COMMUNITY PERCEPTIONS OF BIOMEDICAL HEALTH CARE IN A RURAL AREA IN THE NORTHERN PROVINCE SOUTH AFRICA

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ABSTRACT

The success of strategies to revitalise primary health care services such as those advocated by the Bamako Initiative requires a response adapted to the expectations of the population, especially in terms of quality. The goal of this study was to investigate community perceptions of availability, accessibility, acceptability and affordability of biomedical health care services in a rural area of the Northern Province in South Africa. A multi-stage cluster sampling method was used to ensure random inclusion of respondents. The sample consisted of 85 men (49%) and 89 women (51%), the age ranged from 18 to 88 years with a mean of 32.8 (SD=13.9). Participants were interviewed face-to-face with a structured questionnaire on demographic and health facility data, health status, accessibility, affordability, availability and quality of health care, and a Health Beliefs Questionnaire. Results indicate a low acceptability of biomedical health care: 78% felt that the medical services are poor. There was a significant relationship between not being member of a medical scheme, poorer health status and availability of health care services. The poorer health status was also significantly related with acceptability of health services. Illness attributes, employment status, gender and health beliefs were not related to any of the health services parameters. It is suggested that primary health care policy takes cognisance of the existing differences like that of acceptability and affordability in attitudes toward biomedical health care.

OPSOMMING

Die sukses van strategie om primêre gesondheidsorgdienste soos die wat deur die Bamako Inisiatief voorgestaan word, hang af van 'n reaksie wat rekening hou met die verwagting van die gemeenskap, spesifiek ten opsigte van kwaliteit. Die doel van die navorsing was om die persepsies van die gemeenskap na te vors ten opsigte van beskikbaarheid, toeganklikheid, en bekostigbaarheid van biomediese gesondheidsorgdienste in 'n plattelandse gebied in die Noordelike Provinsie in Suid-Afrika. Daar is van bondelssteekproeftrekking in fases gebruik gemaak om ewekansigheid te verseker. Die steekproef het bestaan uit 85 mans (49 %) en 89 vroue (51 %) met 'n verspreiding van 18 tot 88 jaar met 'n gemiddelde ouderdom van van 32.8 (standaarafwyking van 13.9). Daar is gebruik gemaak van 'n gestruktureerde vraelys waarvan die inligting deur een tot een onderhoude bekom is. Inligting oor die volgende faktore is bekom: demografiese en gesondheidsorginligting, gesondheidstatus, toeganklikheid, bekostigbaarheid, beskikbaarheid, kwaliteit van die gesondheidsorg, en 'n vraelys oor menings oor gesondheid. Die resultate toon 'n lae aanvaarbaarheid van biomediese gesondheidsorg; 78% het aangetoon dat die mediese dienste swak is. Daar was 'n betekenisvolle verhouding tussen faktore soos: om nie lid van 'n mediese fonds te wees nie, swakker gesondheid en beskikbaarheid van gesondheidsdienste. Swakker gesondheid korreleer ook met die aanvaarbaarheid van gesondheidsdienste. Die volgende faktore toon geen verband met gesondheidsorg nie: siektes, geslag, gelowe oor gesondheid en werkloosheid al dan nie. Die gevolgtrekking waartoe die studie kom is dat die beleid ten opsigte van primêre gesondheidsorg kennis moet neem van die bestaande verskille soos die aanvaarbaarheid en bekostigbaarheid in die houdings ten opsigte van biomediese gesondheidsorgdienste.

INTRODUCTION

Medical facilities in the Northern Province are inadequate considering the size of the population. In 1992 there were 4.7 hospital beds available per 1000 people. The national average is 5.1 beds, and 6.5 beds per 1000 people in Gauteng. The Northern Province is in dire need of medical officials, having only 796 practitioners for 5.3 million people in 1992 or 0.2 per 1000 people. The national average is 0.6 doctors per 1000 people. Another important determinant of health status is the availability of health facilities. This includes accessibility and quality of service. In general, health facilities are more readily available in urban areas. However, these facilities have a strong curative bias, and many are situated too far from where the poor people live. Rural people not only have limited facilities, but access to these facilities is also restricted. People living further than 5 km from medical facilities constitute 44.4% of the population, while 11.3% belong to a medical aid benefit fund in the Northern Province. Health status is not only determined by access to facilities for mainly curative purposes, but also by other factors which prevent the onset of illness and malnutrition. Income is seemingly the most important factor in this regard, as there is a strong correlation between income levels and health status (Development Bank of Southern Africa, 1998:53).

The health care needs in rural South African environments are mainly addressed by traditional or faith healers and primary health care clinics run by nurses. In the light of the absence of medical doctors in

near reach this study reflects on the attitudes towards availability, accessibility, acceptability and affordability of biomedical health care services in a rural area of the Northern Province in South Africa. Little attention has been paid to the quality of primary health care services in developing countries. This can be explained by the priority that has long been placed on improving availability of services in contexts where there have been enormous needs that have rarely been met. The evaluation of the quality perceived by the public is justified in the desire to meet users expectations, thereby contributing to the process of democratisation of health care services (Haddad, Fournier, Machouf & Yatara, 1998:382).

During the Reconstruction and Development era, in South Africa, very little literature is found on the provision of Primary Care Services (Thipanyana & Mavundla, 1998:23).

Van Vuuren and Botes (1994:2) found among a culturally diverse population in an urban area in South Africa (greater Bloemfontein) that variables such as population group, age and employment status influence their attitudes towards professional health care. They further emphasise the importance of bringing these issues to the attention of the health care policy makers. Miralles and Kimberlin (1998:345) found among elderly from different socio-economic backgrounds in Rio de Janeiro that residents of the low-income community reported less availability of services, more difficulties with affordability and greater acceptability of pharmacy services than their high-income community counterparts. Heap and Ramphele (1991:117) studied health care strategies among residents of South African hostels indicating that choice of therapy depends on cost, availability, and experience with various healing systems. Haddad, Fournier, Machouf **et al.** (1998:381) studied community perceptions of primary health care services in Guinea. From a taxonomy of perceived quality the following categories were identified: (1) technical competence of the health care personnel, (2) interpersonal relations between patients and care providers, (3) availability and adequacy of resources and services, (4) accessibility and (5) effectiveness of care. On Tanzanian women's views of the quality of Primary Health Care Services, Atkinson and Ngenda (1996:3ff.) found 6 dimensions: (1) conduct of health staff, (2) technical care, (3) convenience of the health facility, (4) organisation of the health care, (5) drugs and (6) structural aspects. In addition, the role of world-views in health care systems has been acknowledged (Craffert, 1997:1; Hildebrandt, 1997:155; Pillay, 1996:4).

Considering the above components and concepts of care and quality of health care, the purpose of this study is to examine the concepts of availability, accessibility, acceptability, and affordability as applied to biomedical health care in a rural South African community (Anyinam, 1987:803).

It is hypothesized that illness attributes (medical, supernatural and psychosocial), socio-economic status, subjective health status, member of medical scheme, and distance to health facilities have an impact on the attitude towards biomedical health care in terms of availability, accessibility, affordability and acceptability. On the basis of these parameters questionnaires were chosen, which were previously used on South African populations, to measure "quality of health care" and "health beliefs".

METHODS

Sample and procedure

The sample consisted of 85 men (49%) and 89 women (51%), the age ranged from 18 to 88 years with a mean of 32.8 (SD=13.9). One hundred and sixty-two (95%) were Northern Sotho and the remaining 12 (5%) belonged to different ethnic groups. Ninety-six (40%) were married , 83 single (48%), 15 widowed (9%), and 7 divorced (4%). Most (72%) including "housewives" were categorised as unemployed and 49 (28%) employed. Sixty-seven (38.5%) belonged to the Zion Christian Church (ZCC), 18 Roman Catholic (10%), 14 African belief (8%), and the remaining 75 (43%) belonged to 15 different religious denominations.

A multistage cluster sampling method was used to ensure random inclusion of respondents from the GaMolepo area, which is 60 kms southeast of Pietersburg (cf. Van Vuuren & Botes, 1994:3). In the first phase villages from the GaMolepo area were randomly selected; in the second phase dwelling units representing households were randomly selected, and the third phase involved the identification of a single respondent per residential unit.

Participants were interviewed face-to-face with a structured questionnaire by a trained African interviewer (with a matric qualification and fluency in English and Northern Sotho) in the language of the participants.

Inventory

The structured questionnaire consisted of 13 items on demographic and health facility data, 1 item on health status, and 17 items on Quality of Health Care (cf. Van Vuuren & Botes, 1994:3f.), and a 30-item Health Belief Questionnaire (HBQ) (Pillay, 1996:5). The questionnaire was tested with 10 participants, which did not form part of the final sample in order to ensure validity and reliability.

The quality of health care questionnaire consisted of

four components: accessibility (3 items), affordability (5 items), availability (3 items), and acceptability (6 items). Answers were rated on a five-point Likert scale from 1=agree fully to 5=disagree strongly. The Cronbach alpha as well as the split-half reliability coefficient for the quality of health care questionnaire was .7 for this sample.

The HBQ consisted of 20 items etiological beliefs (10 external ancestral/evil, 4 medical, 4 self-blame, and 2 physical weakness or body malfunction), 8 items treatment beliefs (4 self-medication, home treatment, 2 medical, 1 prayer, 1 holistic treatment), 2 item preventive belief (1 self-care, 1 hygiene). The items can also be divided into 8 items for medical attribution, 12 items for supernatural attribution, and 10 for psychosocial attributions. The HBQ is designed to ascertain health and illness beliefs. It requires the respondents to rate on a four-point Likert scale whether they agree, sometimes agree, disagree, or were not sure about the statement presented. The Cronbach alpha and split-half reliability coefficient for the HBQ was .81 and .85, respectively, for this sample.

RESULTS

Most (137) (79%) were not members of a medical aid scheme, whereas 37 (21%) were. From those who were employed the mean monthly income was R 1 844 (SD=1354), range R 300 to R 5 600. The nearest clinic was estimated at a mean of 4.8 km (SD=5.2), range 1 to 29 km, and the nearest clinic in minutes: mean 38 minutes (SD=22.3), range 4 to 120 minutes. The nearest doctor was estimated at a mean of 20.3 km (SD=8), and the nearest doctor in minutes: mean 55 minutes (SD=29). The nearest hospital was estimated at a mean of 24.8 km (SD=13.3), and the nearest hospital in minutes: mean 75 (SD=46).

Most participants (33%) rated their health with excellent, whereas 20% rated it as good, 24% reasonable, and 21% as poor.

Table 1 indicates the availability, accessibility, affordability and acceptability of health care in percent. Regarding availability 84% of the participants felt that there are not enough family doctors in their area. On the other hand almost one-third (31%) tended to use medical services just because it is available. More than one-third of the participants stated problems with the

Table 1: Availability, accessability, affordability and acceptability of health care in percent. (N=174)

Availability	AF/A	U	D/DS
1. I don't think that there are enough family doctors (GP's) in our area.	84	3	14
12. People tend to use medical service just because it is available	31	18	51
15. There are medical services I can use even though I can't pay for it	30	22	48
Accessibility			
4. The doctor will only see me during consultation hours	37	15	48
5. All clinics should be open after business hours as well	43	19	38
10. I can never see the doctor without an appointment	38	20	42
Affordability			
2. People should receive free medical care in the hospital	63	12	25
6. Because municipal clinics are free, I 'd rather go to one of them than to a clinic that I would pay	56	11	33
11. Medical services are not really expensive at all	34	17	49
13. Doctors are not expensive considering the type of service they give	38	27	35
14. Medical expenses have become so expensive that I cannot afford it	37	20	43
Acceptability			
3. Generally speaking, clinic nurses should refer their patients for test more often	71	20	9
7. When I am admitted to hospital, I become just another "case" or number	37	28	35
8. The quality of medical services in GaMolepo is excellent	13	9	78
9. Generally speaking, nurses are so busy writing reports and filling in forms that they can't look after their patients properly	51	16	33
16 "Home remedies" are often better than medicines doctors prescribe	25	25	50
17 "Over-the-counter drugs are often better than medicines doctors prescribe	26	15	59

AF (=Agree fully), A (=Agree), U (=Unsure), D (=Disagree), DS (=Disagree strongly)

accessibility of biomedical health care, like 43% felt that clinics should remain open after business hours and 38% that one can never see the doctor without an appointment. About two-third (63%) of the participants felt that one should receive free medical care in the hospital and 56% would rather go to a clinic where medical treatment is free. On the one hand almost half (49%) agreed that medical services are expensive and have even become more expensive (43%) but on the other hand 38% agreed that doctors are not expensive considering the type of service they give. The acceptability of health care in the GaMolepo area was generally considered poor: 78% felt that the medical services are poor, 71% felt clinic nurses should refer their patients for test more often and 51% agreed that nurses are so busy that they can not look after their patients properly. There was high trust in biomedical health care since 59% noted that over-the-counter drugs and 50% that home remedies are not better than medicines doctors prescribe.

Table 2 shows the correlation between independent variables and attitudes towards health care.

There was a significant relationship between not being a member of a medical scheme, poorer health status and availability of health care services. The poorer health status was also significantly related with acceptability of health services. Employment status and gender was not related to any of the health services parameters.

There seems to be a significant association between increasing age, member of a medical scheme, poorer health status and the statement that there are insufficient family doctors (GPs) in the area. The other two health indicators (free hospital care and improved referral by clinic nurses for tests) Were not related to health status and medical scheme membership.

Table 3 indicates health beliefs by differential attributes.

Highest rates for health attributions were found for: (1) visiting a doctor for regular check-ups can prevent a person from getting sick; (2) people go to doctors when they are seriously ill; (3) people get sick because they do not eat proper foods or do not keep themselves clean; (4) illness is caused by infection; and (5) people inherit illness from their parents. Interesting is that participants agreed to a large extent that older people play an important role in terms of knowledge about illness, advise and treatment. The most important supernatural attribute was doctors can make the illness better but they cannot treat the cause. In addition, people should pray and observe rituals to prevent and treat illness. Across the three categories of health attributes medical was most important, followed by psychosocial and supernatural in that order.

The three health belief attributes (medical, supernatural, and psychosocial) were correlated (using

Table 2 : Correlations between independent variables (A) and attitudes towards heath care (B)

(A)

Independent variable	Availability		Accessibility		Affordability		Acceptability	
	F	P	F	P	F	P	F	P
Not member of medical scheme	6.566	**.011**	1.202	.274	.217	.642	.063	.803
Poor subjective health status	3.596	**.015**	1.117	.334	1.883	.134	3.340	**.021**
Employment status	2.214	.139	1.864	.174	.394	.531	.719	.398
Sex	2.519	.114	5.11	.476	1.092	.297	.211	.646

ANOVA significance level

(A)

Independent variable	Availability		Accessibility		Affordability		Acceptability	
	F	P	F	P	F	P	F	P
Married	-.113	.137	-.070	.357	-.151	**.047**	.040	.598
Formal education	-.131	.102	-.009	.907	.034	.672	.054	.500
Income	.116	.405	.028	.839	.163	.240	-.015	.912
Nearest clinic (km)	.089	.254	.039	.618	-.051	512	-.072	.354
Nearest doctor (km)	.199	**.011**	.097	.218	.091	.248	-.018	.816
Nearest hospital (km)	.142	.069	.142	.069	-.092	.239	.062	.429
Medical attributes	.081	.283	.097	.218	.091	.248	.068	.368
Supernatural attributes	-.029	.699	.051	.503	-.136	.071	.025	.742
Psychosocial attributes	.090	.232	.073	.337	.096	.203	.029	.699

Pearson Correlation significance level

(B)

Independent variables	There are not enough family doctors (GPs) in our area	People should receive free hospital treatment	Clinic nurses should refer their patients for tests more often
Age	.089* (.012)	--	--
Employment status	--	.245 (.191)	--
Member of medical scheme	.103* (.026)	.146 (.071)	.139 (.079)
Poor subjective health status	.119* (.030)	.209 (.138)	.169 (.088)

* p<.05: Eta-square significance level in brackets

Table 3: Health belief questionnaire (Agree=1, sometimes agree=2, disagree=3, not sure=4)

Items	M (SD)
Medical attributes (8 items)	
1. People get sick because they are not strong	2.36 (1.12)
4. Illness is caused by infection	2.15 (.97)
9. People go to doctors when they are seriously ill	1.96 (1.02)
10. Doctors are the only ones who can treat people who are ill	2.31 (1.10)
13. People inherit illness from their parents	2.18 (.94)
17. Visiting a doctor for regular check ups can prevent a person from getting sick	1.78 (1.01)
25. People get sick when something foreign invades their body	2.44 (1.11)
28. Sickness occurs because your body is not functioning properly	2.42 (1.06)
Subtotal	2.20 (1.04)
Supernatural attributes (12 items)	
3. Illness is due to desertion from God	2.62 (1.07)
5. Illness is caused by witchcraft or sorcery	2.57 (1.13)
6. People get sick because someone has cursed or done something evil towards them	2.42 (1.12)
8. Sickness 'comes' from the devil	2.55 (1.09)
11. There is nothing a person can do to prevent themselves from getting ill	2.42 (1.01)
18. Doctors can make the illness better but they cannot treat the cause	2.28 (.99)
21. People should pray to God to cure them of their illness	2.33 (1.12)
24. Illness is a form of punishment for the wrong or bad things a person has done	2.69 (1.01)
26. Sickness occurs because you do not do the rituals or prayers required by the priest or ancestors	2.40 (1.06)

27. A person can become ill if they walk or cross over the path or spot where some ritual was performed	2.53 (1.07)
29. Illness is due to demon, evil or bad spirit possession	2.85 (.92)
30. Illness is due to punishment or desertion by the ancestors	2.97 (.99)
Subtotal	2.55 (1.05)
Psychosocial attributes (10 items)	
2. People get sick because they do not eat the proper foods	2.01 (.90)
7. People get sick because they do not exercise regularly	2.53 (1.01)
12. People get sick because they do not keep themselves clean	2.12 (.90)
14. If a person takes good care of themselves they will not get sick	2.38 (1.08)
15. People are able to cure themselves when they are sick	2.45 (1.00)
16. If people get sick it is their own fault	2.54 (1.00)
19. Most illnesses can be treated at home	2.55 (.98)
20. Older people know a lot about illness and can advise other what to do	2.17 (1.03)
22. People get sick because they are lazy and do not work hard enough	2.56 (1.06)
23. When sick the treatment given by elders or older people can really be helpful	2.18 (1.00)
Subtotal	2.35 (.99)

Pearson Correlation) with age, gender, marital status, employment status, membership of medical scheme, subjective health status, income, availability, accessibility, affordability and acceptability of biomedical health care, distance to health facilities. No significant differences were however found apart from being single and affordability, nearest doctor and availability of biomedical health care.

DISCUSSION

This study found a mean distance of 4.8 km from the consumer's home to the nearest primary health care centre. The normal distance between home and clinic is considered to be between 2-5 km. Vlok (1991: 5ff.) states that The Primary Health Care clinic must be accessible to the community, i.e. it should be within 5 km of the consumers of health care. The majority of the participants, 71%, stayed beyond 5 km but at different distances.

In this sample 21% were members of a medical aid scheme, which is higher than the average of 11.3% in the Northern Province. In this study a higher insufficiency of family doctors (84%) was found than that among the urban Black community in Bloemfontein (66%) (Van Vuuren and Botes, 1994:3) but the reverse was true for using medical services as they are just available. Regarding accessibility the participants in this study found their health services more accessible than that of the urban Black community (e.g. 43% felt clinics should be open after business hours as well as opposed to 83%). Regarding the other health parameters the participants in this study generally gave similar responses to that of the urban Black community. An exception was that 64% of the latter agreed their quality of health services is excellent whereas only 13% of the participants in this study did. This may be explained by the greater accessibility of biomedical health care in the urban as opposed to the rural area.

In terms of acceptability this study shows low rates (e.g. the poor quality of the medical services).
This finding needs further study, especially regarding a further qualification of the perceived low quality of health care. Anyinam (1987:810) has shown that if health services are not acceptable to consumers, they

will not be utilised even though they might be available and accessible. Acceptability or quality of health care was, in this study, in contrast to other studies not related to socio-economic status (Calnan, 1988:311).

From this study in line with Van Vuuren and Botes (1994:5) it appears that people without health insurance, along with those who consider their personal health to be poor, are of the opinion that health care services are less available (e.g. insufficient family doctors). Increasing age is associated with less availability, which is in contrast with the Bloemfontein study. This may be explained by the fact that in a rural area older people are less mobile to access health care services.

Participants of this study indicated an emphasis on medical health beliefs. This underlines the importance of doctors, especially for prevention and serious illness. In addition, the lack of proper food and hygiene has also been identified as important reasons leading to illness. It is true that the area under study has problems with clean water supply. Differential health beliefs may have a significant relationship with different health providers like traditional healers, faith healers as compared with biomedical health care, and not as found in this study when correlating biographic and attitudes towards biomedical health care with health beliefs attributes (cf. Pillay, 1996:8). Illness attributes were not as expected related to any of the biomedical health services parameters. One would have expected that medical attributes to illness would be related to higher acceptability of biomedical health care than supernatural attributes. In different studies (e.g. Pillay, 1996:4) it was found that people's health beliefs strongly influence their health and illness behaviour.

Limitations of the study are that the sample is restricted to a small geographic area and it was not stratified by age so that the findings cannot be generalised beyond the community and major age group under study. Furthermore, a more comprehensive - on the basis of qualitative research in the community under study - taxonomy can be developed to identify the components of quality of health care.

CONCLUSION

The study found a low acceptability and quality of biomedical health care as perceived by lay persons in a rural South African community. A number of other factors like subjective evaluation of personal health and not being member of a medical scheme, but not illness attributes influenced their attitude towards health services.

The success of strategies to revitalise primary health care services such as those advocated by the Bamako Initiative rests largely on their ability to meet the expectations of population, especially in terms of quality. The evaluation of the quality perceived by the communities thus constitutes an important complement to the evaluations carried out according to the health authorities' own approaches. It is therefore important that primary health care policy makers take cognisance of the existing differences like that of acceptability and affordability in attitudes toward biomedical health care.

The research provides valuable indications about the changes that should be made to promote some areas of the quality of primary health care services. In the area of acceptability the role of interpersonal relations is important. As in other studies, the conduct of the nurses stands out as a central element of the judgement that users make about health services. Health services must take note that their users want proper reception and treatment. Training may allow for the development or improvement of certain technical or even interpersonal skills.

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BOOK REVIEW

GETTING THE LOVE YOU WANT. A GUIDE FOR COUPLES

Harville Hendrix
Simon & Schuster of Australia Pty Ltd. Sydney

Dr Harville Hendrix is one of the world's leading marital therapists. He began his career as a therapist counselling both individuals and couples. He mentioned that he felt competent and effective with individuals, but saw the marital relationship as a complex system and he was not always capable of dealing with couples effectively. He ended up doing what most therapists did: problem-orientated contractual marriage counselling. This approach was not always useful or effective. His interest in relationship therapy started out of his own despair and disappointment after his divorce, and he had a compelling desire to make sense out of his dilemma.

He did intensive research through professional books and journals, but couldn't find any meaningful discussions of marriage, or no comprehensive theory to explain the intricacies of the male/female relationship. To fill this gap he worked with hundreds of couples in private practice and thousands more in workshops and seminars.

Out of this research and marital therapy he developed a theory of marital therapy called Imago Relationship Therapy. The approach was electric. The divorce rate in his practice declined and the couples who stayed together reported a much deeper satisfaction in their marriages.

This book is about the theory and practice of becoming passionate friends. The book is divided into three parts. Part 1 focuses on "the unconscious marriage", an emerging psychological drama, that reveals all the hidden desires and automatic behaviours that are left over from childhood and form a leading source in creating marital conflict.

Part 2 explores the "conscious marriage" and helps you to satisfy your unmet childhood needs in positive ways.

Part 3 takes on all the ideas in Part 1 & 2, compiled into a unique ten week step by step course in relationship therapy.

This book can be very valuable to all advanced psychiatric nurse practitioners in the field in facilitating a more loving and supportive relationship in couples to promote their mental health.

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