

# THE MANAGEMENT OF MINOR HEALTH AILMENTS BY DOCTORS, CLINICAL NURSE PRACTITIONERS AND CLIENTS AT THE PRIMARY LEVEL OF CARE IN CAPE TOWN

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## Abstract

### Introduction:

Community Health Centres (CHCs) are overcrowded. The overcrowding poses a problem to health professionals as they are in charge of screening clients and the management of minor health ailments (MHA) in the primary health care setting.

### Methodology:

The aim of this study was to describe and compare the perceptions and attitudes of clients presenting with MHA to those of doctors and clinical nurse practitioners (CNPs) (health professionals) at the CHCs regarding the management of MHA. The study was conducted at the four selected CHC in Khayelitsha and Phillipi, Cape Town. Information was collected from 100 clients and 15 health professionals. Data was analysed both qualitatively and quantitatively and the descriptive method was used.

### Results:

All three groups had similar perceptions of what MHAs are and how MHA should be managed. There were different perceptions regarding where these ailments should be managed. The doctors and CNPs were frustrated and felt overburdened by clients presenting with MHA. Doctors were of the opinion that educating clients about the management of these ailments would alleviate their load.

**Conclusion:** Health education was identified as a tool that could assist in the situation of managing MHA and as the key underpinning principle for the delivery of comprehensive primary health care (PHC).

**Key words:** management, minor health ailments, primary level of care

## Introduction

Khayelitsha and Phillipi, the residential areas in which the study was conducted, are two black townships near Cape Town in South Africa. Khayelitsha was established when the apartheid government planned to move all Africans living near the city centre to areas further away from the city and suburbs (in other words, away from white people). Phillipi started at Brown's Farm, where people working on the farm built shack dwellings for housing. Khayelitsha and Phillipi are located

approximately 26 and 20 kilometres respectively from Cape Town city centre, and both areas emerged out of informal settlements.

One characteristic of the informal settlement is rapid population growth. It is estimated that the population increase in Khayelitsha is 8.5% per year. The community profile of Khayelitsha that was done in 2001 estimates that Khayelitsha alone houses approximately 300 000 to 400 000 people. However, because of the rate of people settling in

Khayelitsha, the numbers could be much higher. It is estimated that approximately 110 316 people live in Phillipi. The population of these areas comprises mainly young Xhosa-speaking people, the majority of whom are between ages 19-39 years and 91,1% is unemployed (Anderson, Azari and van Wyk, 2009). Poor conditions, such as overcrowding and poor infrastructure, leave these young people prone to an array of illnesses.

In 1996, the Department of Health of the Provincial Administration of the Western Cape (Department of Health, 1996), in line with the government's national initiatives, developed a district health plan to provide access to health care for all citizens of South Africa. The district health system would be supported by the development of CHCs and clinics to enhance the services provided. Khayelitsha and Phillipi fall under Districts 7 and 3, with three and four CHCs respectively. The doctor:patient ratio is meant to be 1:60 and the clinical nurse practitioner:patient ratio is meant to be 1:25. In reality, both the doctors and the clinical nurse practitioners see far more patients than these, especially when there is a shortage of staff.

While the new post-apartheid health agenda was geared towards shifting both human and financial resources from the large incumbent tertiary institutions to the envisaged district health system. There was no clear plan regarding the percentage of shifts or an operational plan for the different layers of the health delivery system, that is, primary, secondary and tertiary health care (Louw and Edwards, 1997). A psychiatric patient died on the doorstep of a tertiary hospital after having taken an overdose of his psychiatric medication. He was refused access to the tertiary hospital in question because he was not carrying a referral letter from the primary level of health care (Bond, 1997).

A clinical nurse practitioner (Personal communication, Sr. Sigwela, 2001) stated that due to the large numbers of clients attending CHCs, health professionals have no time to educate clients on the prevention and management of minor health ailments. The easiest way to manage the situation is to listen to the patients' problems and prescribe medication for the clients without doing any proper assessment and education. The clients are aware of alternative methods for the management of minor

health ailments but they do not utilise alternative methods and medicines, such as the indigenous health knowledge of elderly persons, traditional healers, community health workers, pharmacists and other resources available within their communities.

The problem of overcrowding of CHCs (Michael Mapongwana and Khayelitsha) was discussed in the community health forum with the facility managers of these CHCs, health professionals, clinical facilitators from the University of Cape Town (UCT), students from UCT and elderly persons from Khayelitsha and Phillipi. There was a group of elderly persons residing in Khayelitsha and Phillipi who had the perception that minor health ailments could be managed at home using home remedies.

The new health care agenda never discussed how communities would work together with government to develop PHC (Louw and Edwards, 1997). The researcher further proposes that if this had been addressed, issues such as client accountability and responsibility, as well as the relationship between clients and staff members at the facilities, including measures to address staff fatigue and issues relating to the sustainability of the services would have been discussed with all parties concerned in community health forums. According to the Alma-Ata Declaration of 1978, PHC should address the main health problems in the community by providing promotive, preventive, curative and rehabilitative services. Education concerning prevailing health problems and the methods of preventing and controlling illnesses underpins the comprehensive delivery of primary health care (Fry and Hasler, 1986).

The implementation of PHC in South Africa was aimed at improving access to health care services. This attempt to shift resources resulted in the proliferation of CHCs in areas such as Khayelitsha and Phillipi, where health services were previously either inadequate or absent. These CHCs in Khayelitsha and Phillipi became overcrowded with clients. The overcrowding undermines access to the CHCs, as people wait for hours before seeing the health professionals. It is not clear whether the clients in this study first tried using any other medication before visiting CHCs. This brings us to the question of how primary health care is

implemented in these communities: Were existing resources within the communities considered, and what is the relationship between the CHCs and the communities that they serve?

In 2003, Minister Manto Tshabalala-Msimang hosted a conference to celebrate the completion of 40 years post Alma Ata. This is what she had to say in her opening address:

*As a result of the implementation of PHC in South Africa, the payment barrier to access to PHC services has been removed. People with disabilities, for example, now have free access to health services, and more than 700 clinics have been built or upgraded to mainly serve the most vulnerable and needy communities. Most surveys indicated that 80% of the public are satisfied with the health care they receive whilst the remaining 20% are unhappy largely with the attitude of health workers and the lack of drugs (Tshabalala-Msimang, 2003; Rasool, 1997).*

Although there are assumptions that the clients do not pay for primary health care services and that they do not utilise available health resources within their communities, no study has been done on clients attending CHCs and presenting with minor health ailments in Khayelitsha and Phillipi in order to investigate the perceptions and attitudes of the clients, doctors and clinical nurse practitioners towards the management of minor health ailments at CHCs.

According to Hjortdahl and Laerum (1992, in Atkinson and Haran, 2004), providing the health care measures of accessibility, availability and convenience are consistently associated with higher satisfaction in health care. The continuity of care providers has also been positively associated with satisfaction. Williams and Calnan (1991, in Atkinson and Haran, 2004) noted the importance of the interpersonal aspects of the patient-professional relationship, such as the amount and clarity of information regarding the condition of the patient, bedside/chairside manner during the consultation, similarity of socio-demographic backgrounds and the extent to which the patient could express opinions. They indicated that these are positively associated with satisfaction about health (Williams and Calnan, 1991, in Atkinson and Haran, 2004).

Overcrowding had been identified as a problem in the Michael Mapongwana and Khayelitsha CHCs. There is a perception that a reasonable number of clients present with minor health ailments. It is believed that clients and health care professionals have different perceptions regarding where these minor health ailments should be managed. Hence the aim of this study was to describe and compare the perceptions and attitudes of clients presenting with minor health ailments, doctors and CNPs at CHCs in Khayelitsha and Phillipi.

## Methodology

### Study design

A descriptive study was conducted using self-compiled and self-administered structured questionnaires. Both quantitative and qualitative methods were used to collect data from participants.

### Sample and sampling methods

A purposefully selected sample of 100 clients was used. Twenty-five clients presenting with minor health ailments were selected from each CHC (Michael Mapongwana, Khayelitsha, Inzame Zabantu and Mzamomhle). Ten doctors and five clinical nurse practitioners who voluntarily agreed to participate in the study were recruited from the purposefully selected CHCs in Khayelitsha and Phillipi except for those working at Mzamomhle CHC because they did not want to participate in the study. The doctors and clinical nurse practitioners identified the 100 clients presenting with minor health ailments after consultation. Pink stickers were put on their folders to distinguish them from clients who presented with serious ailments.

### Patient selection procedure

Doctors and CNPs assisted in identifying clients with minor health ailments. The compilation of the list and the selection of clients with minor health ailments were done with the understanding that minor health ailments are difficult to define, as what is regarded as minor today can later become a serious ailment. A list of minor health ailments that was agreed upon by experts on primary health care, doctors and CNPs from the CHCs was used to identify the clients with minor health ailments. These ailments were **Respiratory**: colds, upper respiratory tract infection, hay fever; **Abdominal and urinary tract infection (UTI)**: diarrhoea,

stomach ache, gastro-intestinal complaints, acute urinary tract infection; **Skin disorders:** insect bite, rash; **Body pains:** back pain, acute back syndrome, migraine, emotional problems; **Ears:** cerumen, acute otitis media; **Accidents:** minor cuts, nose bleeds, accidents or burns.

All clients who presented with these minor health ailments had pink stickers attached to their folders after consultation so that the doctors and CNPs could identify them.

**Instrumentation and methods of data collection**

**Instruments used:** A self-compiled structured questionnaire with closed-ended and open-ended questions was used to collect data that answered the aim and objectives of this study from the clients and health professionals (doctors and clinical nurse practitioners). The instrument was piloted at another CHC for reliability and validity to both clients and health care professionals. This questionnaire consisted of two sections. Section A was used to obtain demographic information and Section B collected information from the participants regarding their own perceptions and attitudes pertaining to the management of minor health ailments.

**Ethical considerations**

Permission to conduct the study was obtained from the Research Ethics Committee of the University of Cape Town and from the facility managers of the CHCs where the study was conducted. Participants were requested to sign a consent form that also informed them of the procedure of the study.

**Data analysis**

Data were collected in 2003 at the different sites in Khayelitsha and Phillipi. All the responses of the clients, doctors and CNPs were gathered separately and the information was summarised according to the responses to the questions. The responses requiring ‘yes’ and ‘no’ answers were counted and presented as percentages. Common themes from qualitative data were identified by coding them for both clients and health professionals. The responses from the questionnaire were captured on an Excel spreadsheet and the results were presented in tables and themes.

**Results**

**Demographic details of participants**

There were 100 clients (63 female and 37 male), 10 doctors (9 male and 1 female), 5 CNPs (all female) who participated in this study. Of the clients, doctors and CNPs who participated in this study the majority (n=108) of the participants fell within the age group of 18 to 49 years, followed by 6 clients who fell within the 50-59 years and only 1 was in the age group 60 to 65 years. Of the clients who participated in the study 55% (n=55) visited the CHC for the first time and 45% (n=45) had visited the CHC more than once for the same minor health ailment on the day of the interview.

**List of minor health ailments mentioned by clients, doctors and CNPs:**

Although a list of minor health ailments to be used for the identification of clients with minor health ailments had been compiled by the researcher in consultation with PHC experts, doctors and CNPs, the clients, doctors and CNPs in this study also mentioned ailments that they knew and regarded as minor. While the participants mentioned many illnesses, the list was shortened by taking the top ten illnesses that were mentioned more frequently than others. Table 1 shows the most common minor health ailments mentioned by the clients, doctors and CNPs.

**Table 1. List of most common minor health ailments mentioned by clients, doctors and CNPs**

Clients	Doctors	CNPs
Fever	Headache	Colds
Stomach ache	<b>Diarrhea</b>	Respiratory tract infection
<b>Cough</b>	<b>Back pain</b>	Otitis media
Chest pain	Common colds	Minor burns
<b>Rash</b>	<b>Rash</b>	<b>Rash</b>
<b>Back ache</b>	Abdominal pain	<b>Back pain</b>
<b>Discharge</b>	<b>Cough</b>	Sore throat
Sores /Wounds	Arthritis	Impetigo
Pimples	Impetigo	<b>Diarrhoea</b>
<b>Diarrhoea</b>	<b>Penis discharge</b>	<b>Cough</b>

The minor health ailments in bold were mentioned by all three groups or by the client and one of the doctors or CNPs. The results shown in Table 1 demonstrate that clients, doctors and CNPs viewed

a number of common ailments as minor health ailments, for example, cough, rash, back pain and diarrhoea. Discharge was also a common ailment mentioned by both the clients and the doctors as being a minor health ailment.

#### **Knowledge of clients regarding minor health ailments that can be treated at home**

Regarding minor health ailments that can be treated at home, 59% (n=59) of the clients knew some of these, while 41% did not know. Table 2 shows the list of minor health ailments mentioned by the clients that can be treated at home. There were clients who identified more than one ailment that can be managed at home.

**Table 2 List of minor health ailments that can be treated at home mentioned by the clients**

<b>Ailment</b>	<b>Number of clients (n=59)</b>
Headache	39
Stomach ache	28
Fever	15
Coughing	10
Diarrhea	9
High temperature	5
Tuberculosis (TB)	4
Vomiting	3

The clients that responded to this question mentioned more than one ailment that can be treated at home. The top three ailments that the clients mentioned could be treated at home were headache, stomach ache and fever, mentioned by 39, 28 and 15 clients respectively. Of concern is the fact that some clients mentioned TB as an ailment that can be treated at home, even though it needs intense investigation and monitoring of the treatment (see Table 2).

#### **Health facilities utilised by the clients when in need of medical assistance**

Table 3 shows the type of health facilities that the clients would use when in need of medical assistance.

As can be seen from the results, the majority of clients (80%) visit CHCs when they are in need of medical assistance. Only 20% use other health facilities.

**Table 3 Health facilities that clients would use when in need of medical assistance**

<b>Health facilities</b>	<b>Number of clients</b>
CHC in study	69
Other CHCs (not those in study area)	11
Private doctor	11
Hospital	8
Other	1

#### **Perceptions regarding assistance received by the clients from the four CHCs when presenting with minor health ailments**

The clients were asked about the assistance that they received at the CHCs besides medication (pills) when they presented with minor health ailments. A total of 53% felt that they had been assisted at the CHC, while 47% felt that they had not been assisted.

The responses of those who were assisted were:

- They were referred to other departments for further assistance.
- They felt better after they had consulted the health professionals.
- They got advice for their ailments during the consultation.
- They were satisfied with the service received from the health professionals.

The responses of those who felt they were not assisted were:

- They had been waiting long hours to get the service.
- The problem lay with the CNPs, whom they regard as nurses without clinical examination skills.
- The other staff members did not treat them pleasantly when they were at the CHC.
- No medication was prescribed for them.
- They did not know what the problem was.
- The problem lay with them, as they did not follow the instructions given to them by the doctors and clinical nurse practitioners at the CHCs.

**Knowledge of the clients, doctors and CNPs of community-based advisors for the management of minor health ailments**

Only 21% (n=21) of the clients knew of people who could advise them of home remedies for the management of minor health ailments. The types of advisors mentioned are listed in Table 4.

**Table 4: Advisors mentioned by clients, doctors and CNPs for managing MHAs using home remedies**

Clients	Doctors	CNPs
Community health workers	Community health workers	Community health workers
Mother/parents	Grandparents	Grandparents
Faith healers	Faith healers	
Nurses	Professional nurses	
Traditional healers		
Social workers		
Sister		
Friends		
Other people		

The results of table 4 demonstrate that the range in advisors known by the clients, doctors and CNPs include family members, community health workers, health professionals, friends, faith healers and traditional healers. These are the people who are found in the community. There is some overlapping information between the clients, doctors and CNPs regarding people who can assist with the management of minor health ailments, namely, community health workers and parents/grandparents. This does not mean that they consult them even if they know that these people can be consulted within the community.

**Education regarding minor health ailments for the clients and the educators**

When the clients were asked if they received education at the CHC regarding the ailments they presented to the doctors and CNPs, only 38% (n=38) said they received education about their ailments at the CHC, while 62% (n=62) said they did not receive any education about their ailments. Table 5 shows the sources of education for clients regarding minor health ailments.

As can be seen from these results, 25 clients received education about their minor health ailments from the clinical nurse practitioners, 10 received education from the doctors, 1 received education from both the doctor and the clinical

**Table 5 Sources of education regarding minor health ailments received by clients at CHCs**

Educators	n=38
CNP	25
Doctor	10
Doctor and CNP	1
CHC	1
God	1

nurse practitioner, 1 received education from the CHC (it is assumed that they received it from the CHC posters), and 1 claimed to have received education from God.

**The impact of overcrowding at the CHCs on service delivery**

Seven doctors said that they felt frustrated, one felt frustrated and burnt-out and two did not feel any different. The latter two doctors said that there was no difference in their feelings whether the CHC was overcrowded or not. The CNPs expressed feelings ranging from being frustrated and burnt-out to feeling energetic or having no change in feelings when the CHCs were overcrowded and when there was a shortage of staff. Of the five CNPs who participated in the study, two experienced no change in feelings, one felt frustrated, one felt frustrated and lazy, and one felt energetic.

### **Problems arising during consultation due to the impact of overcrowding**

Problems that arose during consultation when the CHCs were overcrowded were as follows:

- Improper examination
- Poor doctor-patient relationship
- Limited time to listen to the patients' problems
- Limited time to educate patients about their conditions
- No time to review records of previous visit.

The main area of concern felt by most doctors and CNPs (n=4 for both) was the limited time available to listen to the patients' problems.

### **Discussion**

Gessler et al. (1995) characterised CHCs as overcrowded environments with long queues, long waiting times, and a brief encounter (often less than five minutes) with the doctor or medical staff, no opportunity to express one's own concerns and being given medicine without any explanation of the effects of the drugs. This description is similar to the situation of overcrowding that prevails in the Khayelitsha and Phillipi CHCs. During the data collection period in 2003 CHCs were still overcrowded with clients who presented with different ailments. Khayelitsha CHCs implemented extending services to clients who are presenting MHA since January 2010. This helped the health professionals to spend more time with their clients presenting with MHA (Personal communication, Sr Sigwela, April 2010)

The health professionals were young newly qualified doctors in their mid-twenties. They had minimal experience of working in environments that are faced with the challenges of clients in this study, the majority of whom were also young, ranging from 18 to 39 years and presenting with MHA. These young doctors are introduced at community level to gain experience in working with clients from the community. The clinical nurse practitioners have experience of working with clients at community level and under stressful conditions. They see more clients than the standard ratio of 1:25. Roden (2006) suggests that health professionals use the health belief model as a tool to assist their clients with health problems since it will focus on health promotion especially for young families. Boneham and Sixsmith (2006) acknowledge the experiences

of elderly women in the management of health problems and they strengthened this by having support networks to help each other.

It was clear when the doctors, CNPs and clients were asked to mention minor health ailments that they had a common understanding of what these could be. It is thus recommended that these three groups of participants need to explore further what minor health ailments are and come up with a list of minor health ailments that would be understood by the health professionals and community at large.

Although the researcher was encouraged by the clients' knowledge of minor health ailments that could be managed at home, there is concern about the fact that some of the clients (n=4) believed that illnesses such as TB could be managed at home. The perception of these clients could arise from the service provided by the community health workers who are trained by health professionals to administer TB medication to the clients in the community. Tuberculosis needs medical attention, including being monitored to ensure that the patients are taking medication regularly and correctly and observations to determine how they are responding to medication.

The impact of overcrowding at the CHCs made the doctors feel that they did not assist the clients to their satisfaction, as they miss out on important procedures such as health education, which is one of the most important aspects of primary health care. They also felt frustrated and burnt-out about doing what was required of them when consulting their clients. The clinical nurse practitioners were satisfied with the assistance that they provided to the clients, even though they were overloaded by clients presenting with minor health ailments. They expressed different reactions to overcrowding in the CHCs, ranging from frustration and burn-out to becoming energetic, the latter being quite surprising in the light of the fact that they were seeing more than the required 25 clients per day.

### **Conclusion**

Minor health ailments in particular are seen as contributing to the overcrowding at CHCs. Different perceptions exist regarding how minor health ailments should be managed. The health professionals felt that the assistance that they were

providing to the clients was not up to standard due to overcrowding and very little time spent during consultation. On the other hand, a group of clients was happy with the type of assistance offered at the CHCs. However, some clients were concerned because they were not being educated about their minor health ailments, which disempowered them in terms of strategies that they could utilise to manage minor health ailments.

As identified by the clients and health care professionals, there are people in the community that could assist with the management of minor health ailments, such as family members, community health workers and faith healers. Elderly people in the home and community health workers in the community were identified by the clients, doctors and clinical nurse practitioners as resources that could assist with the management of MHA. The recommendations are: It is recommended in future, that the three groups of the study participants could come together and decide on which ailments should be regarded as minor ailments, and then formulate a strategy for managing these ailments at home. These discussions should be underpinned by education regarding the treatment of MHA, as the study brought to light that this aspect is grossly lacking. It is the researcher's opinion that we will be starting to practice primary health care at its fullest once this level is reached.

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