

**ASSESSMENT OF THE EXPERIENCES OF USERS OF THE FAST  
QUEUE  
IN SELECTED PRIMARY HEALTH CARE FACILITIES,  
IN THE ETHEKWINI MUNICIPALITY.**

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## DECLARATION

I, Dudu Gloria Sokhela, do hereby declare that this study is representative of my work. Where the work of others was used, has been acknowledged accordingly in the text.

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Signature of student

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## ACRONYMS

AIDS	: Acquired Immune Deficiency Syndrome
CHC	: Community Health Centre
DHS	: District Health System
DoH	: Department of Health
DOTS	: Directly Observed Treatment Short course
HIV	: Human Immune Virus
IPHC	: Integrated Primary Health Care
KZN	: KwaZulu Natal
MEC	: Member of Executive Committee
PHC	: Primary Health Care
RDP	: Reconstruction and Development Programme
STI's	: Sexually Transmitted Infections
TB	: Tuberculosis
UK	: United Kingdom
UNAIDS	: United Nations on Acquired Immune Deficiency Syndrome
UNICEF	: United Nations Children's Fund
USA	: United States of America
WHO	: World Health Organisation

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# ABSTRACT

## Background

The South African health care system is guided by the primary health care approach (PHC), which is based on the principles of accessibility, availability, affordability, equity and acceptability which are the cornerstone of primary health care. The Comprehensive PHC Service Package for South Africa is the guiding document for transforming PHC in South Africa standardizing services and increasing access to PHC services. This study will focus on the “Clinic: Fast Queue/Repeats” component of the Package. This is the protocol which guides the management of chronic disease care for adults, geriatrics and paediatrics. According to the Package, this service is for patients who have been assessed previously either at a CHC or at a clinic. For repeat medicines no assessment is required except after three months, and waiting time is minimized through the use of pre-packaged drugs.

## Methods

A cross sectional qualitative design using a descriptive method was used to explore the experiences of the clinic users of the fast queue. A two stage sampling technique was used namely cluster and purposive sampling. In the first instance cluster sampling technique was used to sample clinics in each of the three sub-districts namely south, north and west sub districts of eThekweni municipality and purposive sampling was used to select PHC facilities, those with the highest number of attendees seen over a period of three months and the users of fast queue.

## Results

The findings of the study revealed that there were positive factors which contributed to the satisfaction of participants and negative factors which caused dissatisfaction among participants.

## CHAPTER ONE

### 1.1 BACKGROUND TO THE STUDY

Prior to 1994, the health system through the apartheid policies, promoted racial segregation and discrimination, therefore it was highly fragmented, inefficient and inequitable (African National Congress, 1994). In 1994 the first democratic elections were held, and the African National Congress (ANC) took over the reigns. The ANC with the support of the World Health Organisation (WHO) and United Nations Children's Fund (UNICEF) initiated a process of developing the National Health Plan for South Africa, based on the Primary Health Care Approach. This was done to address the issues of accessibility and affordability, which are the core of the primary health care approach. This approach was adopted by South African health system because it was the most efficient and cost effective means of improving the health of the population (African National Congress, 1994).

As guided by the National Health Act, 2004, and the White Paper for the Transformation of the Health System in South Africa (1997), the health care system has been divided in line with the three spheres of government namely, National, Provincial and Local government. The National Health Department co-ordinates both public and private health care delivery, whereas the Provincial Health Department monitors and evaluates district level services. The District Health Department is made up of districts mainly based on functional and geographic coherence, with boundaries which more or less match those of the administrative and political boundaries (Republic of South Africa, 1997).

Corresponding with the transformation of the health system into a Comprehensive PHC System in South Africa was the introduction of the District Health System (DHS) in 1996, which is a vehicle for the delivery of PHC. Each health district in South Africa has a population of about 50 000 to 750 000 given the varying densities of the urban and rural areas (Nicholson, 2001). The South African health care system is guided by the primary health care approach (PHC), which is based on the

principles of accessibility, availability, affordability, equity and acceptability. These basic components are the cornerstone of primary health care.

PHC is a developmental approach to health which involves communities as partners in health care. In this approach, resources and finances shift away from hi-technical systems, from tertiary hospitals to primary level services, and specialist doctors play a supportive role to nurses working in the clinic, thus moving towards health equity (Nicholson, 2001).

The Comprehensive PHC Service Package for South Africa is the guiding document for transforming PHC in South Africa (Department of Health, 2001), standardizing services and increasing access to PHC services. The package has various purposes namely:

- a tool to negotiate budgets for primary health care;
- a tool used to plan a move towards comprehensive services and integration of non-personal services; and
- to assist health care workers in identifying the scope of service delivery and communities on what they can expect.

The package defines the three main levels of care namely:

- The first level is Community services which include district management functions such as the referral system, drug supply to the district and monitoring of community outreach projects;
- non-personal services including environmental health, health promotion, school health and services to other institutions; and
- personal services like home based care.

All these activities need to be coordinated and monitored by district management even if rendered at a local level.

- The second level being clinics and mobile services. These include services that form part of the Package and are rendered by professional nurses.
- The third and last level is the Community Health Centers (CHC's), which have a 24-hour maternity service, a referral section with specialists and an outpatient department to service the local catchment area (Department of Health, 2001).

This study will focus on the “Clinic: Fast Queue/Repeats” component of the Package. This is the protocol which guides the management of chronic disease care for adults, geriatrics and paediatrics. According to the Package, this service is for patients who have been assessed previously either at a CHC or at a clinic. For repeat medicines no assessment is required except after three months, and waiting time is minimized through the use of pre-packaged drugs (Department of Health, 2001).

The components of this service are:

- routine checkup procedures for chronic diseases, namely: blood pressure measurement; weighing; measurement of glycaemia and cardiac auscultation;
- monitoring for the presence of complications;
- identifying and referring people with disabilities;
- instructions on taking prescribed medicines;
- organization of health education sessions for groups or individuals;
- booking of next visit;
- prescription continuation according to protocols and instructions;
- for children: checking on schedule for preventive activities; information, education, counseling to caretakers; rheumatic heart disease prophylaxis; counseling of parents regarding effect of medication should children fall pregnant while on treatment; sending of reports to school in agreement with parent or legal guardian.
- Mental Health protocols, the components of which include severe chronic psychiatric patients needing basic management; dispensing and monitoring of medication for a limited period according to protocol; identification and referral back for periodic reassessment; crisis counseling and referral; screen, treat and counsel less severe mental disorders and substance abuse; referral to CHC, psychiatric team for new and serious cases;
- Walk through service, which is a service for patients with special needs like working patients. Services are made available to suit their working hours as part of extended service hours or patients to be attended to very early before other services start. The components of this service are dispensing of family planning methods, daily Directly Observed Treatment Short Course (DOTS), chronic patient medicine collection, immunizations, and other agreed upon

services like geriatrics, emergencies and dispensing of sunscreen for people with albinism (Department of Health, 2001).

According to the UNAIDS Report (2008), in South Africa an estimated 5,700,000 people are living with HIV/AIDS, and 350,000 have died of AIDS. Furthermore, the effect of the brain drain on staffing of PHC facilities has led to staff shortages across health care facilities.

In his 2009 budget speech Dr S. Dhlomo, Member of the Executive Committee (MEC) for Health in KwaZulu Natal, embraced the theme “Save Lives. Make health facilities serve the people”, and also made a pronouncement on the “Make me look like a hospital” project aimed at revamping the hospital environment as a whole including: cleanliness; staff attitudes; infection control; safety and security of patients; accessibility to services; availability of drugs; blood and laboratory testing; and reduction of waiting times. This was going to be achieved by ensuring that managers actively manage the hospitals. In 2010 the MEC reported on the amazing progress already achieved in regards to the above project, particularly in rural hospitals.

Dr Dhlomo’s speech is further corroborated by the Gauteng MEC for Health and Social Development, Mrs. Q. Mahlangu, who, in her speech in August 2009, announced that waiting times are a thing of the past, and that she was going to reduce waiting by means of Fast Queues for the elderly, people with disabilities and pregnant women. She further announced that additional queue marshals would be introduced to assist outpatients. Furthermore the MEC stated that the department’s budget would focus on the following:

- Patients being turned away from health facilities;
- Overcrowding due to high patient volumes and the increase in the burden of diseases;
- Poor environmental conditions at the facilities for both patients and staff;
- Intermittent interruption in the supply of medication;
- Failure to procure adequate and appropriate medical equipment.

These are but a few steps in the right direction and if fulfilled will make a big difference in the health system.

## 1.2 PROBLEM STATEMENT

The adoption of the PHC approach and the implementation of its guiding principles and the concurrent introduction of the district health system and its referral mechanism led to an influx of patients in the PHC facilities as the first point of contact prior to referral to the next level (African National Congress, 1994). Poorly staffed health care facilities were faced with the challenge of attending to complex health problems presenting at PHC level, which have been compounded by the impact of the human immune deficiency virus/ acquired immune deficiency syndrome HIV/AIDS epidemic on the disease profile. Efforts to cope with the increased demand for health care at PHC facilities have led to the adoption of comprehensive and integrated PHC (IPHC). In her study on the analysis of the meaning of integrated primary health care in the KwaZulu Natal PHC facilities, Sibiya describes IPHC as a strategy used to increase health service utilization by increasing accessibility and availability of all health services at PHC level (Sibiya, 2009).

In the Comprehensive PHC Service Package for South Africa, Fast Queue is expressed as synonymous with the level of care, and is referred to as Clinic: Fast Queue/Repeats (Department of Health, 2001). Fast Queue/Repeats has been implemented to resolve challenges in a range of services, including, chronic care, emergency care and health promotion, so that a client coming for short consultation is not kept in the clinic for long periods unnecessarily.

While the Fast Queue has been instrumental in the promotion of access to health care, a major goal of PHC approach, it has been observed that this influx has had adverse effects on health care delivery, with queues growing longer and patients having to waiting for long hours for service. According to Barron, Day, Loveday and Monticelli (2005), the suggested target for the nurse workload should be between 20 and 35 clients per day, but it has been found that in some districts the number reaches 92 patients per professional nurse per day. There is not enough space in the facilities to accommodate this influx of patients. In addition, the changing disease profile of clients presenting at PHC facilities compounded by the impact of HIV/AIDS epidemic on the health care system, means that time spent with each patient seems to have increased.

Although the Fast Queue was introduced in 2001, there is no evidence of an evaluation of any form that has been carried out. It also seems that the concept of Fast Queue has not been explored by South African researchers and authors, hence the scarcity of local information on this issue.

### **1.3 SIGNIFICANCE OF THE STUDY**

This study will assist in decision making related to patient flow management, in order to reduce patient waiting time making health facilities more accessible. The study will assist the planners of health care provision to take cognizance of all these factors for future planning including infrastructure and even nurse training. The results of the study will help personnel in health facilities work better while health care users are kept satisfied.

The study results will assist policy makers to improve the comprehensive health care service package for South Africa with regards Fast Queue implementation.

### **1.4 PURPOSE OF THE STUDY**

The purpose of the study is to gain insight into the experiences of the users of the Fast Queue in selected primary health facilities in the eThekweni Municipality. The emergent aim is to facilitate effective implementation of the fast queue and thus improve health care delivery and enhance user satisfaction.

### **1.5 OBJECTIVES**

The objectives of the study are to:

- Describe the experiences of the users of the Fast Queue;
- Determine how their experiences lead to satisfaction or dissatisfaction with the service;
- Make recommendations regarding implementation and use of Fast Queue as a mechanism for reducing patient waiting time.

## 1.6 DEFINITION OF TERMS

For the purposes of this study the following terms will be defined and explained in order to enhance the mutual understanding of these basic and primary concepts.

- “Municipality” refers to a specific area of land, the residents and communities within it, its governing council and the staff employed by the council (Nicholson, 2001).
- “Primary Health Care” is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and the country can afford to maintain at every stage of development in the spirit of self-reliance and self-determination (WHO, 1978).
- “Users” are all people, whether sick or well, who visit the PHC clinic seeking assistance.
- Health care providers are all categories of nursing personnel working in the PHC clinic.



## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

This literature review focuses on previous studies conducted and available literature to give a wider perspective on the study and what the experiences are in terms of waiting in queues for service, and what leads to client satisfaction or dissatisfaction.

#### **2.2 The origins of fast queue**

The Comprehensive PHC Service Package for South Africa is a document that was introduced in 2001 with the main purpose of transforming primary health care in South Africa. It is also regarded as a strategy to standardise services and increase equity and access to PHC facilities. The package prescribes three service points that would be available in the PHC facility namely; children, adults and Fast Queue which itself does not elaborate much on the topic (Department of Health, 2001). Van Rensburg (2004) cites this document, where it describes services that would be rendered at different levels of primary health care namely, community level, mobile and fixed clinics, distinguishing between services for adults, services as part of the Fast Queue/ Repeats, and community health centers. The services that are supposed to be rendered are: child health, sexually transmitted infections (STI's) and AIDS, tuberculosis (TB), reproductive health, mental health, chronic diseases, trauma and injuries and disabilities (van Rensburg, 2004).

In the original document the concept Fast Queue, is expressed as synonymous with the level of care and appears as Clinic: Fast Queue/Repeats. It is described as a range of services. The Fast Queue as described in the Package for Health Care was implemented to streamline the patients making a quick way in and out of the clinic. Van Rensburg (2004) argues that the PHC service package was a huge advance towards the standardization of health care on an equitable basis. The Fast Queue is mentioned as part of the services rendered at mobile or fixed facilities, for repeat clients. Although van Rensburg has written about the main framework of the

implementation of the PHC package as the DHS, within which fixed and mobile clinics, Community Health Centers and district hospitals constitute the basis for service delivery, the DHS does not specifically mention the framework for the implementation of the Fast Queue (van Rensburg, 2004).

### **2.3 Fast Queue Implementation**

The KwaZulu-Natal Department of Health (KZN DoH) Annual Report states that the Fast Queue is being implemented in the Community Health Centers for the chronically ill and aged patients (Provincial DoH Annual Report, 2004). In addition, the KZN DoH web page states that at the Gateway and Poly Clinic at Addington Hospital, priority is given to the very ill and certain other classes of patients by fast tracking them through the system – they are seen before other patients who might have arrived before them (KZN DoH, 2007).

### **2.4 Utilisation of patient waiting time**

Ajayi (2002) carried out research at an outpatient clinic in Nigeria, investigating how best patient waiting time can be utilized, since long waiting is associated with bad service. Patients get bored while waiting. However, it is apparent that it will be difficult to eradicate long waiting periods in outpatient clinics. Ajayi interviewed patients on the activities they engaged in whilst waiting and found that a few read books, spoke to one another, some looked at patients walking up and down the passages, and others slept. He also noted that they would like to occupy themselves with health talks and he requested that they give him topics of interest to them. The topics chosen depended on the level of education of the patients as well as gender. The most popular topic was general and personal hygiene closely followed by causes and prevention of diseases.

It was concluded that if patients' time is occupied fruitfully the waiting is not perceived as long and not as useless because something had been gained from it (Ajayi, 2002).

Internationally, Fast Queue is mostly spoken about in relation to patient satisfaction, waiting time, patient flow, cost of waiting to the institution and quality of care either in the outpatient department, waiting for surgery or waiting for the specialist consultation. Most authors like Ajayi (2002), Mackey and Cole (1997), Press (2003), Eilers (2004) and Thompson and Yarnold (1995) agree that patient satisfaction is directly linked to waiting time and not to care received. They also assert that the shorter the time the patients wait, the more satisfied they are with the service despite no interventions to influence satisfaction.

## **2.5 Types of queuing models**

The Tiresias Company (2009) discusses different types of queuing models developed for the tourism sector, namely:

- Shortest processed first where transactions expected to consume the shortest time are dealt with sooner. An example of the 10-items only till in the supermarket is used to illustrate this queue type. This system usually works well but only if consumers perceive it as fair.
- First in first out is a model of service provision where customers are served in the order in which they arrive. This model seems fair to customers because it makes them think of themselves as equal.
- Single queue, which is a common snake queue format. Customers are served in turn. This format seems fair to customers and reassures them that the queue is progressing. This queue format works well where the transaction time is not long e.g. under seven minutes and also if it is directed by queue barriers.
- Multiple queues as seen in supermarkets. This queue yields a wide range of service time hence customers keep hunting for the shortest queue because not knowing how long one is going to wait frequently breeds resentment and anxiety. This queue model is most appropriate for low-value transaction models where a low level of service is accepted by customers.
- Diffuse queue is where a customer registers and takes a ticket, and can browse while waiting their turn. They don't necessarily follow a specific queue. Consumers have no idea of when they will be served because they do not

know the order they follow each other and this type is regarded as primitive. This type of queue is regarded as the most flexible in cases where the length of transactions varies vastly.

- Head of queue, this is where the next person to be served waits in a single queue environment so that as soon as a place opens up this person proceeds to that point (Qmatic.com, 2005).

## 2.6 Queuing theory models

Fomundam and Herrmann (2007) provide queuing theory models that could be modified and adapted for application in health care settings in order to reduce patient waiting time and improve customer satisfaction. In terms of Waiting Time and Utilization Analysis the following concepts are discussed:

- Reneging is when a patient forgoes the service because of the length of the queue and the length of time the patient has waited. This is usually the result of high patient rate and staff shortage as in an emergency room. Roche et al. (2007) as cited by Fomundam and Herrmann found that reneging can be reduced by fast-tracking non-acute patients.
- Variable Arrival Rate is the rate at which patients arrive in the health facility as affected by time of the day, day of the week or season of the year.
- Priority Queuing Discipline is when priority is given to clients who require shorter service time to minimize waiting time.
- Blocking is when the queue length is limited and patients without appointments are turned away when the waiting room is full, as when the hospital stops admitting patients once the beds are full.
- System Design where the health care system is designed to limit waiting times. This includes determining the capacity of the system in relation to the requirements and the desired goals of the system.
- Minimization of costs is part of a system design where an exercise is carried out to allocate resources that cost the least or generate more profit since cost is assigned to waiting time.

- Appointment systems, which reduce arrival variability because patients arrive near their appointment time thus reducing waiting time at the health facility. The patients can use the time waiting for an appointment fruitfully.
- Bottlenecks are nodes in the queue that the patient need to go through before they are seen by a nurse, it could be one or several nodes and they increase overall patient waiting time.
- System size is the size of the organisation which varies according to hierarchical levels ranging from a small unit, to the health care center and lastly the regional health system (Fomundam and Herrmann, 2007).

## **2.7 Waiting times**

Dissatisfaction with care is linked to long waiting times. According to Mackey and Cole (1997), who undertook a study to evaluate waiting time in a nurse managed primary health care clinic at the University of Texas-Houston, the mean time interval from arrival to examination was 13.75 minutes, plus 22.8 minutes with the nurse practitioner, totaling 49.05 minutes. The waiting time included waiting room, examination room, time spent with the nurse practitioner and the total lapsed time in the clinic (Mackey and Cole, 1997).

Agaba, Bagul, Adenugba and Kenogbon (2002) conducted an audit of patients' waiting time to see a family doctor prior to a fast access breast clinic in the era of the guaranteed 2 week wait in the breast Unit of the Barnsley District General Hospital in the UK. A 2-week wait was introduced by the National Government during which patients with suspected breast cancer should be seen. The general practitioner fills a standard form if he suspects breast cancer and faxes it through to the medical secretary, who in turn arranges an outpatient appointment so that the patient is seen by the specialist breast surgeon within two weeks. This system was abused in that patients knew about it, so they presented all the signs of breast malignancy to the general practitioner who in turn fast tracked them to the specialist but they had no real signs of breast cancer. They did this to get early specialist appointments, which resulted in extended waiting time for urgent referrals (Agaba, et al., 2002).

The Government of Canada pledged an amount of 4.5 billion pounds in an effort to reduce waiting time for cancer care, coronary angioplasty, bypass surgery and angiography diagnostic tests. Provinces were required to create electronic patient registers to track waiting times. These lists had to have comprehensive clinical data, which posed a problem of how patient confidentiality was going to be kept, and how they would protect these patients from being used for other activities such as research because anyone could have access to their details in the computerized register (Slaughter, Carlisle, Williams and Ferris, 2005).

In the disutility of waiting time, Serrano-del-Rosal, Vera-Toscano and Ateca-Amestoy (2002) looked at cutting time at government hospitals by having patients seen at private hospitals. To reduce waiting time, patients who can afford to pay in full and those with subsidized medical aids can be directed to private hospitals and leave cheaper public hospitals for the needy patients. This will help in reducing queues in the public hospitals (Serrano-del-Rosal et al., 2002).

## **2.8 Patient satisfaction**

According to Press (2003), patient satisfaction is growing in importance. A nationwide survey undertaken in America in 2001 revealed that Americans are more satisfied with outpatient departments than emergency rooms because patients like the way staff generally interact with them and they appreciate their technical competence. Emergency rooms are impersonal and emotional (Press, 2003).

Eilers (2004), in his paper on improving patient satisfaction with waiting time, states that waiting times are a significant component of patient satisfaction. Patients actually define care in terms of service (Eilers, 2004). On the other hand, Di Paula, Long and Wiener (2002) state, while the US hospitals work towards reducing costs and striving to improve quality and efficiency, they have shifted from using patient satisfaction as a that to measure organizational performance, and effective clinical and operating practices. (Di Paula et al., 2002).

In a survey related to patient satisfaction with waiting time perception and expectation, Thompson and Yarnold (1995) found that patients are least satisfied when the waiting time was longer than expected, relatively satisfied when time was

perceived as equal to the expectation and highly satisfied if waiting time was shorter than expected. This clearly indicates how patient satisfaction is linked to waiting time (Thompson and Yarnold, 1995).

In an article on optimizing patient flow, May (2004) asserts that patient waiting may be costly in a sense that because of bottlenecks in one part of the queue, some patients end up being kept longer than necessary in more costly areas like the Intensive Care Unit. Redesigning patient and work processes is one way that can be useful in addressing waiting times. This requires assertive leadership from health care executives, a total commitment from medical staff, clerks and ancillary services to implement successful solutions. It is important to look at the whole department to see where the holdup is. It is necessary to begin at the end of the process to determine where bottlenecks are (May, 2004).

The Queuing Management System (Qmatic.com, 2005) offers some solutions to reducing patient waiting time. There is an assertion that good organizational skills are necessary in trying to overcome the problem of long waiting time. The way organizations deal with clients while waiting impacts on the client's perception of the organization. Queue management is about ensuring fairness and showing clients they are waiting in a planned environment and reassuring them that they will be attended to soon. Clients want to know that their time is valued. Considering the current patient flow is another solution. An active search for bottlenecks is necessary so that patients are processed through to the fastest or shortest queue at any given time.

Setty (2004:1-2) reporting on research and evidence based interventions to access quality of reproductive health and family planning services, discusses two principles of client flow, namely balancing client load and client flow. Setty asserts that improving client flow can help shorten patient waiting time, and increase the number of patients a provider sees daily. The other principle is improving client flow by using signs, posted instructions and simplified paths. This helps the clients to find direction on their own and move through the system quicker.

## **2.9 Conclusion**

It is evident that queuing becomes an issue in every setting where people have to wait for service. Hence various authors have dealt with the queues in different ways to address the effect it has on the clients and the service.



## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

This chapter presents the research methodology used in this study. It focuses on study design, study setting, study population, sampling, data collection and data analysis, ethical considerations, and theoretical framework.

#### **3.2 STUDY DESIGN**

A cross sectional qualitative design using a descriptive method was used to explore the experiences of the clinic users of the Fast Queue. According to Burns and Grove (1999), qualitative research is a systematic, subjective approach used to describe life experiences and give them meaning. The qualitative research approach is used to describe groups, communities and organisations. Descriptive research by its nature explores and provides information as accurately as possible on a phenomenon in a real life situation of particular individuals or groups (Welman and Kruger, 2001). This study design is deemed appropriate for assessing the experiences of users of the fast queue programme. Study participants comprised users of the Fast Queue programme of PHC facilities.

#### **3.3 STUDY SETTING**

The study was conducted in PHC facilities of eThekweni Municipality excluding mobile clinics. The eThekweni Municipality is situated within eThekweni district, which is one of 11 districts in the province of KwaZulu Natal in South Africa. The municipality was formulated following the December 2000 election and is a product of seven municipalities that were amalgamated into one. It is divided into three sub districts namely South, North and West. The Municipality has 77 PHC facilities, and 15 mobile units, with 1 CHC shared between the municipality and the provincial department of health. The catchment population ratio per clinic is 1:22570 which is above the national norm of 1:15000 (eThekweni municipality, 2006/2007).

### **3.4 STUDY POPULATION**

The population is the entire set of individuals that meet a certain criteria, making them eligible for inclusion in the sample, sometimes known as the target population (Burns and Grove, 1999). The target population in this study consisted of users of municipal PHC facilities of the eThekweni district, and the groups being studied were the users of the Fast Queue in selected PHC facilities. This target group provided an accessible population, which according to Burns and Grove (1999) is that portion of the target population to which the researcher has reasonable access.

### **3.5 SAMPLING AND SAMPLING TECHNIQUE**

Sampling in qualitative study is concerned with whoever would be information rich data sources for the study at hand. A two stage sampling technique was used namely cluster sampling which is described by Polit and Beck (2008:347) as “a successive random sampling of units”, with the initial sample being a large grouping and successively narrowing it down to the smallest unit, and purposive sampling defined by Burns and Grove (1999) as that technique which involves the conscious selection of certain subjects for inclusion in the study. In the first instance cluster sampling technique was used to sample clinics in each of the three sub-districts namely south, north and west sub districts of eThekweni municipality and purposive sampling was used to select clinics and users of the Fast Queue. This sampling technique was chosen because the researcher wanted to select participants who would provide valuable information according to their experience of the fast queue. In the case of this study municipal PHC facilities were used, because staffing issues and infrastructure are not dissimilar among these facilities.

The sampling criteria are the characteristics that participants must possess in order to form part of the target population (Burns and Grove, 1999). The sampling criterion of PHC facilities in this study was the highest number of attendees seen over a period of three months. Statistics from October 2008 to March 2009 was requested from the informatics manager of eThekweni municipality. Only five facilities were purposively selected from each of the three municipal sub districts. The strategy used was typical case sampling since it consisted of participants who were going to

highlight what is typical. According to Polit and Beck (2008), typical case sampling is described as the selection of those participants who have the ability to draw attention to what is characteristic. The users of Fast Queue were the target group that provided valuable information since they were the consumers of the Fast Queue; they would provide information regarding what is typical for the Fast Queue user. All willing Fast Queue participants who came forward to be part of the study were interviewed.

### **3.6 SAMPLE SIZE**

According to Polit and Hungler (2001) there is no specific sample size in qualitative research; it depends on the purpose of the research, the quality of the participants and the sampling strategy used. A guiding principle in sample size is “data saturation”, which is the point where no new information is coming forth from the participants. From 15 clinics a total of 76 participants were interviewed individually. Participants were interviewed using the Interview Guide containing semi-structured questions (see Annexure 9). In some clinics a very high number of participants were interviewed because they saw this as an opportunity to air their views and complaints. In addition one focus group discussion comprising 7 participants was conducted by the researcher using a pre-formulated semi-structured interview schedule and probing as required. The focus group discussion was conducted with the view to solicit deep opinion and rich information as group members stimulate conversation and arguments from one another.

### **3.7 DATA COLLECTION METHODS**

Individual semi-structured interviews were conducted using the interview guide for those participants that had attended the Fast Queue and were in a hurry to go somewhere else after being attended to. This method allowed the respondents freedom to express their opinion or understanding of the phenomenon without the restrictions of closed ended questions or the interviewer’s opinions (Burns and Grove 1999). In addition, a focus group discussion was conducted by the researcher, with users that came to the facility once a month on a specific day to collect chronic medication. Participants were met in the clinic at mid-morning when they were

relaxed, having refreshments and chatting among themselves. The group was of mixed gender and age and spoke the same language. The interviewer guided the discussion using a pre-formulated interview schedule with open-ended questions that were guided by the theoretical framework, “the Kano’s model of customer satisfaction” discussed below. Each participant had an opportunity to air their views on the topic. A Dictaphone was used to record the discussion and the information was later transcribed.

The researcher conducted the interviews herself in the languages that the participants were comfortable with, mainly isiZulu and English. Responses were audio taped and transcribed in English by the researcher. Essentially, the interview schedule was divided into two sections namely, demographic data and client satisfaction sections. The same interview schedule was used for both individual and focus group discussions.

### **3.7.1 Pilot Study**

A pilot study was conducted in one of the facilities which was not part of the study. The exclusion was because the criterion of high user turnover was not met. No changes were required in the interview guide after the pilot study. It also became clear that the interviews would be guided by the responses of the participants and the researcher would have to probe to obtain more information from each participant. Study participants were people who had been in the fast queue previously or before the interview since the research is about their experiences.

## **3.8 DATA ANALYSIS**

Data analysis occurred in three stages namely description, analysis and interpretation, as described by Burns and Grove (1999).

### **(a) Description phase**

In this phase the researcher listened and re-listened to the interviews from the audio tape recorder. Raw data was transcribed in the languages that interviews were done

in, and those done in isiZulu were translated into English. The researcher also read and re-read the transcripts for the purpose of getting immersed in the data and interpreting it in order to find and make sense of it. The researcher “dwelt with the data” and familiarised herself with the data collected (Burns and Grove, 1999).

### **(b) Analysis phase**

This is the process of taking the data beyond description (Burns and Grove, 1999). Themes and subthemes were identified from the raw data to establish patterns emerging from the data and these were used to interpret data. This was done manually. Burns and Grove suggest that reading extracts may lead the researcher to discover keywords and processes that may capture the essence of the pieces of the narrative data (Burns and Grove, 1999).

### **(c) Interpretation**

The researcher interpreted the data according to her understanding using themes and subthemes identified during the analysis phase and supported her interpretation with the use of excerpts from the interviews to eliminate subjectivity and bias.

## **3.9 TRUSTWORTHINESS**

According to Polit and Beck (2008), trustworthiness is the degree of confidence qualitative researchers have in their data, assessed using the criteria of credibility, transferability, dependability, confirmability and authenticity (Polit and Beck, 2008: 196).

With regards qualitative research, Lincoln and Guba (1985), cited in Polit and Hungler (2001), suggest four criteria for establishing the trustworthiness of qualitative data. These are: credibility, dependability, confirmability, and transferability (Polit and Hungler, 2001). Credibility, dependability and confirmability were used to ensure trustworthiness or validity of data in this study.

### **(a) Credibility**

Lincoln and Guba (1985) describe credibility as confidence in the truth of data and the interpretation thereof (Lincoln and Guba, 1985). In this study credibility was ensured through data triangulation which was achieved by interviewing various participants from different sections that had Fast Queues. These were queues for users collecting TB medication and receiving daily injections, immunisations, family planning and users collecting chronic medications. The same interview guide was used throughout the research. Member checks were conducted whereby the researcher returned to the clinic and chatted with attendees that had similar characteristics with the initial participants. According to Lincoln and Guba (1985), member checking is the most important technique for establishing credibility of qualitative data.

### **(b) Dependability**

Dependability as described by Lincoln and Guba (1985) is stability of data over time and over conditions and is important for credibility (Lincoln and Guba, 1985). An audit trail was developed. Records kept include an audio compact disc of interviews and focus group discussions, transcripts in the original language the interviews were done in and a translated version, summaries of interviews, signed consent forms and correspondence with management.

### **(c) Confirmability**

Lincoln and Guba (1985) describe confirmability as objectivity. This implies that data represents the information provided by the participants and that the interpretations thereof are not the researcher's imagination (Lincoln and Guba, 1985). In this study confirmability was achieved by the use of direct quotes from the raw data to eliminate subjectivity and bias of the researcher.

### **(d) Transferability**

Transferability according to Lincoln and Guba (1985) refers to the applicability of findings in other settings (Lincoln and Guba, 1985). This was achieved by providing

sufficient descriptive data in the research report such that other researchers can test its applicability to other contexts.

### **3.10 ETHICAL CONSIDERATIONS**

The Durban University of Technology Ethics Committee cleared the proposal (see Appendix 1) and the eThekweni Municipality Research Committee granted permission to conduct the study (see Appendix 5). The researcher was required to make presentations to management personnel of all sub districts of eThekweni Municipality to inform them about the form and process in which the study would be conducted. Presentations included both senior and middle management. Thereafter requests were forwarded by the researcher to the secretaries of the sub districts for inclusion in the agenda of the following management meeting where brief presentations were made by the researcher and few logistical questions were asked and answered to the satisfaction of management. They were assured that there would be no interruption in the running of the service since only the users were required to participate and they would be interviewed while waiting for consultation or after they had been seen.

All participants were assured of voluntary participation. Willing participants signed a written consent form after reading and understanding the information letter (see appendix 6). Participants were informed that they could refrain from answering questions that they were not comfortable with and could pull out at any stage of the study if they so wished. Participants were assured of total anonymity and confidentiality at all times and that their participation would not compromise the way they would be treated in the facility. They were informed that the findings and recommendations would be made available to the authorities and a copy would be kept in the municipal health library.

### 3.11 THEORETICAL FRAMEWORK

According to Polit and Hungler (2001), the overall purpose of theory is to make research findings interpretable and meaningful. Theories also allow researchers to consolidate their observations and facts into an orderly system. “This linkage of findings into a coherent structure makes the body of accumulated knowledge more accessible and, thus, more useful both to practitioners who seek to implement findings and to researchers who seek to extend their knowledge base” (Polit and Hungler, 2001:107).

The Kano Model of Customer Satisfaction was chosen as the theoretical framework for this study. Kano describes the customer satisfaction model as a quality management and marketing technique that can be used for measuring client happiness. In addition, (Oakland, 2003), argues that customers are satisfied if the quality of goods or services of an organization achieve the specified requirements, which is what customers expect. In the model, the author distinguishes six categories of quality attributes namely; basic/threshold, excitement, performance, indifferent, questionable and reverse attributes (Kano, 1984). However, only three have relevance to measuring customer satisfaction. Consequently, for the purpose of this study, only those three attributes from the Kano model will be discussed.

The Kano model of customer satisfaction classifies product attributes based on how they are perceived by customers and the effect they have on customer satisfaction. The attributes are:

- Threshold or basic attributes, which are a must of any product and should not be absent at any given time because absence results in customer dissatisfaction. The presence of qualified and highly skilled health practitioners in the health facilities, who can make good decisions about the health of the client, will result in client satisfaction. Clients get an assurance that their health is in good hands, the practitioners know what they are doing and do so with agility. This will facilitate quality care and avoid delays thus shortening client waiting time and increase satisfaction.
- Performance attributes are those for which more is better and will improve customer satisfaction, in which case absence or poor performance attributes



reduce customer satisfaction. Customers are always looking for more than what is considered as normal in a product. In the case of this study, clients may perceive a quick consultation with the health care practitioner as good performance, thus increasing their satisfaction. The client may not have obtained the best care, but because of the shorter time spent in the health facility the client would be satisfied.

- Excitement attributes are those attributes that are unspoken and unexpected by the customer, but can result in high levels of satisfaction. However their absence does not lead to dissatisfaction. When the service provider's performance exceeds the expectation of the client, the client would be satisfied whereas they would also have been satisfied with the normal routine care. Excitement attributes are also known as delighters satisfiers or attractive attributes.

Kano describes the excitement attribute as one in which the health care practitioner goes an extra mile to assist the client with something considered to be out of the scope of the health care practitioner, like in the case of social problems, being referred to social welfare and even phoning through to ensure that the client has the right person when they get there.

The additional attributes mentioned by Kano are:

- Indifferent attributes also known as neutral attributes. The customer does not care about this feature. This attribute neither brings satisfaction nor dissatisfaction.
- Questionable attributes. It is unclear whether the customer expects this attribute.
- Reverse attributes. The customer expected the reverse of this product feature. Reverse attributes bring more satisfaction if absent than if present.

The process of the Kano customer satisfaction model involves identifying the performance and excitement factors, indicating the reaction of the customer if the product has the desired feature and the reaction of the customer if the product does not have the desired feature. Satisfaction has a functional component that is linked to performance and an emotional component that is related to experience (Kano, 1984).

## **CHAPTER FOUR**

### **PRESENTATION OF RESULTS**

#### **4.1 INTRODUCTION**

This chapter presents the results of data obtained from in depth individual interviews and focus group discussion conducted with the users of the fast queue in selected PHC facilities. The organisation of results is aligned with the elements of the theoretical framework that guided the study as well as themes and categories that emerged from the data.

Kano's model of customer satisfaction suggests that the contributory attributes to customer satisfaction are namely; threshold or basic attributes, performance and excitement attributes. The model describes threshold attributes as a must or basic requirement of a product which if absent cause high customer dissatisfaction. Since these attributes are always expected by customers during any interaction, their achievement does not result in excitement about the service or product. With regards performance attributes, the model suggests that when these attributes are achieved, customer satisfaction is enhanced, whereas absence or poor performance reduces customer satisfaction. According to the model, excitement attributes are those that are unspoken and unexpected by the customer but result in high levels of satisfaction. All these attributes of the Kano model are used to describe the experiences of participants with the use of the Fast Queue.

#### **4.2 ATTRIBUTES**

The findings of the study revealed that there were positive factors which contributed to the satisfaction of participants and negative factors which caused dissatisfaction among participants.

### **4.2.1 Threshold or basic attributes**

According to the theoretical framework, threshold attributes are a must or basic requirement of a product, which if absent causes high dissatisfaction. As aligned with the theoretical framework guiding the study, data obtained from the participants indicated a high level of satisfaction with the use of the Fast Queue. However if these attributes are not achieved it results in dissatisfaction. In this regard data indicated that various attributes of the Fast Queue yielded satisfaction for some participants while with others the same attributes yielded dissatisfaction.

Themes namely user flow and communication and subthemes that emerged from data are used to describe the experiences of participants. For those participants that were satisfied with the use of the Fast Queue, it was because it yielded results that they were expecting, and those whose expectations were not met, experienced the Fast Queue negatively.

#### **4.2.1.1 User Flow**

Participants perceived the flow as one of the factors that contributed to their queue being fast and this resulted to satisfaction with the Fast Queue. They believed that bottlenecks were eliminated by good organisation in the clinic. User flow was seen as enhancing the work process thus impacting on the Fast Queue and waiting time and thus satisfaction. In this regard related subthemes cited by participants as factors that influenced user flow positively included (a) floor space, (b) staffing patterns, (c) staff attitudes, (d) waiting time and (e) workload.

##### **(a) Floor space**

The clinic floor plan or structure was perceived to be having a direct bearing on the user flow and ultimately the Fast Queue. Some participants had shared their experiences with delays in a small clinic. In their view the Fast Queue enabled them to be attended to quickly such that they were able to go to work without missing a full day's work. In addition participants were able to go home early to do their house chores while others were happy that they could go back to school.

Furthermore mothers of young babies and children stated that they liked the fact that they were seated away from the sick people thus protecting their children from contracting infections from the sick people. It would seem some participants experienced the Fast Queue positively. This also indicates that for participants the Fast Queue had different uses. Their views are expressed in the following excerpts:

*“This queue is very fast because when I arrived here there were many of us and I thought I will leave late. When I came inside, there were many different queues that we were directed to. It was fast.”*

*“I am not sure. Maybe it is the load of work. This clinic used to be very full before it was moved to these new premises. Since moving to this new clinic the work seems lighter, but I think it is because this clinic is more spacious, there is more space for us to move and be separated into different specific queues and there are definitely more nurses now.”*

*“It was much better today than last month, because last month we were all mixed. This month we are separated nicely. We were mixed with all the sick people and were delayed. Today we will get to work on time. I think this process is going to help us.”*

## **(b) Staffing**

It was apparent that a decreased number of staff contributed to dissatisfaction with the Fast Queue because it was seen to contribute to an increase in waiting time. Those participants that experienced the Fast Queue negatively were aware of the problem of poor staffing faced by the health care providers. Although they were sympathetic about the situation, they still expected good and fast service. Staff shortages according to participants resulted in work starting late because of trying to sort problems in other areas and this led to the Fast Queue being delayed because participants had to wait for one health care provider who was caught up with other duties. This yielded high levels of dissatisfaction from the participants. Their dissatisfaction is expressed as follows:

*“I am okay with it, but the staff is short, so the fast queue is not so fast. For an example people with TB are not supposed to wait in the general waiting area they are supposed to go straight to the nurses because other people can contract TB. Sometimes we are told there are only two or three nurses in the clinic.”*

*“...it’s just that they start late on some days. The nurses are few sometimes only two attending to patients. At the moment there is no one; I think she is at tea. Some can say they are neglecting their work.”*

*“We come early in the morning to show that we empathize with the way they work but then it is them who are delaying, ending up creating a lack of communication between themselves and the patients. They will shout because I need to go explain to them what is wrong with me. Even when we meet, I would say nurses in the clinic work hard.”*

### **(c) Staff attitude**

Staff attitude was yet another dominant subtheme relating to satisfaction with the Fast Queue; it would seem some participants had a positive experience of the attitude of health care providers in the Fast Queue while others experienced it negatively due to the poor attitude of staff. They perceived the ability of the health care providers to communicate and their good skills when rendering service as good attitude thus enhancing satisfaction. On the other hand the opposite was perceived as bad attitude resulting in dissatisfaction. Their views were expressed in the following quotes:

*“This guy looked at me and smiled saying and I said to myself ‘this is a pantsula, a guy from the township. I can see even in his step’. We greeted each other and it was nice, I wish he would be there every day but I could not do anything because I am not part of the administration but I felt very comfortable with him.”*

*“I was happy, very happy. I think the attitude of nurses is changing towards patients and is changing for the better. I hope other clinics do the same.”*

*“It is the care that I received from this sister, I did not think the health system would have changed so much, and there would still be nurses who cared. I told her that she deserves an award.”*

Participants lamented about the bad experiences they had in the Fast Queue. According to them this was a deterrent to visiting the clinic whether for themselves or for their children hence high levels of dissatisfaction. Dissatisfaction with the Fast Queue was expressed by participants in the following quotes:

*“Because with immunization we had a problem before, the male who gave injections did not treat us well. The injection site would be swollen, he would not care even when you came back to complain. It is better now; this new male nurse treats babies well and plays with them. This other one used to just give an injection; that is all and call the next one. Sometimes if the baby cries, he would tell you to go and change the baby’s nappy even if you had just changed the baby. It is better now.”*

*“The nurses do not show that they care. Their faces tell you that they do not have the time for you. I was lucky my baby got an injection just before they went for tea. My sister, the hand cannot do what the face is not doing and the face cannot do what the heart is not doing. I feel that nurses should be taught how to work with people. This is a public service, we voted and we expect to be treated nicely. My baby is small; this is my second time here. They do their work but they do not have a way of interacting with the people. We are patients here but we are also human beings, they need to think about that.”*

*“I am very scared of injections, so when this nurse was giving me an injection and I was crying because of pain, she stopped with the needle in my bum and said ‘look you are already crying’. I did not like it because all the time she was talking the needle was stuck in my bum. Then she finished the injection.”*

*“I don’t like it because when the baby gets unwell after the injection, you might think that it’s because the nurse was in a bad mood when she injected the baby.”*

#### **(d) Waiting time**

Government health institutions are overcrowded, with long waiting times and long delays. Long waiting was mainly experienced during the process of registration and not in the fast queue. In the fast queue waiting was very minimal as expressed by users in these quotes:

*“I was very happy because it saved me a lot of time; I am going to be able to go to class at 12h00. I had even reported at school that I will be absent, but because it is organized and fast I am now going to be able to go to school.”*

*“There is no waiting after you have registered. The queue for babies is fast and I like it because you leave before the baby gets bored. It is very upsetting if you are in the clinic and the babies cry non-stop. With the fast queue it does not happen.”*

*“I am happy, because we get help quickly. Sometimes one is unwell with shortness of breath and can’t wait for too long. I was happy that we have our queue where we can go without joining the long queue. It s fast, we go home quickly.”*

Participants that experienced long waiting time negatively expressed it as follows:

*“Waiting makes people fed up and they can leave before they are attended to, and end up falling pregnant because maybe you are rushing to work, you can get fired for late coming. Therefore one may decide to leave if the queue is not fast.”*

*“The queue was not fast at all. I waited very long to be seen with the baby, the nurses are slow. Though I cannot count the hours, but I waited long.”*

*“The waiting is very tiring especially if you have a baby and when you are pregnant, you come here in the morning, you are tired and stressed as well. They should come in earlier to open for us because we are standing from 5h30 and they only come at 7h30. If they can ask the guard to open for us. We stand in the dark because there are no lights.”*

### **(e) Workload**

Increased workload was also perceived as a factor that contributed to long waiting time which was why users complained about the Fast Queue not being fast. In this regard participants had made an observation that on a particular day of the week the health care provider of the section had a high number of users to attend to. This was when there were admissions from the hospital and the work load was increased. The following quotes express the participants' views:

*“I cannot say, but I think it contributes to service delivery. It happens that, on Monday there are admissions which take long to open files for. I suggest that there is a way of attending to people coming to collect tablets only and not mix them with new admissions because that's what takes up time. Sometimes one is hungry because he knows he is only collecting tablets so it should not take long. That*



*should be corrected. Dealing with medication only is very quick, and one does not even spend five minutes.”*

*“It depends on days. Mondays are full because most people come in from hospital to start treatment and open files in the clinic. The queue is faster on Tuesday, Wednesday and Thursday because there are no admissions. Friday is also ok, no new admissions.”*

*“The only problematic day is Monday. He also works hard for a long time that is why he loses his temper.”*

#### **4.2.1.2 Communication**

Communication emerged as another theme that influenced satisfaction or dissatisfaction of participants in the Fast Queue. Data revealed that some participants experienced good communication with health care providers while others reported dissatisfaction with the communication style of health care providers. They stated that good communication meant good care and enhanced satisfaction with the fast queue and the clinic as a whole, as highlighted in the following excerpts:

*“I don’t mind that there was a small problem which a nurse explained to me nicely because I thought I was going to go first since I was number one, but they explained that babies go first.”*

*“I commend the clerks, they are very fast. They kindly give you information and when they recognize a person that is in pain, on a wheelchair or a child, they take them first and help them. They explain about babies, I like that, it is very good. It’s my first time here but I like the way they work.”*

*“The nurse that gives injections does it well. She asks the age of the baby, and one time they forgot to write the return date in the card but I remembered it because they had told me about it while I was in the clinic.”*

Other participants reported feeling very dissatisfied with poor or no communication from the health care providers. Poor communication was perceived as poor staff attitude and was associated with dissatisfaction with the Fast Queue. This how dissatisfaction was expressed:

*“I am not satisfied with the service provision; the person who renders service does not know how to communicate with patients, because he is the provider, he needs to communicate effectively.”*

*“They sent me to the immunisation queue where I was sent back to weigh the baby which I had not done when I went in for the baby’s illness and I did not like that.”*

*“No, I have never come across such a discussion. As you can see today, they have taken out different tablets than the ones we are used to, they have not told us anything about these new tablets.”*

#### **4.2.2 PERFORMANCE ATTRIBUTES**

Performance attributes generate satisfaction proportional to the performance of the product. It is postulated in the performance attributes that more is better and will improve satisfaction. Interviewees have certain expectations when they visit the clinic and if those expectations are met, they become highly satisfied (Kano, 1984). The main theme and subthemes that emerged from the results of the study is discussed below.

##### **4.2.2.1 Expectations**

Data indicated that participants were satisfied if they received what they expected, which was medication and sometimes supplementary foods for those that qualified for it, and more satisfied if they received more than they had expected or service was rendered to their utmost satisfaction. Performance of health care providers was associated with the expectations of participants. If these were not met, participants were dissatisfied. The following are the responses from some interviewees:

*“I did not expect to be assisted today the way I was. But because I have been helped, I am happy that I am going to know whether I have TB or not because it is a disease that eats you away without you realizing it.”*

*“It is very good. The relationship with the doctor male nurse that I collect medication from is very, very good. He does not give any indication that he is in a hurry and he is patient. Today I came with another issue and he helped me to the best of his ability and he still said he would refer me to have more information.”*

*“I was expecting to wait long because there are doctors who work differently but when I came I got help fast.”*

The following subthemes emerged (a) care in the Fast Queue, and (b) health promotion given.

#### **(a) Care in the Fast Queue**

Participants perceived care in the clinic as the ability of the health care provider to play with the baby and talk even if it was a general non-health related conversation, because when they visited the clinic they did not only seek medical help, they needed holistic care, empathy, understanding and being listened to. For some care was when the health care provider did not shout, was gentle when giving injections, was not rude to them and had a cheerful disposition. The care was perceived to be good for these reasons and this was expressed by participants in the quotes as follows:

*“The sisters are nice. They smile and play with the baby and they give the injection nicely. My baby has just been given an injection but is quiet now, he cried for a short while.”*

*“The nurse is very nice, she greets or when you greet she responds well.”*

*“It is very good ... he does not give any indication that he is in a hurry.”*

The following quote seems to capture the essence of caring for this participant:

*“She phones me to tell me to fetch my results if there are any tests that I had done.”*

The user did not expect this; she was very happy about it and said that was good care.

### **(b) Health Promotion**

As part of the normal consultation, health care providers are expected to discuss health issues with each user during a consultation. Participants knew that they were supposed to be given health talks. Others were aware and were expecting it, while others were surprised none the less. What transpired during interviews is that this did not happen all the time as is evident from the following quotes:

*“We normally talk as sisters, like when I have a problem, she advises me about my health and even when she notices that I am upset she finds a way to make me feel better.”*

*“The nurse told me that this is the last injection for this age, the baby had a measles injection. He is nine months old, but they said I must bring him back at one year for vitamin drops and worm medicine. I did not know a baby gets free of charge since I do not have my own baby yet.”*

*“They advise us about how to take care of the baby, like me I want to see the baby growing big and fat quickly, so I do things that the baby is not supposed to get because I want the nurses to praise my baby when I go to the clinic. They warn me about those things.”*

*They tell me to breastfeed until a certain age and then when I can start giving solids like how we quickly give mashed potatoes. This clinic is the best.”*

#### **4.2.3 EXCITEMENT ATTRIBUTES**

According to the theoretical framework excitement attributes are those attributes that are unspoken and unexpected by the customer, but can result in high levels of satisfaction if received. However absence of these attributes does not lead to dissatisfaction. Sometimes the expectations of the participants were exceeded by health care providers according to their perception and this brought excitement and high levels of satisfaction. According to the participants these were things like being asked checking questions, being given a health talk, motivation on healthy lifestyle. Participants state that in some instances the health care provider went an extra mile in rendering the service. The following quotes illustrate their views:

*“... yes and talk about many other things that pertain to the baby. Today they asked me about family planning and they explained it to me. I decided to take the method, which I would not have done if the sister had not spoken to me. I am very excited that I have taken the method, I am safe now. My husband is also going to be very excited about this. The sisters here are very good.”*

At times participants were excited and very happy with the care received at the clinic because of what they had heard from the experiences of other participants. They came to the clinic with pre-conceived ideas and fear of not knowing what their experiences would be like, as it shown in these quotes:

*“It is the care that I received from this sister, I did not think the health system would have changed so much, and there would still be nurses who cared. I told her that she deserves an award.”*

*“I was happy, very happy. I think the attitude of nurses is changing towards patients and is changing for the better. I hope other clinics do the same.”*

## **CHAPTER FIVE**

### **DISCUSSION OF RESULTS**

#### **5.1 INTRODUCTION**

In this chapter the results presented in the previous chapter are discussed. The discussion is based on the study objectives and the theoretical framework as discussed in Chapters One and Three of the study respectively. New literature is discussed where necessary to support and explain new themes and subthemes that have emerged from data analysis.

#### **5.2 THRESHOLD ATTRIBUTE**

According to the results, some users expected to stay long in the clinic but those that already knew about the Fast Queue did not expect this. Participants tended to be more satisfied when they perceived the Fast Queue to be fast enough for them. The Fast Queue is intended for those participants that have come for short consultations to be seen first so as to decrease congestion in the clinic as stated in the comprehensive package of care for South Africa (2001) which describes services to be rendered in a PHC facility with the Fast Queue being one of them. The document further describes the Fast Queue as a service for people that have been assessed previously and have come to collect medication only (Department of Health, 2001). It is clear from the results that some participants were satisfied with the Fast Queue while others were not. This was influenced mainly by two themes namely; user flow and communication.

##### **5.2.1. User Flow**

The results of the study revealed that good organisational skills by health care providers played an important role in user flow. Where health care providers were able to channel users in a logical manner, work happened smoother and faster. There are other nursing interventions that needed to be done before users were channeled to the Fast Queue, like the weighing of babies—streamlining users for

these interventions ensured fast processing into the Fast Queue. Sending the users back and forth as experienced by some participants was a typical example of poor work organisation which led to unnecessary delays and subsequent dissatisfaction. Fomundam and Herrmann (2007) note that a patient may have to go through several nodes and thus several bottlenecks in order to be moved along for consultation thus contributing to long waiting time. Furthermore the Queuing Management System (Qmatic.com, 2005) suggests ways of reducing waiting time such as good organizational skills and considering the patient flow. This system also proposes that an active search for bottlenecks is necessary so that the patient is channeled through to the fastest or shortest queue at any given time. Similarly, Setty, (2004) supports research and evidence based interventions to access quality of reproductive health and family planning services. The author offers solutions to client flow problems and discusses two principles of client flow, namely balancing client load and client flow, arguing that improving client flow can help shorten patient waiting time, and increase the number of patients a provider sees daily, enabling the provider to spend more time with the patient during a consultation rather than time spent waiting. The other principle is improvement of client flow by using signs, posted instructions and simplified paths to help clients to find direction on their own and move through the system quicker.

The following subthemes were identified as emerging from user flow; namely floor space, staffing, staff attitude, waiting time and workload.

### **5. 2.1.1 Floor Space**

The results of the study revealed that availability of space in a PHC facility facilitated user flow in that, users could be moved around and be accommodated easily in the different queues. This was important since every user was able to be directed to the queue that they needed to follow without any delays and hesitation because of lack of space. Availability of space also assisted in minimizing cross infection from one user to the other and the participants seemed to be happy about it. This was especially the case with small babies and children who visited the well baby clinic for routine assessments and immunisation. These babies would be exposed to infections if they were made to wait in the general waiting area with adult patients.



Participants highlighted this as one factor that enhanced satisfaction with the Fast Queue. Even though some structures were built such that users had to be accommodated in separate buildings, they were still satisfied as long as consultations were going to be conducted fast.

The National PHC Facilities Survey conducted in 2003 by Health Systems Trust revealed that waiting areas were adequate only in 48% of facilities, with lack of adequate seating being the most common deficiency. This is an indication that space is of utmost importance in health care facilities.

Fomundam and Herrmann (2007) discuss the use of queuing theory for the analysis of different types of health care processes. They present a discussion of queuing theories used in each of the three areas of health care namely; waiting time and utilization analysis, models for evaluating system design, and appointment systems.

The authors argue that in waiting time and utilization, health care providers have conflicting goals with regard to ensuring shorter waiting time and maximum utilization of resources. Four queuing theories are described in this area, namely:

- reneging where patients may decide to forego the service because they do not wish to wait any longer and reneging increases with the queue length and how long they must wait to be served.
- variable arrival rate whereby patients arrive at the clinic at varying times as affected by time of day, day of the week or season of the year, avoiding arrival at congested times. This affects the length of the queue because as soon as patients realise when waiting time is likely to decrease the arrival rate increases thus increasing the queue again.
- priority queuing discipline which is when clients requiring the shortest service are processed first to reduce waiting time.
- blocking where the length of the queue is limited and patients are turned away when the waiting room is full.

The second area is models for evaluating system design; where the authors argue that healthcare systems should be designed such that waiting times are limited because waiting is undesirable for patients and long waiting is associated with high costs.

The third area is appointment systems which reduces arrival variability and long waiting time compared to systems without appointments. The theory is used to determine the number of places that can be left empty during routine scheduling. Bottlenecks are described as nodes that occur in the queue where services are dispensed. It is therefore important to identify where bottlenecks are and resolve them as soon as possible to reduce waiting time.

Finally the system size, where the authors describe different levels of healthcare systems according to size. The smallest being a unit performing a single function or a group of closely related functions. The next larger system is a health care centre with a group of coordinated departments among which patients can flow and the largest a regional health system where intensive and most specialised services are conducted.

#### **5.2.1.2 Staffing**

The results of the study identified a shortage of staff as one of the factors that resulted in delayed queues and thus dissatisfaction. The introduction of free health services through the National Health Plan in 1994, aimed at increasing access to primary health care and improving the health of the poor in South Africa, has had negative effects on staffing through putting strain on the already poorly staffed facilities (Department of Health, 1994).

Leatte, Shung-King, and Monson (2006) in their study support the statement that free health services has resulted in a staff shortage among other factors. These authors state that children's rights to basic health care services are upheld through this policy (Hall, 2001). Furthermore, the emergence of the HIV/AIDS pandemic and the down referral of stable chronic users from hospitals are some of the factors that affected staffing in PHC facilities. Even though there is a shortage of staff, those

health personnel that are available are still expected to render quick and efficient service.

Oosthuizen and Ehlers (2007) cite inadequate remuneration, poor working conditions, excessive workload, lack of personal growth and career advancement possibilities and inability to meet safety and security needs as major factors that influence nurses' decisions to emigrate. The authors argue that the entire health care service suffers because of the large number of nurses who emigrate, since nurses constitute the largest professional group in South Africa's health care system and form the backbone of PHC in South Africa.

Van Rensburg and van Rensburg (1999) discuss strategies embarked upon by the South African Government to address shortages, disparities and maldistribution of health professionals. These include the recruitment of doctors from Cuba and other countries; the introduction of compulsory community service in 1998 for health professionals for two years after completion of training; construction of residential accommodation in rural areas and rural allowance being paid to attract health personnel to work there; recruitment and bursaries for under-privileged individuals; and changes to the curriculum to attract and retain health professionals in the public service.

### **5.2.1.3 Staff Attitude**

According to the results, participants experienced staff attitude both positively and negatively. The ability of health care providers to communicate and good skills when rendering services was perceived as good attitude thus enhancing satisfaction. On the other hand the opposite was perceived as poor attitude resulting in dissatisfaction. Leebov (2007) asserts that patients and their families judge nurses according to how they interact with others on the care team. They also judge them according to their attitude towards work, co-workers and the organisation and further states that a positive nurse-patient relationship enhances patient and family satisfaction. They found that attitudes of health care providers had an impact on user care and compliance in that where positive attitude was experienced they had a good impression about the clinic as a whole. However, those that had experienced

negative staff attitude had no desire to return to the clinic. Participants could be reluctant to use the service if the attitude is bad thus defaulting on treatment. Fomundam and Herrmann (2007) describe reneging as a queuing theory where patients forego the service because of the length of time they have had to wait. Reneging can also happen when users had a negative experience of staff attitude if they had no choice of which health care provider to consult with.

#### **5.2.1.4 Waiting Time**

Staff shortage as discussed above contributes to long waiting time which is a challenge in PHC facilities. This is compounded by improved accessibility to PHC services. According to the results participants were satisfied with shorter waiting time, since long waiting is associated with poor service. The shorter the time spent waiting, the more satisfied they were with the service despite no interventions to influence satisfaction and vice versa. Most authors like Thompson and Yarnold (1995), Eilers (2004), and Agaba, Bagul, Adenugba and Kenogbon (2002), agree that patient satisfaction is directly linked to waiting time and not to care received. Thompson and Yarnold (1995) found that patients are least satisfied when the waiting time was longer than expected, relatively satisfied when time was perceived as equal to the expectation and highly satisfied if waiting time was shorter than expected. Furthermore the way organizations deal with clients while waiting impacts on the client's perception of the organization. The authors further assert that queue management is about ensuring fairness and showing clients that they are waiting in a planned environment and reassuring them that they will be attended to, soon.

The Fast Queue was perceived as one mechanism of counteracting unnecessary waiting. Some authors like Ajayi (2002) recommend activities to engage patients so that the wait does not feel too long. Ajayi found that patients preferred health education talks while waiting. This made patients feel that their time was valued and made them feel better about waiting. Redesigning patient and work processes is another way that is useful in addressing waiting times.

### **5.2.1.5 Workload**

Increased workload was one of the subthemes that emerged from the study. Some factors that contributed to increased workload have already been discussed in the previous sections namely; the introduction of free health services, staff shortage, the emergence of the HIV/AIDS pandemic to mention a few (Pendukeni, 2004).

According to Barron, Day, Loveday, and Monticelli (2004), the nurse clinical workload measures the number of patients seen by a professional nurse per day. The suggested target for the nurse workload is about 35 clients per day, but it has been found that in certain districts the target reaches 92 patients per professional nurse per day. In her study, Hall (2001) found that the secrecy surrounding HIV/AIDS increased the nurses' workload because seeing that the HIV status of many patients are unknown, nurses have to apply universal precautionary measures when nursing all patients in their care and these precautionary measures affect productivity because they take more time to administer. This study further argues that poor record keeping of patients' HIV results also contributed to heavier workload because patients get tested for HIV more than once at different facilities thus resulting in nurses seeing the same patient or patients thus increasing the number of patients seen in the clinic. Furthermore some nurses felt that caring for AIDS patients is demanding and time consuming since these patients require labour intensive care, take longer to recover and most times there is lack of support from the patients families. The above is supported by Pendukeni (2004), who found that the growing number of patients with HIV/AIDS increased the demand for health care services. The author further asserts that nurses themselves are affected by HIV/AIDS. There is an increase in the number of nurses who die from the disease and are not replaced which increases the workload for the remaining nurses.

### **5.2.2 Communication**

Communication was yet another theme that was identified from the results of the study. It was evident from the results of the study that participants were satisfied where the health care provider communicated with them even if it was just general talk and not health related. Communication is an important tool in rendering a service. Dissatisfaction with the health care provider may result in users being

reluctant to visit the PHC facility with resultant defaulting on treatment. Press (2003) found that Americans are more satisfied with outpatients than emergency rooms because patients like the way staff generally interact with them and appreciate their technical competence in the outpatients department. On the other hand the emergency room was seen to be impersonal and emotional since treatment was carried out in a rushed manner as patients were critically ill and as a result health care providers were unable to interact sufficiently with either the patients or their families (Press, 2003).

According to Leebov (2007), nurse communication has the greatest impact on how patients rate their experience of the service. Leebov asserts that nurses are central in the care of patients in that both patients and families rely on nurses to keep them informed and to connect them with the doctors and other health care providers and allay their anxiety during their health care experience.

Yazdi, Tavafian, Emazdadeh, Kazemnejad and Ghofranipour undertook a study in 2008 to measure to what extent communication skills training could improve client satisfaction. The authors state that while the overall communication skills of health care providers improved, patient satisfaction also showed significant improvement. The health care providers were taught skills in interpersonal communication; socio-emotional communication including communicating with patients considering their individual socio-demographic characteristics, values, and culture in order to gain the patient's confidence; and verbal and non-verbal communication including diagnostic communication skills where the main emphasis was on effective listening and question asking skills in order to elicit information that would lead to a diagnosis and possibly solutions to the patients' problems. Lastly they were trained on counseling skills—teaching health care providers how to educate and consult with patients effectively by applying effective methods for consulting according to how they perceived their patients' problems.

### **5.3 PERFORMANCE ATTRIBUTE**

According to the theoretical framework a performance attribute is when customers are satisfied as a result of more being offered. The results of this study reveal that participants expected to leave the clinic carrying something in the form of medication or having been issued with supplementary food. This resulted in satisfaction regardless of the expertise and the skill used during the consultation. The main theme that emerged from the results of the study is discussed below i.e. expectations, care and health promotion.

#### **5.3.1 Expectations**

According to the results of the study, when participants were sick they expected to receive medication, which meant that there would be a problem if this expectation was not met. Sometimes users are given a health promotion talk only, which is an important part of management of illness and maintenance of health, and this could result in dissatisfaction. The results of the study revealed that participants were satisfied if they left the clinic having been given something tangible like medication or were given an injection and sometimes supplementary foods for those participants that required it. Participants expected both the positive and the negative. However expectations differed from one person to the other depending on who they were and where they were from as is evident in the following studies where patients' expectations are contrary to the results of this study. According to Bara, van den Heuvel and Maarse (2001), there are personal traits that influence satisfaction or dissatisfaction of patients such as educational level, health status, economic standing, and environmental factors e.g. the area they live in. The authors argue that the people who have attained a better social standing tend to have high expectations and are more highly dissatisfied with the service than those who are from low socio-cultural background who have low expectations and high levels of satisfaction. On the other hand Zebiene, Razgauskas, Basys, Baubiniene, Gurevicius, Padaiga and Svab (2004) argue that patients mostly expected information, explanation of the problem, understanding diagnosis and treatment. They found that patients were satisfied if these expectations were met.

Haas (1998) found that participants had definite expectations in terms of process of care and most of these expectations were expressed as “hopes”; because they did not wish to raise their expectations in case they were not met and would be dissatisfied.

### **5.3.2 Care**

The question regarding care in the Fast Queue sought to elicit the performance of the health care providers in delivering the service. Hornby (2008:163) defines care as “the process of caring for somebody or something and providing what they need for their health or protection”. However the results of the study revealed that participants’ judgment of the care in the PHC facility was based on the length of time spent waiting rather than the performance of the health care provider. The shorter the time they waited the more satisfied they were with the care. Contrary to this finding Chandwani, Jivarajani and Jivarajani (2009) found that patients were highly satisfied when they perceived the health staff to be competent and competency for them meant good care hence satisfaction. In another study McKinley, Stevenson, Adams and Manku-Scott (2002) found that patients were satisfied if the care received was what they had expected and those that visited the health care facilities were more satisfied than those that were visited at home. Wells and Polders (2009) found that black gay people were less satisfied with the care they received than white gay people who were more satisfied with care. This was attributed to the fact that the black people attended public health facilities which were less resourced whereas the white people attended private sector facilities where they were allowed a wide choice of whom to consult.

### **5.3.3 Health Promotion**

Health promotion is an old concept defined by WHO (1984:3) as “the process of enabling people to increase control over and improve their health”. In the move to achieve Health for All by the year 2000, a conference was held in Ottawa in 1986, where the Charter for Action was presented in relation to achieving this goal. It was building on the Declaration of PHC at Alma-Ata in 1978.



According to the results of this study, not all participants expected health care providers to talk to them during a consultation, while those participants that expected it, were satisfied that it happened. The results of the study revealed that participants were surprised and satisfied with health education given because it did not happen very often as it was supposed to. This is supported by Schneider, Kaplan, Greenfield, Li, and Wilson (2004) who found in their study of the physician-patient relationship that increased physician-patient communication resulted in better health outcomes in that it improved compliance with treatment in persons with HIV. According to Ntanyiya (1998), health promotion is a pillar of PHC and an element of all PHC service therefore all health personnel should see themselves as health promoters.

#### **5.4 EXCITEMENT ATTRIBUTES**

Excitement attributes are those attributes that are unspoken and unexpected by the customer, but can result in high levels of satisfaction if received. However, absence of these attributes does not lead to dissatisfaction. It has been observed that often the standards of care are not maintained by health care providers as a result users are not aware of what standards of care they are entitled to. The results of the study revealed that when users were attended to by a practitioner who provided the service efficiently, they became excited not knowing that they were entitled to that kind of service in the first place. Consequently the results revealed that participants were excited with being asked checking questions about what they had come to the clinic for. It is apparent that customer satisfaction depends mainly on the basic and performance attributes, which if absent overshadow the presence of excitement attributes (Kano, 1984).

Excitement attributes become ineffective if the customer is dissatisfied with the basic attribute. The results of this study illustrated that participants were excited with the basic and performance attributes which then became excitement attributes, as it would appear that they were experiencing them for the first time since these were not routinely offered by the health care providers.

According to Kano (1984), customer satisfaction highly increases with the increasing excitement attribute; however there is no corresponding decrease in customer satisfaction with the decrease in the excitement attribute. Kano gives an example of a cosmetic customer who may not be satisfied if there is no free bonus with the cosmetic bought, but may be more satisfied if a bonus is provided (Kano, 1984).

Shan et al., (2000), as cited by Tan and Pawitra (2001), point out that the Kano model proposes that those attributes that had once been exciting, with time are taken for granted and lose the “exciting status” and become basic because they will now be expected. Therefore, in the field of service provision it is imperative to be innovative about ways to keep the customers excited because of high competition.

## **5.5 CONCLUSION AND SUMMARY**

Overcrowding is a problem in health facilities and the Fast Queue is one strategy that is attempting to address it; however it was demonstrated by the results of this study that users are either satisfied or dissatisfied with the Fast Queue for many different reasons as discussed. It seems there is a need to improve on the different aspects of the Fast Queue in an effort to address the problem of overcrowding and long waiting time in the health facilities. The involvement of the Healthy Ministry is very crucial in supporting this endeavour.

## 5.6 RECOMMENDATIONS

The following recommendations are presented to attempt to address gaps that were identified by this study.

- Employment of queue marshals as already been suggested by the MEC for health and social development in Gauteng. The marshals would assist in directing users to the respective queues until they leave the facility. This would reduce waiting time and would keep users satisfied when they feel that they are being taken care of.
- Use of sign posts where there is lack of human resources to direct users. These would be effective since even illiterate users could easily follow the signs to their destination and would also save on cost.
- Health care providers can organise work better by streamlining interventions required before consultation so that users do not waste time going to and fro for these interventions. This could be achieved through triage by a trained health care provider. This would assist not only by limiting time wasted but also with early diagnosis and management of the user.
- Involvement of health care providers in planning construction of health facilities, because they would be able to have input as to what is required in practical situations like waiting areas considering patient flow, the issues of infection prevention and control, provision of privacy and many such issues, instead of allowing the architects and the builders to work alone.
- Re-opening of hospital based, free training of nurses to happen on a much bigger scale than it is presently, in order to close the gap of gross staff shortages experienced in the country.
- Multiskilling of nurses is of vital importance for holistic and continuity of care.
- Strengthening relationships with overseas countries that poach nurses from South Africa so that the numbers of migration are restricted e.g. a certain percentage of nurses allowed to go overseas for a fixed period.
- Training of staff on the significance of the government initiatives like Batho Pele translated as People First, the Patients' Rights Charter for the benefit of the service followed by monitoring and evaluation of these to measure their usability and to ensure their effectiveness.

- Effective complaints mechanism for users to ensure that complaints are followed up.
- Provision of employee assistance programmes and debriefing services to assist staff to de-stress and thus improve their attitudes.
- Re-enforcing use of the fast queue to reduce waiting time.
- Gainfully occupying users while they are waiting as suggested by Ajayi (2002) like health promotion talks conducted by a person or watched on video
- Addressing the users about any challenges that may affect waiting time as part of Batho Pele discussed above.
- Encourage users to arrive at the facility throughout the day, rather than the present practice where all users arrive in the clinic early in the morning. This variable arrival rate (Fomundam and Herrmann, 2007) encourages users to arrive at times when the facility is less congested so that work is balanced throughout the day.
- Individual health promotion talks and demonstrations to be conducted during a consultation depending on the presenting problem. Use of community health workers by giving health talks at home before communities contract diseases.
- Educate health care providers about the rationale of the Fast Queue system, because the better they understand it, the better they can implement it.
- The South African Department of Health has to improve threshold and performance attributes to afford health care users acceptable standards of care. Only once this is achieved can excitement attributes have a role to play in the South African Health System.

## **6. LIMITATIONS OF THE STUDY AND SUGGESTIONS FOR FURTHER RESEARCH**

In this study, only the experiences of the users of the fast queue were studied. More information could be obtained if the health care providers are studied as well. It would benefit the profession if research is conducted on the health care providers on their views, understanding and experience of the Fast Queue. There are unanswered questions, that health care providers can assign meaning to and so assist in understanding the Fast Queue, like what do they understand by the Fast Queue and it can best be utilised. The PHC facility managers would also contribute information that could be used when reviewing the document on Fast Queue as to what significance is seen from the use of the Fast Queue which they (PHC facility managers) observe as they supervise health care providers and manage the day to day running of the clinic.

## REFERENCES

African National Congress (ANC). 1994. **The National Health Plan for South Africa**. Johannesburg: African National Congress.

Agaba, A. E., Bagul, A., Adenugba, J. B. and Kenogbon J. I. 2002. Audit of patient's waiting time to see their family doctor prior to referral to a fast-access breast clinic in the era of a guaranteed 2-week wait. **Breast** [online], 11(5):430-3. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/14965707> [Accessed 23 March 2010].

Ajayi I. O. 2002. Patients' waiting time at an outpatient clinic in Nigeria – can it be put to better use? **Patient Education and Counseling** [online], 47:121-126. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/12191535> [Accessed 23 March 2010].

Bara, A. C., van den Heuvel W. J. A., and Maarse J. A. M. 2003. **Discrepancies between Romanian patient expectations and experiences of health care**. [Online], Chapter 7. Available at: <http://dissertations.ub.rug.nl/FILES/faculties/medicine/2003/a.c.ionila/c7.pdf> [Accessed 23 March 2010].

Barron, P., Day C., Loveday, M, and Monticelli, F. 2005. **The District Health Barometer Year 1. January – December 2004** [online], Health Systems Trust. Available at: <http://www.hst.org.za/publications/689> [Accessed on 23 March 2010].

Burns, N. and Grove, S. K. 1999. **The practice of nursing research: conduct, critique and utilization**. 3<sup>rd</sup> Edition. Philadelphia: WB Saunders.

Chandwani, H., Jivarajani, P. and Jivarajani, H. 2009. Community perception and client satisfaction about the primary health care services in a tribal setting of Gujarat – India. **The internet Journal of health** [online], 9(2):1-13 Available at: [http://www.library.nhs.uk/booksandjournals/details.aspx?t=\\*Perception&stfo=True&sc=bnj.ovi.amed,bnj.ovi.bnia,bnj.ebs.cinahl,bnj.ovi.emez,bnj.ebs.heh,bnj.ovi.hmic,bnj.pub.MED,bnj.ovi.psyh&p=18&sf=srt.publicationdate&sfld=fld.title&sr=bnj.ebs&did=2010588941&pc=2694&id=269](http://www.library.nhs.uk/booksandjournals/details.aspx?t=*Perception&stfo=True&sc=bnj.ovi.amed,bnj.ovi.bnia,bnj.ebs.cinahl,bnj.ovi.emez,bnj.ebs.heh,bnj.ovi.hmic,bnj.pub.MED,bnj.ovi.psyh&p=18&sf=srt.publicationdate&sfld=fld.title&sr=bnj.ebs&did=2010588941&pc=2694&id=269) [Accessed 26 February 2010].

Dhlomo, S. 2009. **Department of Health KwaZulu-Natal budget speech by Dr S. M. Dhlomo MEC for health** [online]. Available at:  
<http://www.kznhealth.gov.za/speeches/2009/budget2009.pdf>[Accessed 23 March 2010].

Dhlomo, S. 2010. **Budget speech presented by the MEC for Health S Dhlomo at the KwaZulu-Natal Legislature House** [online]. Available at:  
<http://www.search.gov.za/info/previewDocument.jsp?dk=%2Fdata%2Fstatic%2Finfo%2Fspeeches%2F2010%2F10042212551001.htm%40Gov&q=%28+%28%28dhlomo%29%3CIN%3ETitle%29+%29+%3CAND%3E%28+Category%3Cmatches%3Es+%29&t=S+Dhlomo%3A+KwaZulu-Natal+Health+Prov+Budget+Vote+2010%2F11>  
[Accessed 29 April 2010].

Di Paula, A., Long, R., and Wiener, D.E. 2002. **Are your patients satisfied?** Marketing, Health Services, 22 (3). Available at  
[www.ncbi.nlm.nih.gov/pubmed/12233235](http://www.ncbi.nlm.nih.gov/pubmed/12233235) [accessed 13 March 2010]

Eilers, G.M. 2004. Improving patient satisfaction with waiting time **Journal of American College Health** [online], 53(1):41-48. Available at:  
<http://heldref-publications.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,6,6;journal,36,78;linkingpublicationresults,1:119928,1> [Accessed 29 April 2010].

Fomundam, S. and Herrmann, J. 2007. **A survey of queuing theory applications in healthcare** [online], ISR Technical Report 2007-24. Available at:  
[http://www.lib.umd.edu/drum/bitstream/1903/7222/1/tr\\_2007-24.pdf](http://www.lib.umd.edu/drum/bitstream/1903/7222/1/tr_2007-24.pdf)  
[Accessed 17 March 2010].

Haas, M. 1998. **An empirical exploration of patient expectations of health care** [online], CHERE Discussion Paper 35. Available at:  
<http://www.utsydney.cn/chere/pdf/dp35.pdf> [Accessed 17 March 2010].

Hall, E. J. 2001. **The challenges HIV/AIDS poses to nurses in their work environment** [online], Employment and Economic Policy Research Human Sciences Research Council.

Available at:

[http://www.hsrc.ac.za/research/output/outputDocuments/3371\\_Hall\\_ThechallengesHIVposes.pdf](http://www.hsrc.ac.za/research/output/outputDocuments/3371_Hall_ThechallengesHIVposes.pdf) [Accessed 17 March 2010].

Hornby, A. S. 2005. **Oxford Advanced Learner's Dictionary**. Oxford: Oxford University Press.

Kano, N. 1984. **Customer Satisfaction Model** Available at:

[http://www.12manage.com/methods\\_kano\\_customer\\_satisfaction\\_model.html](http://www.12manage.com/methods_kano_customer_satisfaction_model.html)  
[Accessed 17 June 2006].

KwaZulu-Natal Department of Health, 2004. **Annual Report 2003/2004**.

Pietermaritzburg, KwaZulu Natal.

KwaZulu-Natal Department of Health, 2007. Addington Hospital. **Gateway and Poly Clinic**. [Online]. Available at: [www.kznhealth.gov.za/addington/poly.htm](http://www.kznhealth.gov.za/addington/poly.htm) [Accessed: 17 March 2010].

Leatte, A., Shung-King, M. and Monson, J. 2006. **Healing inequalities: the free health policy** [online], Children's Institute, University of Cape Town. Available at:

[http://www.ci.org.za/depts/ci/pubs/pdf/general/gauge2006/gauge2006\\_healing.pdf](http://www.ci.org.za/depts/ci/pubs/pdf/general/gauge2006/gauge2006_healing.pdf)

[Accessed 17 March 2010].

Leebov, W. 2009. **The quality experience: the nurse patient relationship is central to patient satisfaction**. [Online]. Available at:

<http://www.quality-patient-experience.com/nurse-patient-relationship.html>

[Accessed 16 February 2010].

Lincoln, Y. S. and Guba, E. G. (1985). **Naturalistic inquiry**. Newbury Park, CA: Sage Publications.



Mackey, T. and Cole, F. L., 1997. Patient Waiting Time in a Nurse Managed Clinic. **The Internet Journal of Advanced Nursing Practice** [online], 1(1):1-8. Available at:

<http://www.ispub.com/ostia/index.php?xmlFilePath=journals/ijanp/vol1n1/time2.xml>

[Accessed 16 February 2010].

Mahlangu, Q. 2009. **Health Budget speech tabled by MEC for Health and Social Development, Ms Qedani Dorothy Mahlangu** [online]. Available at:

<http://www.info.gov.za/speeches/2009/09080614251002.htm>

[Accessed 23 March 2010].

May, E. L. 2004. Optimizing patient flow. **Improve patient throughput and processes while delivering efficient, high-quality care. Health care Executive.** 19(32):32-34

McKinley, R. K., Stevenson, K., Adams, S. and Manku-Scott T. K. 2002. Meeting patient expectations of care: the major determinant of satisfaction with out-of-hours primary medical care? **Family Practice** [online], 19(4) :( 333-338). Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/12110550> [Accessed 23 March 2010].

Nicholson, J. 2001. **Bringing health closer to the people: Local Government and the District health system.** Durban: Health Systems Trust.

Ntayiya, S., Mntuyedwa, M., Nomabunga, N., Klaas, L., Gogo, F. and Magaqa, H. 1998. Health promotion in a rural health district making it more effective and efficient [online], **Kwik Skwiz #11**, Health Systems Trust, Durban. Available at:

<http://www.healthlink.org.za/uploads/files/kwiksk11.pdf> [Accessed on 23 March 2010].

Oakland, J. S. 2003. **Total quality management: text with cases.** Oxford: Butterworth-Heinemann.

Oosthuizen, M. and Ehlers V. J. 2007. Factors that may influence South African nurses' decisions to emigrate. **Health SA Gesondheid**, 12(2):14-26.

Pendukeni, M. 2004. **The impact of HIV/AIDS on health care provision: Perceptions of nurses currently working in one regional hospital in Namibia.** Master's in Public Health mini-thesis, [online], University of the Western Cape. Available at:  
[http://etd.uwc.ac.za/usrfiles/modules/etd/docs/etd\\_init\\_3642\\_1175160167.pdf](http://etd.uwc.ac.za/usrfiles/modules/etd/docs/etd_init_3642_1175160167.pdf)  
[Accessed 26 February 2010].

Polit, D. F., Beck, and Hungler, B. P. 2001. **Essentials of Nursing Research: methods, appraisal and utilization.** 5<sup>th</sup> edition. Philadelphia: Lippincott.

Polit, D. F., Beck, C. T. 2008. **Nursing Research: Generating and assessing evidence for nursing practice** 8<sup>th</sup> edition. Philadelphia: Lippincott.

Press, I. 2003. Patient satisfaction with the outpatient experience. How does your organization measure up? **Health Care Executive**18 (3):94-95.

**Qmatic.com. 2005. Queuing management system** [online]. Available at: [www.qmatic.com/](http://www.qmatic.com/) [Accessed: 06 June 2006].

Republic of South Africa. 1996. **The National Health Plan of South Africa.** Pretoria: Government Printer.

Republic of South Africa. 1997. **White Paper for the transformation of Health System in South Africa. Notice 667 of 1997.** Pretoria: Government Printer.

Republic of South Africa. 2004. **National Health Act (Act 61 of 2003).** Pretoria: Government Printer.

Republic of South Africa, Department of Health. 2001. **The comprehensive primary health care package for South Africa.** Pretoria: Formeset Printers Cape for the Government Printer.

Schneider, J., Kaplan, S. H., Greenfield, S., Li, W. and Wilson, I. B. 2004. Better physician-patient relationships are associated with higher reported adherence to

antiretroviral therapy in patients with HIV infection. **Journal of General Internal Medicine** [online], 19(11):1096-1103. Available at:  
<http://www.ncbi.nlm.nih.gov/pubmed/15566438> [Accessed 26 February 2010].

Serrano-del-Rosal, R., Vera-Toscano, E., and Ateca-Amestoy, V., 2004. **The disutility of waiting time: Evidence from the Public Primary Health care Service in Andalucía** [online]. Available at  
<http://ideas.repec.org/p/esa/iesawp/0406.html#download>  
[Accessed 26 February 2010].

Setty, V. 2004. **Organizing work better** [online], HRH Global Resource Center. Available at: <http://www.hrhresourcecenter.org/node/1076>  
[Accessed 26 February 2010].

Sibiya, M.N. 2009. **A model for the integration of primary health care services in KwaZulu Natal, South Africa**. Thesis submitted in fulfillment for the requirements for D.Tech: Nursing in the Faculty of Health Sciences, Durban University of Technology, 2009. [Online] Available at:  
<http://ir.dut.ac.za/xmlui/handle/10321/453> [Accessed 26 February 2010].

Slaughter, P. M., Carlisle, J., Williams, J., and Ferris L. E. 2005. A National Strategy for waiting times research. **Canadian Medical Journal Association** [online], 172(10):1283-4. Available at:  
<http://www.cmaj.ca/cgi/content/full/172/10/1283> [Accessed 26 February 2010].

Tan, K.C. and Pawitra T.A. 2001. Integration of SERVQUAL and Kano's model into quality function deployment (QFD) for service excellence development. **Managing Service Quality**, 11(6):418-430

Tiresias. 2009. **Queue Management System for the tourism sector** [online]. Available at:  
[http://www.tiresias.org/happytourist/queue\\_management\\_systems.htm](http://www.tiresias.org/happytourist/queue_management_systems.htm)  
[Accessed 10 February 2010].

Thompson, D. A. and Yarnold, P. R. 1995. **Relating Patient satisfaction to waiting time perception and expectations: the disconfirmation paradigm.** Academic Emergency Medicine. [online]. 2(12):1057-1062

Available at:

<http://www3.interscience.wiley.com/journal/121422600/abstract?CRETRY=1&SRETRY=0> [Accessed 23 March 2010]

UNAIDS. 2008. **2008 report on the global AIDS epidemic** [online]. Available at: [Accessed 23 March 2010].

Van Rensburg, H. C. J. 2004. **Health and Health Care in South Africa**, editor. Pretoria; Van Schaik Publishers.

Van Rensburg, D. and van Rensburg, N. 1999. Distribution of human resources. In: Crisp, N. and Ntuli, A. editors. **South African Health Review 1999.** Durban: Health Systems Trust.

Wells, H. and Polders, L. 2009. **Gay and Lesbian people's experience of the health care sector in Gauteng.** Research initiative of the Joint Group conducted by Lesbian, Gay, Bisexual and Transgender well-being in collaboration with the UNISA Centre for Applied psychology.

Welman, J. C. and Kruger, S. J. 2003. **Research methodology for the business and administrative sciences.** 2<sup>nd</sup> Edition. Cape Town: Oxford University Press.

World Health Organisation (WHO). 1978. **Declaration of Alma-Ata, International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September 1978.** [online]. Geneva: WHO Available at: [http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf) [Accessed 23 March 2010].

World Health Organisation (WHO). 1986. **Ottawa Charter for Health Promotion, First International Conference on Health Promotion Ottawa, 21 November 1986.** Geneva: [online]. WHO Available at:

[http://www.who.int/hpr/NPH/docs/ottawa\\_charter\\_hp.pdf](http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf) [Accessed 23 March 2010].

Yazdi N. A., Tavafian S. S., Emadzadeh A., Kazemnejad A. and Ghofranipour, F. 2008. Communication training and patient satisfaction: A randomized trial study from Mashhad, Iran. **Patient Preference and Adherence** [online], 2(2):137-142. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19920954> [Accessed 23 March 2010]

Zebiene, E., Razgauskas, E., Basys, V., Baubiniene, A., Gurevicius, R., Padaiga, Z. and Svab, I. 2004. Meeting patient's expectations in primary care consultations in Lithuania. **International Journal for Quality in Health Care** [online] 16 (1):83-89 Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15020564> [Accessed 23 March 2010].

**ETHICS CLEARANCE CERTIFICATE**

Researcher Name	Ms D G Sokhela	Project No.	20426435
Research Title	FHSEC 052/08	Date of FRC Approval	24 November 2008
Research Topic	Assessment of experiences of users of the fast queue in selected primary health care facilities in the eThekweni Municipality		

In terms of the ethical considerations for the conduct of research in the Faculty of Health Sciences, Durban University of Technology, this proposal meets with Institutional requirements and confirms the following ethical obligations:

1. The researcher has read and understood the research ethics policy and procedures as endorsed by the Durban University of Technology, has sufficiently answered all questions pertaining to ethics in the DUT 186 and agrees to comply with them.
2. The researcher will report any serious adverse events pertaining to the research to the Faculty of Health Sciences Research Ethics Committee.
3. The researcher will submit any major additions or changes to the research proposal after approval has been granted to the Faculty of Health Sciences Research Committee for consideration.
4. The researcher, with the supervisor and co-researchers will take full responsibility in ensuring that the protocol is adhered to.
5. **The following section must be completed if the research involves human participants:**

	YES	NO	NA
◆ Provision has been made to obtain informed consent of the participants	√		
◆ Potential psychological and physical risks have been considered and minimised			√
◆ Provision has been made to avoid undue intrusion with regard to participants and community			√
◆ Rights of participants will be safe-guarded in relation to:	√		
- Measures for the protection of anonymity and the maintenance of Confidentiality.	√		
- Access to research information and findings.	√		
- Termination of involvement without compromise	√		
- Misleading promises regarding benefits of the research	√		

Appendix 2

9 Old Fort Place  
Durban 4001  
22 February 2009

LETTER TO THE MUNICIPALITY.

The Research Committee.

Request for permission to conduct a study.

My name is Dudu Sokhela. I am a Nursing Service Manager Quality Assurance at eThekweni municipality and I am an M-Tech student at the Durban University of Technology. I would like to conduct a study entitled "Assessment of experiences of users of the fast queue in selected primary health care clinics in the eThekweni municipality".

The purpose of the study is to establish a common understanding of the concept of fast queue, among users as a mechanism for reducing patient waiting time. The emergent aim is to facilitate effective implementation of the fast queue and thus improving health care delivery and enhance user satisfaction.

The interview will take about 15 minutes and focus groups will last about 30 – 45 minutes. Participation is voluntary. Anonymity and confidentiality will be kept at all times. Participants will be informed that they are free to withdraw at any stage of the study if they so wish. This study will not compromise them in any way, and will not result in victimization. The normal functioning of the clinic will not be disrupted in any way.

The study will benefit the clients, the personal health section of the municipality and the nursing profession; in that decisions will be made with respect to patient flow management, reducing waiting time and future planning for clinics, thus improving clinical practices. A copy of the completed research will be available in the municipal library health section.

For further information please contact the researcher Dudu Sokhela (NSM-QA) at 031 311 3709 (w) or 0722 644 670 (cell) or the research supervisor Jabu Makhanya at 031 3732293.

Thank You.

D.G. SOKHELA (NSM-QA).

Appendix 3  
**ETHEKWINI MUNICIPALITY**  
**Health, Safety and Social Services Cluster**  
**Health Unit**

9 Old Fort Place  
 Durban 4001  
 P O Box 2443  
 Durban 4000

Tel: (031) 3113679  
 Fax: (031) 3113710

Website: <http://www.durban.org.za>



**Our Ref:**

**Your Ref:** Dr Cheryl Weaich  
**Enquiries:** Phone 0313113539  
 Weaichc@durban.gov.za  
 6 March 2009

**RE: RESEARCH REQUEST**

The following information is required:

		YES	NO
1	A full written protocol, with written proof of approval by an accredited Ethics Committee (NB: This will also be required for changes to research methodology).	✓	
2	A briefing meeting with relevant staff, or community if indicated.	✓	
3	An assurance that our services will not be disrupted	✓	
4	An understanding that participation in your study by members of the public is on a voluntary basis.	✓	
5	Compliance with Access to Information Act and other relevant legislation	✓	
6	You will assume full responsibility for obtaining informed/written consent from the public/patients, and maintaining confidentiality.	✓	
7	All drugs used in research trials/studies must be registered with the MCC	N/A	
8	eThekweni Municipality – Health Department requires indemnity against any claim that may be brought about by researchers/research workers in terms of the Compensation of Occupational Injuries and Diseases Act.	✓	
9	The eThekweni Municipality Health Department requires indemnity against any claims that may arise as a direct or indirect result of any acts or omissions by the research team.	✓	
10	Submission of progress reports/meetings at appropriate intervals, or on request	✓	
11	Obtain prior permission from this Department before press releases, and release of results to communities/ stakeholders	✓	
12	Withdrawal of permission to conduct research will be left to discretion of the eThekweni Health Department.	✓	
13	This Department is to receive recognition for the assistance given, and a copy of the research results on conclusion of the study must be submitted before publication.	✓	
14	Other Request		

Having accepted and complied with the above terms, you will then be informed of the outcome of your request.

Yours faithfully

S Cele  
**ACTING HEAD : HEALTH**



**GENERAL INDEMNITY**

I, Sokhela Dudu Gloria

(In my capacity as Researcher and duly authorised hereto by Mrs A.D. Maseko hereby indemnify the eThekweni Municipality (hereinafter referred to as the "Council") and its officers and servants and hold them harmless against:

- 1) any action, liability, claim or demand that may be brought against it or them in respect of any damage, injury or death including any consequential loss and/or damage arising therefrom;
- 2) any legal costs or expenses incurred in relation to such claims, actions or other legal proceedings arising out of the foregoing;

where the loss, damage, injury or death contemplated in (1) above arises out of or is consequent upon, the undertaking of research by myself in \_\_\_\_\_, Durban. Staff at the \_\_\_\_\_

Signed at Durban on this 28<sup>th</sup> day of April 2009

\_\_\_\_\_  
SIGNED

**WITNESSES:**

- 1. ....
- 2. ....

**ETHEKWINI MUNICIPALITY**  
**Health, Safety and Social Services**  
**Health Unit**



9 Old Fort Place  
Durban 4001

P O Box 2443  
Durban 4000

Tel: (031) 3113679  
Fax: (031) 3113710

Website: <http://www.durban.org.za>

**Our Ref:**

**Your Ref:** Dr Cheryl Weaich  
Phone 031 3113539

**Enquiries:**  
18 May 2009

**Dudu Gloria SOKHELA QA EthekeWini Health**  
**Work 031 3113709**  
**Home 031 7055921**  
**Cell 0722 644 670 (Cell.)**  
**DUT Student Student Number: 20429436**

Dear Dudu

**ASSESSMENT OF EXPERIENCES OF USERS OF THE FAST QUEUE IN SELECTED  
PRIMARY HEALTH CARE CLINICS IN THE ETHEKWINI MUNICIPALITY.**

Approval is granted for the above study to be conducted at  
SOUTH: CDC, Cato Manor, Township Centre, Lamont and Overport.

NORTH: Verulam, Newlands West, Redhill, KwaMashu B and Inanda Seminary.

WEST: Pinetown, Reservoir Hills, Queensburgh, New Germany and Waterfall.

Please contact our reps in North, South and West. They are Yasmin Akbar, Sibahle Maphumulo and Muzi Majola respectively who will assist you in confirming dates when you can present your research proposal. The subdistrict heads' secretaries will then ensure the proposal presentation will be on the agenda for their next management meeting

We wish you all the best in your study. Please provide us with a report at the end of your research

Please contact Dr. Cheryl WEAICH on 031 – 311 3539 or 0834146488 for any queries

**HEAD: HEALTH**

## **Appendix 6**

### **INFORMATION LETTER TO PARTICIPANTS.**

Dear Participant,

My name is Dudu Sokhela. I am a Nursing Service manager Quality Assurance at eThekweni municipality and I am an M-Tech student at the Durban University of Technology. I am conducting a study entitled "Assessment of experiences of users of the fast queue in selected primary health care clinics in the eThekweni municipality". The purpose of the study is to establish a common understanding of the concept of fast queue, among users as a mechanism for reducing patient waiting time in selected primary health facilities in the eThekweni Municipality. The emergent aim is to facilitate effective implementation of the fast queue and thus improving health care delivery and enhance user satisfaction.

The interview will take about 15 minutes and focus groups will last about 30 – 45 minutes. Participation is voluntary. Anonymity and confidentiality will be kept at all times. You are free to withdraw at any stage of the study if you so wish. This study will not compromise you in any way, and will not result in victimization.

The study will benefit you and the nursing profession in that decisions will be made with respect to patient flow management, reducing waiting time and future planning for clinics, thus improving clinical practices.

If you have any questions feel free to contact the researcher Dudu Sokhela at 031 311 3709 (w) or 0722 644 670 (cell) or the research supervisor Jabu Makhanya 031 3732293.

A copy of the completed research will be available in the municipal library health section.

Thank you for your participation

D.G. Sokhela. (NSM-QA).

## Appendix 7

### INCWADI YOKUNIKA ULWAZI KULABO ABAZIKHETHELA UKUNGENELA UCWANINGO

Igama lami ngingu Dudu Sokhela. Ngingumhlengikazi osebenzela kuMasipala weTheku, ngenza izifundo zeziqu zeMasters esikhungweni semfundo ephakeme inyunivesi okuthiwa iDurban University of Technology. Ngenza ucwaningo olusihloko sithi ukucubungula ukuphatheka kwabasebenzisi bemitholampilo. Ngohlelo lomugqa/ulayini osheshayo emitholampilo ethile kaMasipala weTheku". Inhloso yalolucwaningo ukuthola ukuqonda okuvunyelwana ngakho ngabasebenzisi bomtholampilo abaningi ngaloluhele lukalayini osheshayo, njengohlelo olunciphisa isikhathi sokulinda emtholampilo.

Inhlosongqangi ukukhuthaza ukusetshenziswa kwaloluhele lukalayini osheshayo ukuze kuphuculwe isimo somsebenzi wokuhlenga ngezempilo nokugculiseka ngempatho kwabasebenzisi bomtholampilo. Ukuxoxisana lokhu kungathatha imizuzu eyishumi nanhlano bese kuthi inkulumompikiswano ezobanjwa neqembu elithile yona ibe imizuzu engamashumi amathathu kuya kwengamashumi amane nanhlano.

Ilabo abathandayo kuphela nabazokhethela bona abazoba ingxenye yalolucwaningo, akuphoqiwe. Yonke imininingwane namagama kuzoba imfihlo nesifuba somcwaningi kuphela. Ungahoxa futhi noma kunini noma kuliphi izinga locwaningo uma usufisa. Lolucwaningo aluzubeka muntu engcupheni futhi ngeke luholele ekuhlukunyezweni kwanoma iluphi uhlobo.

Lolucwaningo luzosiza wena kanye nomkhakha wezempilo wonkana ngokuthi iziphathimandla zezempilo ezenza izinqumo sezizobhekelela ukuhleleka kwabasebenzisi bomtholampilo, kunciphise nesikhathi sokulinda, nokuhlelwa kwemitholampilo emisha ukuze kwenze ngcono ukusebenza kwabahlengikazi.

Uma unemibuzo ungakhululeka ukushayela umcwaningi uDudu Sokhela kulembolo yocingo 031 311 3709 emsebezini noma 0722 644 670 umakhalekhukhwini noma umphathi kulolucwaningo uJabu Makhanya kulombolo yocingo 031 3732293. Umfanekiso walolucwaningo uyotholakala esigcinamiqulu kuMasipala weTheku emnyangweni wezempilo.

Ngiyabonga,  
Dudu Sokhela

Dudu Sokhela (NSM-QA)

March 2009