrowded, with clients standing in every possible available space inside the facility and the parking areas. It should

be noted that the appointment system was established to decrease influx of clients to facilities in the morning and to spread the load more evenly during the day. This even scheduling of clients was however not noted in every facility.

Another observation was the lack of preparation by HCPs to perform their daily tasks, such as preparing their consultation rooms, stocking up on medication, ensuring clinical equipment available and in working condition prior to the start of consultation. This was common across all facilities, irrespective of size and staffing levels. This was evident as interviews were interrupted no less than four times in some facilities, in order to access stock from the interview space to support a different consulting room. These interruptions were experienced despite the communication with managers and staff regarding the interview process for this study.

#### *ii. Attitude of staff*

Some participants vehemently highlighted the bad attitude of staff as a deterrent to accessing care or adhering to appointment dates. These observations and sentiments were mainly shared in the medium and large facilities. Some participants noted that they did not feel respected and that their views were not considered in the selection of appointment dates and times.

Communication and lack thereof came out strongly as a contentious point, as participants felt that if delays and short staff were communicated they would be willing to sit and wait their time.

One participant (30yr old female, employed, medium facility) said: *“I have not been to the clinic for almost a year, the staff are not very friendly, some even very rude”*

Another participant (32 year old female, employed, medium facility) said: *“Very unhappy about the way we are treated,.....unprofessional, .....unethical. Staff has no respect for patients, they are impatient and condescending”*

Not all participant felt as disenfranchised by staff attitude. Six participants attending small and large facilities, highlighted satisfaction with services, staffing and the appointment system within their clinics.

One participant (45 year old female, unemployed, small facility) says that since the implementation of the appointment system: *“I can now speak to the sisters and nurses at the clinic, they listen attentively and give me the opportunity to question them....the level of communication is better”*.

Another participant (38 year old female, employed, small facility): *“No issues with staff, they are very nice and friendly”*.

The differences of participants' experiences could further be distinguished between small, medium and large facilities. The participants from smaller facilities appeared happy with staff attitude and engagements as compared to those in medium and larger facilities.

### ***iii. Staff shortages or rotation***

Most of the participants across the various facility size categories, felt that there is a shortage of HCPs in their facility. Some participants described the 'one stop shop' approach being implemented as a strategy to reduce waiting times. Participants noted the delays within this process as it requires the same HCP to prepare, consult, diagnose and treat the client. Some participants raised concern that not all HCPs are skilled to render all services within the health facility, this placed more strain on those who were able to render more services. Other participants felt they could not access the particular service they required when it suited them, but based on when the service was rendered at the particular clinic, which as related to the skilled HCPs availability and that this limitation had an added impact on both their time and finances. The researcher observed that facility managers were practicing as both manager and HCP due to the staff shortages.

The participants' unanimously echoed sentiments to have staff complement increased to support the demands of the community.

One participant (21 year old female, unemployed, medium facility) said: *"Need more staff to attend to people...[currently] only one nurse for twenty clients per hour", "employ more staff and divide patients into smaller groups"*.

Two participants (Ages 28 and 45 respectively, female, small facility) stated: *"It would help to have more staff"*.

#### ***iv. Lack of consistency in services and communication***

Some participants raised concerns regarding conflicting messages received in the same facility. They highlighted one professional nurse advising family planning clients to come directly to her consulting room to see her whilst the other would expect the client to go via reception and the weighing room. These messages were perceived as confusing and often led to heated engagements between staff and clients, which creates a negative client perception of the health services.

Participant (33 year old female, unemployed, medium facility) noted: *"The system changes and it creates confusion"*.

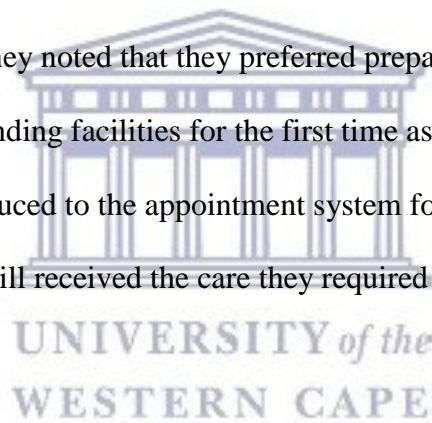
Delays in folder retrieval or locating missing folders were also raised as this led to confusion when duplicate folders were opened and the client has to repeat history with the health care practitioner due to missing information. These issues were raised and linked to the clients who felt the processes were flawed, long and dissatisfying.

One participant (42 year old female, unemployed, medium facility) said: *"She [the nurse] will see all the clients here [sitting in the waiting area], she will leave and not say anything"*

In terms of communication regarding the appointment system it was noted that no posters or pamphlets informing clients about the new system were displayed in any of the health facilities visited. Participants confirmed this as they noted that community members notified each other about the appointment system. Four of the participants found out about the appointment system by word of mouth in the community, one was informed via a pamphlet, another two via self-enquiry at the facility whilst the rest discovered the appointment system on arrival to the facility for another service.

Participants conveyed visiting the health facility for information regarding women's wellness programmes and then being informed regarding the appointment system. The participant was offered a date and could determine the time she wanted to attend, this was deemed highly acceptable by the women as they noted that they preferred preparing for these sessions.

Participants also reported attending facilities for the first time as curative clients or with ill children and then being introduced to the appointment system for a follow up visit. This was noted as satisfactory as they still received the care they required when ill.



#### **4.4.2 Appointment related**

##### ***i. Proximity***

All participants highlighted that they attended the respective clinics, as they live close to it. Some indicated having attended neighboring facilities but that the traveling led to them abandoning those and attending locally. They reported preference to other clinics but no longer being allowed to attend there due to their addresses or as a result of the money they needed for transport to attend there. Two participants currently attending a medium facility described functioning appointment systems at larger City Health facilities, they remarked on how efficient the services were and how there was no overcrowding.

## *ii. No value vs Value of appointment system to clients*

Some participants described their system as a mixed appointment modality, the health care practitioner would see up to five appointment clients, then see unbooked clients. Other participants described a more integrated version of the mixed appointment modality where unbooked clients would receive a number and the health care practitioner would alternate between appointment and unbooked clients. Some participants described the process as subject to their luck on the day, this would determine whether they would have a short or long wait.

The participants were divided when it came to considering whether the appointment system was of benefit or value to them. Just over half of the participants felt the appointment system did not benefit them at all, citing that *“with or without an appointment, we leave together”*.

Participant (48 year old female, unemployed, medium facility) states: *“sometimes it’s better to even not have an appointment, some days you are just lucky and other days not”*.

One participant (33 year old female, unemployed, medium facility) said: *“If you have an appointment you are treated differently, ....staff look at your card and help you, if you missed appointment or have no appointment, they look at your card and tell you to go and sit”*

Another participant (40 year old female, employed, medium facility): *“There is nothing good about **not** having an appointment, ...when you come with an appointment, you get helped sooner”*.

One participant said, *“I no longer feel despondent about coming to the clinic anymore, as it no longer takes up the entire day”*.

Participants reported coming to the facility early despite the presence of an appointment system, this added to their waiting time. They preferred being at the facility early, even if it



meant prior to the facility being unlocked, in order to be seen earlier, irrespective of their appointment times. Less than half of the participants felt that they were able to do other things during the day when they were given an appointment. These clients were also found to be satisfied with the service and level of communication regarding delays.

Participants in this group also displayed the understanding that not having an appointment was linked to waiting to be seen but attending without an appointment and being sick led to being assisted more swiftly. Participants noted that their main expectation was to be seen closest to the time given by the health care practitioner but in a more general sense, the expectation was to receive the care they were seeking in the first place, irrespective of the duration of the wait.

Another participant: *“It’s better now [with appointment] as I can plan my day, I am able to go back to work”*.

#### **4.4.3 ASLI Process variation**

##### ***i. Variation between services (Curative/Acute/Wellness), appointment modalities and facilities***

There were marked differences between appointment modalities noted within the same setting based on the services. Child curative services is not an appointment based service within the City Health facilities, as it is driven by the ill-health of the child. Interestingly, these child curative service users seemed to be the group of participants who raised the most dissatisfaction about long waiting times. Participants appeared more satisfied with the appointment system within Antiretroviral Clinics, Family Planning and TB clinic. This finding highlighted the benefit of having an appointment system of any nature versus no appointment system. The varying degrees of satisfaction in Family Planning services stems from health practitioner preference, some indicating clients to return directly to them, whilst



the facility practice dictates all clients should enter via reception. This dual system in one facility leads to miscommunication, inconsistent messaging about the appointment system and negative impact on client- provider rapport. Further, differences in time allocation was also noted, with some facilities giving a set time, others giving a two hour blocked slot and others giving a four hour blocked slot dependent on service.

This mixed method scheduling ranged from either a single time slot per five clients (e.g. Five clients booked for 08:30) or a blocked scheduling time slot (e.g. 15 -20 clients booked between 08:30 – 10:00). The sampled facilities then also differed on their approach to unbooked clients. Some facilities accommodated an unbooked client after five booked, or all unbooked clients were expected to wait for the booked clients to be seen first.

The appointment system in smaller facilities were very well accepted and appeared to be functioning well from participants' reports. Participants interviewed in small health facilities stated satisfaction with the services, quality of care and waiting time. They reported a personal primary health care service, with HCPs who were concerned and interested in their health and well-being.



In medium and large facilities, participants reported more dissatisfaction with waiting time and quality of care. The waiting areas appeared more crowded and more limited staff in relation to headcount, which reflected in the interviews as well.

#### **4.4.4 Advocacy platforms**

##### ***i. Awareness of platforms***

The interviewer also asked clients about their knowledge of Health Committees or Health Forums and other representative structures within the communities. Of the sampled participants only three were aware of the Ward Councillor only and two participants were aware of a forum of some sorts, not necessarily a health forum. Thirteen of the participants

indicated a willingness to actively participate on the platforms if they knew about its existence. Participants all appeared very vocal and felt that they could contribute to the shaping of the appointment system via the Health committee or Health Forum. None of the participants knew that a Health committee existed or was being revived within their area. The participants were not aware of the benefits of being part of this forum, nor that they were able to influence the implementation of the appointment system by giving input and advising regarding satisfaction with the processes and the appointment system itself. Some participants highlighted knowing their local ward councilor but admitted that they had not raised any concerns regarding their appointment system at their health facility via that route either.

#### **4.5 Summary**

This chapter analysed and illustrated the findings of the fifteen interviews done with clients of City Health facilities in Cape Metro District, Western Cape. All participants were female and of either coloured or black descent. The findings highlighted the variation of appointment system implementation at facility level and how these differences impact on the client. It further highlighted dissatisfaction with primary health care services as a result of staff attitude, lack of communication and long waiting times. Participants were split about the value of the appointment system and whether it brought positive impact on their daily lives. This split was also as a result of inconsistency in messaging and communication by staff. The participants who displayed satisfaction with services, generally had positive staff-client engagement, better communication and empathy with staff workload. Advocacy platforms were generally unheard of and majority of the participants appeared interested in participating on a Health Forum if it was established, some concerns were raised regarding impact on their work or schedule but they generally felt they could contribute to shaping their health services, more specifically the appointment system in the clinic.

## **Chapter 5**

### **Discussion**

#### **5.1 Introduction**

The objectives of the study were to investigate and understand the clients' experience of PHC services prior to, and post the implementation of the appointment systems; to understand the clients' role in shaping their appointment system and lastly, the clients' perception of the engagement with HCPs in the introduction of the ASLI.

This chapter discusses the findings from chapter 4 and highlights the link between literature review discussed extensively in chapter 2. The discussion section starts by discussing long waiting times, then highlights differences between small, medium and large health facilities with regard to the appointment systems. The value or perception of no value of distractions within waiting areas whilst awaiting consultation is noted. This is followed by lack of engagement with the community with regard to the ASLI and lastly, the lack of communication with community members regarding the appointment system, waiting times and delays in service delivery.

Vallabhjee (2011) notes that long waiting times remain prevalent in PHC facilities and states that bottle necks reflect poor management of the PHC facilities. This research study was focused on understanding how the appointment system has impacted on the clients' experience at City Health clinics. The research explored aspects of the clients' perceived value added or any unintended consequences created by the ASLI, since its commencement. This research allowed clients accessing PHC services to voice their experiences of the appointment system in the City Health Clinics. The discussion highlights the views of the clients which emerged from the interviews.

The clients gave insights into their perception of appointment systems within the City Health facilities. Notably, some clients highlighted good experiences, whilst majority raised concerns about staff attitude, staffing ratios and communication.

#### *Differences between small, medium and large health facilities*

Appointments can take many shapes and forms, and ASLI purposefully took an approach which allowed facilities to customize the system to their needs, and then to learn and adapt as they went along (although the latter intent was undermined by the move to a rapid scale-up in 2017/18). There were marked differences highlighted between small, medium and large facilities. During the data collection phase in the sampled clinics, it was noted that City Health most commonly use a mixed method scheduling of appointments. As each health facility was given authority and autonomy to implement the appointment system throughout selected or all programmes, this led to confusion among clients and led to some negative incidents within programmatic areas where clients felt disadvantaged by the system.

As mentioned above, there was no standardization to the implementation of ASLI. Each facility and service acted autonomously when they introduced a system, which they attempted to tailor to the context of their staffing and to a lesser extent the community dynamics. This is an approach that is supported by Harper & Gamlin, (2003), who highlight that alternative appointment schedules, referring to mixed appointment method, have been proven to dramatically reduce patient waiting times.

Clients in smaller facilities appeared satisfied with the quality of services irrespective of the implementation of the appointment system. They noted that they were happy with services before the implementation of the appointment system and that it made no difference to them whether the appointment system was implemented or not.

A participant (36 year old female, unemployed) in a small facility, said: *“No issues with staff, they are very nice and friendly”*.

The element of confusion came out very strongly, where clients would note various methods of appointment scheduling within the same health facilities and even within the same programmes within the same facility. They highlighted that one HCP would allow them to throw their clinic cards directly into the pigeonhole at the consultation room and another HCP would expect them to go via the reception and weighing room. Additionally, TB clients would be able to access family planning within the TB room for the duration of their TB treatment but would transition into the general clinic once TB treatment is completed. This service would then require an appointment, which they were not aware of when they attended the TB clinic.

This confusion and lack of communication appeared multiplied within the bigger facilities which presented much more complex appointment scheduling which is programme specific.

*Communication while waiting*

Dansky (1997) noted that activity filled waiting time is not interpreted by clients in the same way as empty waiting time and is notably more acceptable to clients. This suggests that if HCPs provided regular, scheduled health talks and communicated delays frequently throughout the day, clients would be more likely to understand and wait patiently. The lack of communication between HCPs and clients was observed during the sessions at each facility.

Davis et al. (1998) highlight the importance of waiting times, showing in their research that a client's perception of waiting time is a more critical indicator of quality of care than the measurement of actual waiting time survey and essentially stating that clients do not like to wait irrespective of the use of distractions, i.e. introduction of TVs in a waiting area. This is

not entirely in contrast, to Dansky (1997), who suggests that HCPs should fill the waiting time with health talks or updating the client regarding waiting times, as Davis et al. (1998), note that distractions which are not aligned to the reason clients attend appear to be futile. They note that clients are more likely to be receptive of the distraction of waiting time if they received information in line with their needs.

Daniels et al. (2017) and Benjamin et al. (2011) noted that the poor environmental conditions in waiting areas and inadequate communication about possible waiting times resulted in longer perceived waiting times. This was corroborated during this study as clients raised dissatisfaction with levels of communication between them and HCPs regarding delays.

Daniels et al. (2017) also highlighted that the acceptability of waiting time was dependent on the duration of time spent at the facility; the service clients were accessing, whether preventative, curative or emergency; the environment within the facility; and the communication regarding delays. Knowing that long waiting time is no one's idea of quality of care, the clients in this study have highlighted their association with long waiting time and their visit to the health facility. The study highlighted the situation in smaller facilities as being more acceptable to clients, which was in contrast to medium and larger facilities. Some participants have noted that if they received adequate communication during the wait, they would be less likely to feel dissatisfied.

The need to implement the appointment system with client-centred approach and engaging the client appears to be the most striking theme, suggesting that the client should be part of the implementation of an appointment system in order to address the needs of the community. Some clients expressed appreciation at the fact that they felt that since the implementation of the appointments system, nurses at the clinics were more approachable and less rushed.

Clients were able to reflect back to the period the PHC services rendered a ‘first come, first serve’ service. Clients in smaller facilities noted the service was the same and that the appointment system made no real impact on their perception of the services. The medium and large facilities noted that the appointment system created confusion due to the various appointment scheduling techniques used by HCPs. Profoundly, over half the participants (from medium and large facilities) cited that “*with or without an appointment, we leave together*”.

#### *Clients’ awareness about Advocacy platforms*

The majority of the clients had not heard of advocacy platforms available to them. Clients did not realize these platforms existed but noted that they would gladly participate on these platforms in order to shape their health services. Some clients made reference to ward councilors and were aware of who they were, but not all knew how they could access them to discuss their services at their health facility. Not all clients felt they would participate in such platforms, less than half who were interviewed stated it was not for them, with some being concerned about the time implications of participating in a health committee or forum.

#### *Community participation, development and engagement*

None of the clients interviewed were aware of a campaign or awareness programme, which communicated the new appointment system within their health facilities. Most had heard about it by word of mouth in the community. It is evident that the community was not engaged during the processes of implementing the new system. However, both the literature and the findings of this study emphasize that it is integral to the success of the appointment system that clients participate in order to have buy-in and accountability with regard to health seeking behavior. Literature regarding community participation and engagement emphasizes the power of community voices in shaping programmes to suit their context. The community



members are more aware of issues and barriers within their space than the HCP. The inputs from the community may give some valuable reshaping to the current systems and might decrease the number of unbooked clients within the facility. Thus, having the representation from the community within a health forum and as part of systems design processes, allows the HCP to adjust their approaches to a more acceptable, responsive and appropriate appointment system which considers all the social determinants that the respective community is facing.





## **Chapter 6**

### **6.1 Conclusion**

This research has addressed the objectives of the study. It has provided insight into what was known anecdotally with regard to appointment systems and waiting time.

The research was predominantly conducted to explore the perceptions of the clients regarding the appointment system, but has shown that clients' perception of the appointment system is largely linked to their perception and experiences of broader issues of quality of care and waiting times. This is corroborated by many studies about waiting time, quality of care and appointment systems.

Additionally, lack of communication has featured strongly in this study, the participants echoed a sense of being left behind in the planning and implementation of the ASLI.

The differences noted between smaller facilities and larger ones, are in contradiction with NCS and ICRM as clients felt the appointment system did not add value to their experience and that their PHC services were satisfactory prior to the appointment system. This speaks to a more contextual approach to ASLI than a 'one size fits all', national approach.

### **6.2 Recommendations**

The recommendations are not only reflective of the researcher but includes recommendations noted by the clients themselves and could improve client satisfaction which is noted as an indicator of quality of care but also most importantly, support the reshaping of the appointment systems within PHC facilities.

#### **i. Community involvement, participation and engagement**

A strong sense that the client was left behind in the decision making of the appointment system came across during this research. A recommendation to engage communities in the

establishment of the appointment system and its reshaping is needed. The call to re-establish or revitalize health committees, which took place in Feb 2018, should be seen as an opportunity to truly centralize the client in all activities. Decisions regarding health should be done in consultation with the community. The processes undertaken by Western Cape Government, to establish health committees should be revisited and a robust communication plan should be implemented to ensure representation from all groups within the community.

## **ii. Communication**

Communication processes should be reviewed and a standardized communication process should be relayed by all health facility staff during their engagement with communities. The standardized communication process noted above refers to a social media campaign with unified messaging regarding appointment systems, this could be posters in local languages with infographics raising awareness of appointment systems within City Health facilities. The communication strategy could also be shared with non-governmental organisations (NGO) or partners supporting these City Health clinics to strengthen referral pathways and re-inforce the appointment system at a community level with Community Health Workers (CHWs), HIV Counsellors and NGO nurses. The implementation of a standardized communication process and inclusion of NGO partners should also address NCS and ICRM assessment measures. Communication methods should be accessible and understood by the targeted communities i.e. should be in a language they understand, should include people with disabilities and should be easy to grasp.

## **iii. Appointment system modalities**

Lastly, but definitely most importantly, the research has highlighted the variations in appointment system modalities that are implemented within one facility. It is recommended that although an appointment system should be flexible, there should be standardization

within a facility as it creates confusion if each service adopts a different modality. The recommendation then further includes deciding on a modality with the staff and community and implementing it throughout the facility to create uniformity and an agreed process that can be known by both staff and clients.



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Appendix 1: UWC Ethics approval



OFFICE OF THE DIRECTOR: RESEARCH  
RESEARCH AND INNOVATION DIVISION

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09 November 2017

Ms RL Sparks  
School of Public Health  
Faculty of Community and Health Sciences

**Ethics Reference Number:** BM17/9/13

**Project Title:** Exploring the clients' experience of Primary Care Services prior to and post the implementation of appointment systems in City Health Clinics, Western Cape, South Africa.

**Approval Period:** 27 October 2017 – 27 October 2018

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

**Please remember to submit a progress report in good time for annual renewal.**

The Committee must be informed of any serious adverse event and/or termination of the study.

A handwritten signature in black ink, appearing to read 'Josias'.

*Ms Patricia Josias  
Research Ethics Committee Officer  
University of the Western Cape*

**PROVISIONAL REC NUMBER -130416-050**

Appendix 2: CCT Ethics approval



CITY OF CAPE TOWN  
ISIXEKO SASEKAPA  
STAD KAAPSTAD

CITY HEALTH

Dr Nalocha Berkowitz  
Epidemiologist: Specialised Health

T: 021 400 4238 F: 021 421 4894  
E: Nalocha.Berkowitz@capetown.gov.za

2018-01-24

**Re: Research Request: Exploring the clients' experience of Primary Health Care services prior to and post the implementation of appointment systems in City Health Clinics, Western Cape, South Africa (7928)**

Dear Ms Sparks

Your request has been approved to conduct interviews at the following City Health facilities:

**Eastern & Khayelitsha**  
Contact Person

Town Two CDC & Wesbank Clinic  
Dr Virginia de Azevedo (Area Manager)  
Tel: (021) 360- 1258

**Northern & Western**  
Contact Person

Bloekombos & Protea Park Clinics  
Dr Andile Zimba (Area Manager)  
Tel: (021) 400 3922

**Klipfontein & Tygerberg**  
Contact Person

St Vincent Clinic  
Mr Ruberto Isaaks (Acting: Area Manager)  
Tel: (021) 444 0893

**Please note the following:**

1. All individual patient information obtained must be kept confidential.
2. Access to the clinics and clients must be arranged with the relevant Managers such that normal activities are not disrupted.
3. A copy of the final report must be sent to the City Health Head Office, P O Box 2815 Cape Town 8001, within 6 months of its completion (which is currently scheduled for Feb 2018) and feedback must also be given to the clinics involved.
4. Your project has been given an ID Number (7928); please use this in any future correspondence with us.
5. No monetary incentives to be paid to clients on the City Health premises.
6. If this research gives rise to a publication, please submit a draft before publication for City Health comment and include a disclaimer in the publication that "the research findings and recommendations do not represent an official view of the City of Cape Town".

Thank you for your co-operation and please contact me if you require any further information or assistance.

Yours sincerely

DR N BERKOWITZ  
Epidemiologist: SPECIALISED HEALTH

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E-mail: [soph-comm@uwc.ac.za](mailto:soph-comm@uwc.ac.za)

### **PARTICIPANT INFORMATION SHEET**

**Project Title:** Exploring the clients' experience of Primary Health Care services prior to and post the implementation of appointment systems in City Health Clinics, Western Cape, South Africa

In a nutshell: We are wanting to understand what your experience was like before the clinic had an appointment system and what it has been like since they introduced an appointment system.

#### **What is this study about?**

This is a research project being conducted by René Sparks, a Masters of Public Health student at the University of the Western Cape. We are inviting you to participate in this research project because you have experience of the clinic, before and since the introduction of their appointment system. Your input will be of great value in understanding how the appointment system at your clinic works and how it affects you and your community. The purpose of this research project is to voice your experiences, as a community member and client of the clinic, which will allow City Health to shape the appointment system to suit your needs, as well as those working in the clinic to improve services to both you and your community.

#### **What will I be asked to do if I agree to participate?**

Firstly, you will be asked to read this information sheet. Feel free to ask as many questions as you would like regarding it and once you are happy that you understand it, you will be asked to read and sign a consent form. This consent form is an agreement to participate in a +/- 30 min interview which will be conducted by the researcher. The interview will be recorded in order for the researcher to go back and make sure nothing valuable has been missed. Your personal information will be coded to protect your identity. The interview will be conducted in a private room and the researcher will try not to delay your journey at the clinic too much. There will always be opportunity for you to stop and ask any question as it arises. We invite you to be comfortable and relax, answer as best as possible and assist us with understanding your experiences. The consent form, recordings and interview notes will be kept by the researcher for safe keeping.

#### **Would my participation in this study be kept confidential?**

The researcher will protect your information about who you are and what you have shared so that no one is able to recognise you. Your information will be coded as described below:

- (1) your name will not be written on the interview notes and other collected data;
- (2) a code will be placed on the interview notes and other collected data;
- (3) through the use of a special ID key, the researcher will be able to link your interview notes to you; and lastly,
- (4) only the researcher will have access to the ID key.

To further ensure your confidentiality, Rene Sparks will keep all interview materials locked in a safe space and only use the above mentioned identification code. The audio recordings of the interview will be kept on a password-protected computer.

If we write a report or article about this research project, your identity will remain protected.

### **Shared confidentiality**

In accordance with the law and/or professional standards, we must disclose any information that comes to our attention concerning child abuse or neglect or potential harm to you or others. This disclosure will only be to the appropriate individuals and/or authorities. In this event, we will inform you that we have to break confidentiality to fulfil our legal responsibility, in order to protect yourself or others from further harm or danger. Again, this information or shared confidentiality will only be reported to the designated authorities.

### **What are the risks of this research?**

There may be some risks from participating in this research study.

All interactions between people which involve talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act immediately to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

### **What are the benefits of this research?**

This research is not designed to help you personally, but the results may help the investigator learn more about how the appointment system in your clinic affects you and others in your community and, if there are gaps, these could be addressed to improve services at the clinic, which is a huge benefit to all clients who use the service. We hope that in the future other communities and health staff might benefit from this study through improved understanding of appointment systems and the role communities have in shaping service delivery at the clinic.

### **Do I have to be in this research and may I stop participating at any time?**

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized, victimised or lose any benefits to

which you otherwise qualify. If you chose to withdraw from the study, none of your contributions will be added to future reports or articles.

### **What if I have questions?**

This research is being conducted by René Sparks under the supervision of *Professor* Uta Lehmann and Dr Martina Lembani, at the University of the Western Cape. If you have any questions about the research study itself, please contact Prof Uta Lehmann or Dr Martina Lembani at: School of Public Health, University of the Western Cape; 021 959 2809.

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof Uta Lehmann or Dr Martina Lembani: School of Public Health, UWK, 021 959 2809

Prof Uta Lehmann  
School of Public Health  
Head of Department  
University of the Western Cape  
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Prof Anthea Rhoda  
Acting Dean of the Faculty of Community and Health Sciences  
University of the Western Cape  
Private Bag X17  
Bellville 7535  
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This research has been approved by the University of the Western Cape's Research Ethics Committee. REFERENCE NUMBER: *BM17/9/13*

### **BIOMEDICAL RESEARCH ETHICS ADMINISTRATION**

**Research Office**

**New Arts Building,**

**C-Block, Top Floor, Room 28**

**University of the Western Cape**

**Private Bag X17**

**Bellville 7535**

We, thank you for your time and input into shaping your clinic's appointment system and look forward to future engagements.



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### **DEELNEMER INFORMASIE VORM**

**Projek titel:** Ondersoek van kliente se ervaringe van Primere Gesondheids Sorg dienste, voor en na die implementasie van die afspraak stelsel in City Health klinieke, Wes Kaap, Suid Afrika

Basies, wil ons U ervaringe van kliniek dienste, voor n afspraak stelsel en na die stelsel inplek gesit is verstaan.

#### **Wat behels die studie?**

Die navorsing projek word deur René Sparks, n Meesters in Publieke Gesondheid's student by Universiteit Wes Kaapland, gedoen. Ons nooi U om deelteneem aan hierdie projek omdat U die ervaring van die kliniek het, voor dit n afspraak stelsel gehad het en nou sedert hulle een begin het. U bydra is van groot waarde en sal vir ons help om U ervaring te verstaan en hopelik te verbeter. Die doel van hierdie studie is om U stem en die stemme van die gemeenskap te hoor en om die afspraak stelsel te verander, indien nodig, om U en die gemeenskap se behoeftes te vervul.

#### **Wat sal Ek moet doen as Ek instem om deel te neem?**

U sal eers gevra word om hierdie vorm te lees. Voel vry om enige vrae te vra en as U tevrede is, sal U n toestemming vorm moet teken. Die toestemming vorm is n ooreenkoms om deel te neem aan 'n +/- 30 min onderhoud wat deur die navorser gedoen word. Die onderhoud sal afgeneem word sodat die navorser terug kan gaan en verseker dat geen waardevolle informasie gemis word nie. U persoonlike informasie sal deur n kode beskerm word. Die onderhoud sal in a privaat kamer geskiet en die navorser sal as probeer om nie te veel van U tyd te vat nie. U mag enige tyd stop om vrae te vra of om meer verduideliking te soek. Ons nooi U om te ontspan, U gerus te maak en as bes moontlik die vrae te beantwoord. Dit sal sorg dat ons die mees waardevolle brokkies uit U ervaring skulder. Die toestemming vorm, onderhouds notas en opnames sal deur die navorser inbekerking gehou word.

#### **Sal my deelneming in hierdie studie vertroulik gehou word?**

Die navorser sal al U informasie en bydrae wat U kan uitken beskerm deur n kode te gebruik. Hierdie kode sal op al die dokumente verskyn en sal alleenlik deur n ID sleutel geken word. Die navorser sal die enigste een wees wie die ID sleutel het om die kode te erken. Sy sal die dokumente, opnames en onderhouds notas behou en beskerm. Alle informasie sal op a komper met n beskermde kode geplaas word.

Indien ons n report of artikel skryf oor hierdie studie, sal U identiteit nog steeds beskerm word.

### **Gedeelte vertroulikheid**

In ooreenstemming met die wet en die professionele standarde, is ons verplig om enige informasie oor kinder mishandeling, verwaarlosing of skade aan self of ander aantemeld. Ons sal dit slegs met toepaslike mense bespreek en ons sal dit eers met U bespreek. Dit sal slegs gedoen word om ons verantwoordlikheid teenoor die wet na te kom en om U en anders te beskerm. Weereens, die sal slegs met toepaslike mense bespreek word.

### **Wat is die risiko as Ek in hierdie navorsing deelneem?**

Daar is moontlike risiko as U deelneem in die studie. Enige interaksie tussen mense, waar hulle deel oor hulself or anders het risiko aanverbond. Ons probeer bes moontlik om enige risiko aan U te verminder en sal onmiddelik te werke gaan om U gerus te laat voel. Indien U enige fisiese, geestelike or ander ongeriewe waarneem, sal ons dit onmiddelik probeer regstel. Waar U moontlike verwysing benodig, sal toepaslike verwysing deur die navorser gedoen word.

### **Wat is die voordele as Ek deelneem in hierdie studie?**

Hierdie navorsing was nie ontwerp om vir U persoonlik te bevoordeel nie. Hopelik sal die informasie wat deur die studie uitgebeeld word, die afspraak stelsel vir U en U gemeenskap verbeter. Die uitkoms sal in die kwaliteit van sorg en die ervaringe van almal wat die kliniek besoek verryk. Ons hoop dat die voordele deur U en die gemeenskap ervaar word.

### **Moet Ek in die studie wees en mag Ek enige tyd my deelneming stop?**

U deelname in die studie is heeltemal vrywillig. U mag enige tyd besluit om U deelname te stop. As U die toestemming geteken het, en begin deelneem het, mag U nogsteeds enige tyd stop as U so voel. U sal nie gestraf of geviktimizeer word nie. As U besluit om te onttrek, sal geen van U bydrae in die artikels or studie report verskyn nie.

### **Wat as Ek nog enige ander vrae het:**

René Sparks, doen hierdie navorsing onder die toesig van Professor Uta Lehmann and Dr Martina Lembani, Universiteit Wes Kaapland. As U enige ander vrae oor hierdie navorsing het, mag U vir hulle kontak:

Prof Uta Lehmann or Dr Martina Lembani: School of Public Health, UWK, 021 959 2809

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This research has been approved by the University of the Western Cape's Research Ethics Committee. REFERENCE NUMBER: *BM 17/9/13*

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Baie Dankie vir U tyd en bydrae, dit sal help om U kliniek se afspraak stelsel volledig te evalueer en verander om U behoeftes te vervul.



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### **IPHEPHA LOLWAZI KUMTHATHI-NXAXHEBA**

**Isihloko seprojekthi.** Kufunwa ukuva ngamava abantu abandwendwela amaziko ezempilo wethu phambi nasemva kwenkqubo ye 'appointment' kumaziko empilo aseNtshona Koloni, emzantsi-Afrika.

Sifuna ngokuphandle uqonda nokwazi ukuba ubuphatheka njani eclinic phambi nasemva kwalenkqubo ye 'appointment'.

#### **Oluphando lungantoni?**

Oluphando lwenziwa ngu Rene Sparks umfundi we 'Masters in Public Health' kwiDyunivesiti yaseNtshona Koloni.

Siyakumema uthathe inxaxheba kuba unamava okanye uke wasebenzisa amaziko ethu ezempilo wokuqala njenge klini zethu.

Injongoyoluphando kukuba sithethe ngamava ethu xa sityelele amaziko ezempilo phambi nasemva kohlelo lwe 'appointments' kwikliniki zethu nanjengamalungu omphakathi nabasebenzisi bekliniki zethu.

Oluphando luzokwazi ukwenza isixeko saseNtshona Koloni sifezekise imfuno zenu nagalenkqubo ye 'appointment'.

Iphinde incede ukwenza ngcono inkonzo zempilo kumphakathi wethu nakuthi.

#### **Yintoni ekufuneka ndiyenzile xa ndifuna uthatha inxaxheba kulophanda?**

Okokuqala kufuneka ufunde konke okuqulathwe kwiphepha lolwazi ngoluphando.

Kufuneka ukhululeke ubuza imibuzo malunga noluphando, xa sewazi ngalo ufuna uthatha inxaxheba kufuneka utyikitye isvumelwano sothatha inxaxheba.

Esisivumelwano kuvuma ukuba uzoba nodliwano ndlebe lizoshicilelwa ukwenzela umphandi angashiya kwanto ebalulekileyo, Luzobasekhusini oluphando kwaye igama lakho lizokhuselwa libe yimfihlo.

Oludliwano ndlebe aluzuthatha xesha lakho elide, kwaye kufuneka ukhululeke uthethe yonke into oyaziyo ngale nkqubo ye appointment. Ushicilelo nokubhalwa ngumphandi nesivumelwano sogcinwa ngumphandi.

#### **Ingaba uthatha inxaxheba koluphando kuyimfihlo?**

Umphandi uyogcina yonke into iyimfihlo ukwenzela kungabikho namnye umntu onokwazi.

1. Igama lakho aluzubhalwa kudliwanondlebe
2. Kuzosetyenziswa usghicilelo
3. Kuzo setyenziswa isazisi esikhethekileyo umphandi anokwazi uqhagamshelana nawe.

4. Ngumphandi kuphela ozokwazi ufumana isitsixo sesazisi

**Ulwazi ekufuneka lwazi we ngabanye abantu.**

Ngokomthetho kufuneka inkcukacha ezingohlukunyezwa kwabantwana nokungabanakekeli nezinto ezibabeka ebungozini kwabelwane ngazo. Kodwa xa kuyimfuneko oko uyokwaziswa nabasemagunyeni.

**Oluphando lubaluleke ngantoni?**

Oluphando alwenzelwanga unceda wena isiqu kodwa ukwazi banzi ngalenkqubo ye appointments eNtshona Koloni nokuthi wena ikuchaphazela njani nomphakathi. Abasebenzi bezempilo nomphakathi uyancedakala ngoluphando.

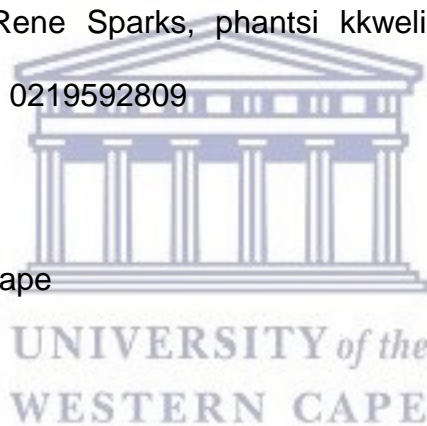
**Ngaba kuyimfuneko uthatha inxaxheba koluphando, kwaye ndingarhoxa kulo nanini na?**

Uthatha inxaxheba ngokuzithandela unganyanzeliswanga. Ungangathathi nxaxheba ufuna, kwaye ungarhoxa nanini na ufuna. Xa uyeke phakathi koluphando inkcukacha zakho azizusetyenziswa koluphando.

**Xa ndifuna inkcukacha ezithe vetshe?**

Olophando lwenziwa nguRene Sparks, phantsi kkweliso lika Professor Uta no Dokotela u Matina  
Bafumaneka kwezinombolo 0219592809

Prof Uta Lehmann  
School of Public Health  
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Olu phando luvunywe yiKomiti yeeNkcazo zokuPhando yeNyuvesi yeNtshona Koloni. REFERENCE NUMBER: *BM 17/9/13*

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Thina, siyabonga ngexesha lakho kunye negalelo ekubunzeni inkqubo yakho yokuqeshwa kwekliniki kwaye ujonge phambili kwiintetho ezizayo.



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### CONSENT FORM

**Title of Research Project:** Exploring the clients' experience of Primary Health Care services prior to and post the implementation of the appointment system in City Health Clinics, Western Cape, South Africa

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that the interview will be audio recorded and kept safe by the researcher. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

#### **Audio taping**

This research project involves making **audiotapes** of you to assist the research team capture all the information. The information will be kept confidential and only accessible to the researcher and securely locked in the cabinets. The information will be destroyed after the research

I agree to be audiotaped during my participation in this study.

I do not agree to be audiotaped during my participation in this study.

**Participant's name:** .....

**Participant's signature:** .....

**Date:** .....

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### TOESTEMMINGS VORM

**Titel van die Navorsings Projek:** Ondersoek van kliente se ervaringe van Primere Gesondheids Sorg dienste, voor en na die implementasie van die afspraak stelsel in 'City Health' klinieke, Wes Kaap, Suid Afrika

Hierdie studie was in 'n taal wat Ek verstaan aan my verduidelik. My vrae oor die studie was beantwoord. Ek verstaan wat my deelname behels en gee toestemming om deel te neem, uit my eie wil en keuse. Ek verstaan dat die onderhoud opgeneem word en dat die navorser dit onder toesig bewaar. Ek verstaan dat my identiteit beskerm sal word. Ek verstaan dat Ek enige tyd my deelname kan onttrek, sonder dat dit enige negatiewe het impak op my moontlike voordele en sonder enige nagevolge.

#### **Audio opneeming van onderhoud**

Hierdie navorsingsprojek behels die maak van **audio opname** van die onderhoud te maak om die navorsingspan te help om al die inligting te kry. Die inligting sal vertroulik gehou word en slegs die navorser sal toegang het tot dit, dit sal veilig in die kas gesluit wees. Die inligting sal na die ondersoek vernietig word.

\_\_\_ Ek stem in om tydens my deelname aan hierdie studie n audio opname toetelaat.

\_\_\_ Ek stem **nie** saam om tydens my deelname aan hierdie studie audio opgeneem te word nie.

**Deelnemer se naam.....**

**Deelnemer se handtekening.....**

**Datum.....**

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### IFOMU YOMSEBENZI

**Isihloko soPhando lweProjekthi:** Ukuhlola amava abaxhamli beenkonzo zokuNakekelwa kweMpilo yePrayimari ngaphambi kokuqala nokuphunyezwa kwenkqubo yokuqeshwa kwiiKlinikhi zeMpilo zeSixeko, eNtshona Koloni, eMzantsi Afrika.

Uhlolisiso luye lwachazwa kum ngolwimi endiluqondayo. Imibuzo yam malunga nokufunda iphendulwe. Ndiyayiqonda into yokuba inxaxheba yam iya kubandakanya kwaye ndiyavuma ukuthatha inxaxheba kokhetho lwam kunye nenkululeko yokuzikhethela. Ndiyaqonda ukuba udliwano-ndlebe luya kubhala olurekhodiweyo kwaye lukhuselekile ngumphandi. Ndiyaqonda ukuba i-ID yami ayiyi kutyhilwa kumntu. Ndiyaqonda ukuba ndinokurhoxisa isifundo nanini na ngaphandle kokunika isizathu kwaye ndingenako ukoyika kwimiphumo emibi okanye ukulahlekelwa kwezibonelelo

#### **Uluhlu oluthile**

Le projekthi yophando iquka ukwenza ii-audiotaps zakho ukunceda iqela lophando lithinte lonke ulwazi. Ingcaciso iya kugcinwa iyimfihlo kwaye ifumaneke kuphela kumphandi kwaye ikhuselwe ngokukhuselekileyo kwiiKhabhinethi. Ulwazi luya kutshatyalaliswa emva kophando

\_\_\_ Ndiyavuma ukuba i-audiotaped ngexesha lokuthatha inxaxheba kweso sifundo.

\_\_\_ Andivumelani ukuba i-audiotaped ngexesha lokuthatha inxaxheba kweso sifundo.

**Igama leNxaxheba:** .....

**Isayinwe somthathi-nxaxheba: .....**

**Umhla: .....**

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Appendix 9: English interview guide

**Interview guide for clients of City Health clinics: experiences prior to and post the implementation of the appointment system**

<b>Facility code:</b>	<b>Date and time of interview:</b>
<b>Ask: Facility Manager</b>	
1) When was appointment system implemented:	
2) Was it implemented to all services:	
<b>Advice: Client</b>	
<b>Reminder: This interview will require you to think back to previous attendance at this clinic before the appointment system was in place.</b>	

- 1) Can you tell me about your experience of the clinic you attend?
  - Describe why you attend this clinic?
  - Have you attended any other clinics?
- 2) Are you attending with an appointment today?

**ONLY ANSWER QUESTION 3 & 4: IF CLIENT ATTENDING WITHOUT APPOINTMENT TODAY:**

- 3) If you did not attend with an appointment today, how has this been different from booked visits?
- 4) No appointment today: Can you tell me what benefits or problems you have experienced attending without an appointment today?
- 5) How did you learn about the appointment system in your clinic?
  - Was the information given clear?
  - What type of information did you get e.g. Posters, pamphlets, talks, announcements?
- 6) What do you expect when you are given an appointment in a clinic?



- 7) Can you tell me about how you felt the experience of visiting the clinic was before you could get an appointment?
- Describe for me what a normal visit was like for you before you could get an appointment?
    - Think back to a visit without an appointment: How long did it take to be helped? Did you wait a long time to be seen?
    - Did you have to see many staff members to get what you came for?
    - Did you know where to go or where to find the person who was going to see you?
- 8) Describe your experience of clinic visits since they introduced an appointment system
- Can you think about something specifically that has changed for you now that you can get an appointment?
  - How do you think the appointment system has changed to your clinic visit?
    - Describe how by using an example, if possible
- 9) How has having an appointment impacted on your life?
- Are you able to do other things? Describe how it has changed from the time you didn't have an appointment.
  - How does an appointment system help you to get the care you came for?
- 10) You can take your time on this one: I need you to think back and compare your experience of clinic service before an appointment system and now, what value or benefit do you see in having an appointment system?
- 11) Describe any areas of improvement or change to the appointment system in your clinic that you can think of. Doesn't matter how big or small you think it is.
- Think of whether the appointment system is working as it should for you

12) To your knowledge can you describe any platform (in the form of a committee or informal group) available for you, and your community to add to the changes in the appointment system?

- Are you or anyone you know active on this platform?
- What role could you or community play in shaping the appointment system within your clinic?

I would like to offer you the opportunity to add anything that has come to mind after the interview and to ask any other questions you may have.

Our discussion ends here and I would like to take this opportunity to thank you for your time and sharing your experiences with me.



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**Onderhoud gids vir kliente van City Health klinieke: ervaring voor en na die stigting van die afspraak stelsel.**

<b>Faciliteits kode:</b>	<b>Datum en tyd van onderhoud:</b>
<b>Vra: Kliniek Bestuurder</b>	
1) Wanneer was die afspraak stelsel geïmplementeer:	
2) Was die afspraak stelsel in elke diens wat die kliniek lewer, geïmplementeer:	
<b>Advies: Klient</b>	
<b>Herhinderings: Hierdie onderhoud benodig dat U terug moet dink, dink aan die tyd wat U die kliniek besoek het, voor n afspraak diens gegee, in vergelyking met die huidige diens met n afspraak.</b>	

1) Kan U my vertel van U ervaring van die kliniek vertel?

- Beskryf hoekom U hierdie kliniek besoek?
- Het U enige ander klinieke besoek?

2) Het U vandag met n afspraak kliniek toe gekom?

**VRA NET VRAG 3 & 4 AS KLIENT SONDER n AFSPRAAK GEKOM HET:**

3) As U vandag sonder n afspraak kliniek toe gekom het, hoe is dit anders van tye wat U met n afspraak gekom het?

4) Geen afspraak vandag: Kan U vir my vertel van enige probleme of goeie punte wat vir U uitstaan?

5) Hoe het U uitgevind van die afspraak dienste van die kliniek?

- Was die informasie maklik om te verstaan en goed oorgedra?
- Watter tipe informasie het hulle gegee eg. Posters, pamflete, praatjies, aankondigings?

6) Wat verwag U as U n afspraak van die kliniek gekry het?

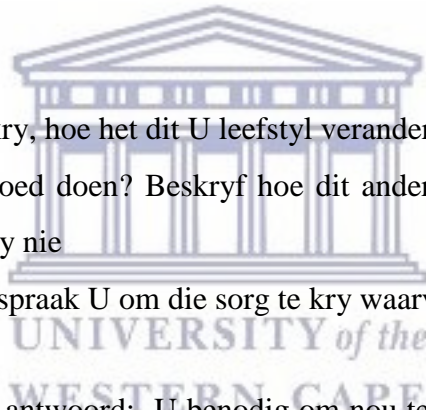
7) Kan U my vertel oor U ondervinding van die kliniek dienste voor U n afspraak kon kry?

- Beskryf hoe n normale besoek so wees voor U n afspraak gekry het

- Dink terug, voor afsprake bestaan het: Hoe lank het U gewag om gehelp te word? Moes U lank wag voor U gesien word?
- Moes U meer as een kliniek werker gesien het om U probleem uittesorteer?
- Het U geweet waar U moes gaan and wie U so sien?

8) Beskryf U ervaring van U kliniek besoeke sedert or vandat die afspraak diens beskikbaar is

- Kan U aan iets spesifiek dink wat vir U verander het, nou dat U n afspraak kry?
- Hoe dink U het die afspraak stelsel n verandering tot U kliniek besoek gemaak?
  - Gebruik voorbeelde om dit te verduidelik, as dit help or dit makliker maak.



9) Nou dat U n afspraak kry, hoe het dit U leefstyl verander?

- Kan U ander goed doen? Beskryf hoe dit anders is van die tyd wat U nie n afspraak kon kry nie
- Hoe help die afspraak U om die sorg te kry waarvoor U gekom?

10) Wat U tyd met hierdie antwoord: U benodig om nou terug te dink aan die tye wat U die kliniek besoek het voor hulle n afspraak stelsel gehad het. U sal daardie ervaring en die huidige ervaring, met n afspraak, moet vergelyk. Sien U enige waarde in n afspraak stelsel?

11) Verduidelik of daar enige areas van verbetering in die afspraak stelsel is wat U aan kan dink. Dit maak glad nie saak hoe groot of klein U dink dit is nie. Deel asseblief dit met my.

- Dink daaraan of die afspraak stelsel vir U werk soos dit moet

12) Is daar enige forums of groepe waarvan U weet, waar U or die gemeenskap veranderinge kan aanvra, in verband met die afspraak stelsel in U kliniek?

- Is U of enige iemand wie U ken aktief in hierdie groep or forum?

- Watter rol speel U of lede van die gemeenskap in die verbetering van die afspraak stelsel van die kliniek?

Ek wil graag hierdie geleetheid beskikbaar maak indien U enige ander informasie or bedrae wil maak. Voel gerus om ook enige vrae te vra.

Ons gesprek is nou tot n einde en Ek wil graag vir U hartlik bedank vir U eranging wat U met my gedeel het. Waardeer dit!



Appendix 11: isiXhosa Interview Guide

**Umcebisi-ngcebiso kubathengi beekliniki zeMpilo zeSixeko: amava ngaphambi kokupasa nokuphunyezwa kwenkqubo yokuqeshwa**

<b>Ikhodi yomnxeba:</b>	<b>Umhla kunye nexesha lokudliwano-ndlebe:</b>
<b>Buza: UMphathi weziko</b>	
1) Kwakuba nini inkqubo yokuqeshwa iphunyezwa:	
2) Ngaba iphunyezwe kuzo zonke iinkonzo:	
<b>Iseluleko: Umxhasi</b>	
Isikhumbuzo: Olu dliwano-ndlebe luyakufuna ukuba ucinge emva kwabafundi beli klinikhi ngaphambi kokuba inkqubo yokuqeshiswa ibekwe.	

1) Unokundixelela malunga namava akho eklinikhi oya kuyo?

- Chaza kutheni uya kule klinikhi?
- Ngaba uye waya kwezinye iiklinikhi?

2) Ngaba uhamba kunye nokuqeshwa namhlanje?

**IMPENDULO YOKUPHEPHA UMBUZO 3 & 4: UKUBA UKUQALA NGAPHAMBI UKUNIKWA KWENYAKA:**

3) Ukuba awuzange ungene kwi-aphoyintimenti namhlanje, le nto ihluke njani ekutyelweni okubhengeziweyo?

4) Ufunde njani malunga nenkqubo yokuqeshwa kwiklinikhi yakho?

5) Ingaba ulwazi luye lwacaca?

- Luhlobo luni lwazi olufumene umz. Iposter, iiphamfulethi, iintetho, izaziso?

6) Yintoni okulindeleyo xa unikezelwa ukuqesha kwiklinikhi?

7) Ngaba unokundixelela malunga nendlela ozive ngayo ngamava okundwendwela iklinikhi ngaphambi kokuba ufumane i-aphoyintimenti?

8) Ndixelele ukuba kutyelelo oluqhelekileyo lwalufana nani ngaphambi kokufumana ukuqesha?

- Cinga emva kokutyelelwa ngaphandle kokuqeshwa: Kuthatha ixesha elingakanani ukuncedwa? Ngaba ulinde ixesha elide ukuba libonwe?
- Ngaba kufuneka ukuba ubone abasebenzi abaninzi ukuba bafumane ntoni na?
- Ngaba uyazi apho uya khona okanye apho ungayifumana khona umntu oza kukubona?

9) Chaza amava akho ekhenkethi ukutyelela njengoko baqalisa inkqubo yokuqeshwa

- Ngaba unokucinga ngento ethile ngokutshintshileyo kuwe ngoku ukuba unokufumana isigqibo?
- Ucinga ukuba inkqubo yokutyunjwa yatshintshile njani ekhenklini yakho?
  - Chaza indlela yokusebenzisa umzekelo, ukuba kunokwenzeka

10) Unokuthatha ixesha lakho kule nto: Ndifuna ukuba ucinge emva kwakho uze uqhathanise amava akho kwinkonzo yeklinikhi phambi kwinkqubo yokuqeshisa kwaye ngoku, yiyiphi inzuzo okanye inzuzo oyibonayo ekubeni neenkqubo zokuqeshisa?

11) Chaza nayiphina indawo yokuphucula okanye utshintsho kwinkqubo yokuqeshwa kwiklinikhi ongayicinga ngayo. Akunandaba nokuba unkulu okanye umncinci ucinga ukuba.

- Cinga ukuba inkqubo yokuqeshwa iyasebenza njengoko kufanelekile kuwe

12) Ukuba nolwazi lwakho ungachaza nayiphi na iplani (ngendlela yekomiti okanye iqela elingacwangciswa) elifumanekayo kuwe, kwaye uluntu lwakho ukuba longeze kwiinguqulelo kwinkqubo yokuqeshwa?

Ndingathanda ukukunika ithuba lokunceda nayiphi na into evela engqondweni emva kokuba udliwano-ndlebe kwaye ubuze nayiphi na enye imibuzo onokuyenza.

Ingxoxo yethu iphelela apha kwaye ndifuna ukuthatha eli thuba ukuba ndibulele ngexesha lakho kwaye nixelela nabanye ngamava akho.