

Health in Site B

A Community Needs Assessment

About This Study

The following study is a base-level exploration of conceptions of health, community health status, perspectives on public health care, health education, and preventative health care in Khayelitsha's Site B.

What: A 10-week study conducted by undergraduates of Stanford University

When: January-March 2006

Where: Khayelitsha Township, Cape Town, SA

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This report is dedicated to our community guides:
Christina, Thembeke and Veronica. Thank you.

An electronic version of this report is available online at <http://humbio148x.stanford.edu>.

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I. EXECUTIVE SUMMARY

Introduction

This report is the result of a 10-week study conducted by seven Stanford student researchers in the Site B area of Khayelitsha. The study was conducted on the behest of the University of Cape Town Primary Health Care Directorate, UCT Department of Public Health and Family Medicine, UCT Faculty of Health Sciences and Stanford University. This report is based on a synthesis and analysis of responses from community members and health service workers from Site B and is intended to advise future service work conducted in the area, and also to help primary care facilities have a better understanding of community issues—ultimately improving their ability to provide health services.

Methods

Data for this report was gathered primarily through direct interaction with community members in the form of interviews and focus groups. Previous published material and various clinical statistics were also gathered. Our efforts focused on conducting door-to-door semi-structured interviews, waiting room interviews, focus groups, and interviews with various hospital and NGO staff operating in Khayelitsha. Questions for interviews fell under the five following categories:

- 1) Conceptions of health
- 2) Identified community health concerns
- 3) Community use and perception of primary care health facilities in Site B
- 4) Access to Health Information
- 5) Preventative Health Care

Results

Conceptions of Health:

- Community members identified personal behavior such as exercising, external support mechanisms such as hospital care, and community concerns such as environment and neighborhood cleanliness as being important contributors to community health

Health Status:

- Community members identified (in order of importance) HIV, TB, High Blood Pressure, Diabetes, Diarrhea, and Asthma as the major health concerns facing community members of Site B.
- Several specific causes were cited as influencing the incidence of these various health concerns. Problems stemming from unemployment, poverty, and environmental conditions were identified as important general concerns that negatively impact the health status of community members.

Perceptions of the Clinic:

- The Site B Day Hospital was identified as the most important provider of primary health care for residents of Site B.

- Complaints concerning the Site B Day Hospital centered on the following themes (in order of relative frequency):
 - Long waiting times
 - Nurse and staff behavior and attitude towards patients
 - Medications not in stock at hospital pharmacy
 - Understaffing
 - Staff Efficiency
 - Overcrowding
 - Triage effectiveness
 - Lost patient folders

Health Information:

- The Site B Day Hospital was noted as the most common source of health information in Site B
 - A strong desire for increased health information at the hospital was noted, with hospital health educators noting that much of their time is spent translating for doctors, with less time being spent educating community members
- Community Health Workers were noted as an especially valuable source of health information, while many respondents cited a shortage of such workers and expressed a desire for a stronger presence in the community from this group.
- Schools and radio programming was also cited as good sources of health information.

Preventive Health:

- The most common methods for prevention cited by community members included clean living spaces, personal hygiene, clinic care, and nutrition.

Discussion

Analysis of our results yields the following conclusions, and identifies several key areas for future research:

- There appears to be a greater need for diabetes education, along with pre-sickness education to aid in prevention
- Translation in the hospital is an especially important issue, as health educators are being forced to translate for doctors, leading to decreased health education.
- Service delivery and efficiency at the Site B Day Hospital can be improved. A more comprehensive analysis of past efforts is needed to guide effective solutions for the future.
- There is a strong correlation between nutrition and unemployment, as people are unable to buy healthy foods.
- There were a large group of respondents who identified exercise as a key component of health, but did not regularly exercise themselves.

Limitations

This study acknowledges several limitations. These include a limited amount of time spent in the community, lack of completely randomized interview sampling, and language barriers.

Recommendations

Recommendations gathered from community members, hospital and NGO staff, and this study's researchers include the following:

- Improve dialogue between the Site B Day hospital and community members
- Conduct morning staff meetings at the Site B Day Hospital to improve hospital efficiency and communication.
- Recruit community volunteers as administrative assistants and interpreters.

II. INTRODUCTION

The following report was compiled by a group of seven Stanford undergraduates working in Site B, Khayelitsha, with the UCT Faculty of Health Sciences to produce a community health needs assessment. This report is intended to aid active community members, future community health volunteers, UCT med students, and current existing primary care facilities in improving the delivery of health services to residents of Site B. This report focuses on community conceptions of health, perceptions of service delivery at the Site B Day Hospital, health education resources, and preventative health care.

Our official partner was the UCT Faculty of Health Sciences. We also worked closely the Site B Day Hospital, City of Cape Town Community Development Workers (Khayelitsha District), and various community health workers.

Prior to beginning our study, we did not identify any previous works that could serve as a foundation for our research. This research evolved through participatory interactions with community members and hospital personnel. The direction of the study is based on identified needs within the community. We hope that this information will help to stimulate a dialogue between service providers and the community members, and to ultimately improve communication and service delivery.

III. DESCRIPTION OF THE COMMUNITY IN FOCUS

History of Khayelitsha and Site B

Khayelitsha was born from a political struggle. After the Group Areas Act of 1950 that restricted individuals to residences based on race, it was illegal for Blacks to live in the city of Cape Town. However, because many Blacks were employed within the city bounds, geographic proximity was essential. Communities of informal settlements were erected around the city's periphery; whole neighborhoods of shacks were erected in areas such as Old Crossroads. These living areas were considered illegal, though, and in the 1970s and early 1980s the apartheid government conspired to relocate all those Africans who were residing in the illegal settlements in Cape Town. To better manage and repress the population, they aimed to contain all urban Blacks in one area.

In 1983 Khayelitsha, or the "new home," was conceived. Khayelitsha was established as an area for all Black families living in the illegal settlements for more than 10 years. Many Blacks did not want to move from their original settlements; they fought and protested against the move.

In response, the apartheid government created political divisions within the township government of Crossroads. Government officials exacerbated and exploited the political rivalry between Johnson Ngxobongwana, elected Chairman of Crossroads in 1979, and his vice chairman Oliver Memani—resulting in political violence from April 1983. Unsettled by the unrest that resulted from this political battle, many Blacks fled to Khayelitsha despite earlier objections.

The government also coerced Blacks to move by promising better housing and services. They built several thousand brick homes to accommodate the initial migrants, but the number of houses was miniscule compared to the 450,000 who would move to Khayelitsha by 1990. Instead, most would live in informal settlements. The promise of new services was dwarfed by rapid population growth. Throughout the 1990s thousands of Blacks migrated from rural areas in the Eastern Cape in order to find jobs, and many settled in Khayelitsha. Sites C and B were the first areas occupied and have thus remained the most overcrowded parts of Khayelitsha.

Demographics and Resources of Khayelitsha and Site B

The most recent South African census, conducted in 2003, placed Khayelitsha's population at 405,000. However, community members suggest that the population grows daily, and population estimations range from 750,000 to over 1,000,000. Currently there are 35 primary schools, 17 high schools, and 3 police stations in Khayelitsha. Several community members have estimated unemployment rates as high as 60 percent, however we do not know if this is measuring formal or informal unemployment. There are 8 clinics providing primary care in Khayelitsha. An additional clinic is being planned for the near future. The Site B Day Hospital is the only primary care facility in Khayelitsha offering 24-hour emergency care. According to the Isilimela Project's 1999 report on

Khayelitsha, the Site B Day Hospital serviced 113,725 people from 1998 to 1999. Internal review statistics for the Site B Day Hospital presented to the Municipal and Provincial Departments of Health indicate that in 2003 the Site B Day Hospital saw 118,393 patients. The same source indicates that in 2004 this number rose to 199,263 patients.¹

Boundaries of Site B

Site B is located in the northern portion of Khayelitsha south of the N2. It is divided into two parts, North and West. Most of our study focused on Site B West near Bonga Drive, which is in the direct vicinity of the Day Hospital. There are 8 primary schools and two secondary schools in Site B, along with one day hospital and one police station.

Health Indicators in Khayelitsha

According to the Cape Town Department of Health's health indicators², there were 3,701 new sexually transmitted infection (STI) cases reported at the Site B Day Hospital in 2005. The same source indicates that the Site B Youth Center, affiliated with the Day Hospital, saw 7,458 new STI cases. In 2005, the Department of Health also indicates that the STI incidence for all of Khayelitsha was nearly 10%. The Department of Health reports that the tuberculosis (TB) incidence for all of Khayelitsha was 4,223, with a cure rate of 69.6% in 2005. The mortality rate with respect to HIV/AIDS is 102 per 100,000 compared to a 53.6 per 100,000 Cape Town average.

There were 2260 births at Site B Clinic in 2004. In the same year for the greater Khayelitsha area 6.13% of births were teenage births compared to 5.17% as the Cape Town average. The infant mortality rate in Khayelitsha as of 2004 is the largest of all Cape Town sub-districts standing at 36.62 per 1000 compared to the Cape Town average of 23.8 per 1000. Diarrhea and Gastro-Enteritis has surpassed HIV/AIDS as the number one killer of children under 5, claiming the lives of 60 children in 2004 (Department of Health 2004).

¹ We acknowledge that there is a huge increase in the number of patients seen by the Site B Day Hospital between 2003 and 2004. However, due to time constraints, we are not able to confirm these statistics.

² Complete statistics from the City of Cape Town Department of Health can be found in Appendix B.

IV. PURPOSE OF THE ASSESSMENT

Our assessment aimed to use a community-based participatory research model in order to ascertain the community's definition of health, to learn about perceptions of the Site B Day Hospital, and to identify education and prevention resources. In carrying out our investigation, we spoke with community members, hospital staff, and various NGOs in Site B.

We posed the following questions:

- What are the community's conceptions of health?
- What is the community's perception of the status of health in Site B?
- What health resources does the community identify, and how effective are those resources?
- Where does the community go for health information, and what information does it receive?
- What preventative health measures does the community take?

We sought an understanding of the community definition of health in order to establish the context in which we framed our more specific health-related questions. Establishing the community's perception of its health status is critical in shaping its collective ability to more effectively and appropriately address health needs and challenges.

We intend for this research to be used in improving health conditions and expanding resources in Site B. Identifying resources and their perceived effectiveness is an important prerequisite to progress. Because of the overwhelming focus on primary care in the community, we also chose to examine existing preventative practices—identifying concerns and resources that may have been overlooked in the preliminary stage of our study. Questions regarding health information were also integral to our exploration of preventative care—health problems cannot be prevented without a comprehensive understanding of them.

V. ASSESSMENT PLAN

Our study included four main data collection methods. A basic description of each collection method, accompanied by the rationale for our selection of the method, follows:

(1) *Semi-structured interviews with key informants from hospital and non-governmental organization (NGO) staff*: We conducted a total of **58** interviews with representatives from **9** community organizations. Teams of one to four interviewers conducted these interviews, with a translator when needed.

This method was particularly useful in the first weeks of our study. Initial interviews with hospital staff helped to paint a general picture of the health services provided at the facility and in the community more generally. These first interviews also provided us with a basis for questions posed to community members regarding their perceptions of these services. Starting our inquiry at the hospital caused a slight bias in the kinds of questions that we asked thereafter, but this bias was outweighed by the amount of information procured.

We continued interviews with informants from hospital and NGO staff throughout the duration of our study, and as weeks progressed the specificity of these interviews increased. Follow-up interviews with key informants were frequent.

(2) *Door-to-door interviews*: We interviewed residents of Site B, living in both informal and formal housing. **22** community members were interviewed in their homes between the hours of 9am and 12pm, by teams of two interviewers with one translator present. Our translators selected the interviewees prior to the date of the interview. Interviews were conducted with a semi-structured list of questions [See APPENDIX A]. Questions focused on conceptions of health, health status, perceptions of the clinic, health education, and preventative health care.

This method was selected because it allowed direct access to community members. Because interviews were conducted in the homes of the community members, the comfort level of the informant started much higher and interviews could be conducted for longer periods of time with fewer environment-based distractions.

We sought geographic diversity in our sample of interviewees, speaking with residents of both sides of Site B, however the sample was compromised by our inability to assemble it ourselves. It was not a random or representative sample, but the information obtained remains useful and informative.

(3) *Waiting-Room Interviews*: We interviewed patients of Site B Day Hospital and Clinic in facility waiting rooms while they were waiting to receive service. These interviews were conducted in the waiting rooms for folder distribution, pediatric care, and TB/HIV care. A total of 17 waiting-room interviews were conducted. The same interview protocol was used as for door-to-door interviews was used [See APPENDIX A].

Interviewees were selected according to convenience: we interviewed those with sufficient room on the bench next to them for interviewers and translator. The interview protocol was frequently interrupted due to the chaotic environment of the waiting room, and interviewees often had to end the interview before reaching the end of the protocol.

Despite the limitations to the efficiency of this method, essential perspectives were gained and interviewers gained a better understanding of the experience of seeking care in Site B Day Hospital.

(4) *Focus Groups*: A total of five focus groups were conducted—two with mothers, one with men, one with NGO community health workers focusing on child nutrition, and one with youth. Each group had between six and ten participants, and the conversation was based off of the same interview protocol used in door-to-door and waiting room interviews, with additional questions added with pertinent to the focus group demographic [e.g. health workers were asked additional questions about community perceptions of nutrition and challenges in conducting their duties, etc.]

Focus groups were an essential complement to one-on-one interviews. Although full participation of each community member present was not guaranteed, interaction and natural community-based probing and follow-up on subjects of interview yielded deeper insights. Interviewees rather than interviewers dictated the focus and response.

Focus groups were neither representative nor random. Our translators invited community members to attend prior to the date of the focus group.

SUMMARY OF METHODS

Total number of informants:	58
Semi-structured interviews with staff:	10
Door-to-door interviews:	22
Waiting-room interviews:	17
Focus group attendees:	35

VI. RESULTS

Our results are grouped into five major subject areas: conceptions of health, community health status, community perceptions of Site B Day Hospital and Clinic, sources of information about health, and approaches to preventative care.

A. CONCEPTIONS OF HEALTH:

What does “health” mean in Khayelitsha’s Site B?

Prior to embarking on a detailed assessment of health services, education, and prevention, it was important to gain an understanding of the community perceptions of a more basic idea—health. Before asking questions about health services, health challenges, health education, etc., we sought to understand what community members associated with the word that was the baseline for all of our subsequent questions. We wanted to safeguard against an easily prevented miscommunication that could have affected the rest of our data set. Is health something you do? Something you have? Or something that is done to you? Our questions and the following analysis fall into three areas:

1. How “health” makes community members feel
2. Where good health starts, in terms of:
 - Personal behavior
 - External support, and
 - Community and environment.
3. What community members do to keep healthy, including:
 - Personal behavior
 - External support, and
 - Resources and environment.

Health was frequently defined as the mere absence of illness. When asked to describe a healthy person, seven out of 22 informants included some variation of a “lack of sickness” in their description. Other respondents explored the notion of health in terms of feeling, causes of good health, and actions that affect health.

1. How does being “healthy” make community members feel?

Some responses in interviews and focus groups focused on a personal definition of health as a set of feelings. The following are a few examples of this type of response:

Looking healthy
 Energetic
 Something inside of you
 Happy
 Everything is good

These responses indicate that being healthy can include physical appearance, physical and emotional feelings, and a more general sense of satisfaction. Good health can also make a person feel “happy.” One interviewee said, “A healthy person is made of a 50% contribution of happiness, and then the other 50% is from food and pills and such. If you

are happy, then the other 50% comes.” According to this individual, mental and physical health are interdependent.

2. What do community members think affects health? Where does good health start?

Responses indicated that community members attribute their health status to personal behavior, actively sought external support, and uncontrolled community and environmental factors.

In terms of **personal behavior**, one respondent pointed out that there is “health that we can do at home without going to the clinic.” This comment indicates that for some residents, individuals have agency in determining their health, and actions in the home can have an impact on health status—before a patient goes to the clinic.

Respondents also mentioned diet, exercise, employment, and lifestyle as personal behaviors that impact health status:

Figure 1. Personal Behaviors as Contributors to Health

PERSONAL BEHAVIOR	FREQUENCY (OUT OF 22 RESPONSES)	KEY COMMENTS
Diet	12	“It means you eat healthy balanced food.”
Exercise	5	“Must wake up in the morning, exercise, and have a balanced diet.” “Exercise and get check-ups.”
Work (Employment)	1	
Look after yourself	1	
Changing lifestyle	2	

Responses relating to **external support** as a control of health emphasized the need to consult medical professionals and adhere to their recommendations:

Figure 2. External Support as Contributor to Health

EXTERNAL SUPPORT	FREQUENCY (OUT OF 22 RESPONSES)	KEY COMMENTS
Visit doctor	3	“You must eat green food, and visit a doctor for check ups.” “Health is from day hospitals.”
Take medication	1	

A third category of responses explored health as something that cannot be controlled, rather something that is determined by community and environmental factors. These responses indicate that health is in part controlled by external dynamics:

Figure 3. External Factors as Contributors to Health

EXTERNAL FACTOR	FREQUENCY (OUT OF 22 RESPONSES)	KEY COMMENTS
Hygiene, sanitation, cleanliness	6	“It means you must be clean. The

		place where you stay must be nice and neat.”
Feeling in the community	2	“Health is the way you live; it is the way you feel in the community.”

Outside of these three lenses, one key informant—a male employee of multiple NGOs—gave a more holistic view of health. He said, “It is a very big word. In school, I thought it was concerning you as an individual. But it’s concerning more: concerning the community, the way we speak, the way we present ourselves. It defines someone’s condition. Health is total well-being for the individual and for the community at large.”

3. What keeps Site B residents healthy and prevents sickness?

When discussing their ability to maintain good health and prevent illness, community informants discussed three types of factors: personal behavior, external support, and resources/environment.

Personal behaviors were thought of in two ways: characteristics of a healthy individual (see discussion above), but also actions that can be taken to maintain or improve health status. In this sense, a personal behavior can be a form of preventative health care. Diet and exercise, while also discussed in the context of defining health, were mentioned with more frequency within the context of staying healthy or preventing illness. Hygiene and nutritional supplements were also mentioned as individual actions in the context of prevention:

Figure 4. Personal Behaviors as Prevention

PERSONAL BEHAVIOR	FREQUENCY (OUT OF 31 RESPONSES)	KEY COMMENTS
Diet (“good nutrition”)	26 (18)	“I eat the right foods that are energy-givers. The fruits and veggies are body builders.” “Eat healthy foods like carrots, cabbage, and vegetables. Keep balanced food to build the body.”
Hygiene, cleanliness (Hand-washing) (Clean Home)	19 (9) (11)	“It is important to clean your house, to clean the toilets. Before and after you eat, you must wash your hands.” “Our health is affected by the way we live with the dirty water, the dirty places where we live.”
Exercise	2	“Physical fitness and diet. You need to do exercise. But there are no facilities for exercise and money limits access.”
Supplements	1	
No Stress	1	[Unclear whether informant viewed stress as a controlled or uncontrolled factor.]

Some community members associated the maintenance of good health and the prevention of sickness with their behaviors in accessing external support:

Figure 5. External Support as Prevention

EXTERNAL SUPPORT	FREQUENCY (OUT OF 31 RESPONSES)	KEY COMMENTS
Visit clinic/checkup	9	“Go to the clinic and get medicine when you need it.” “Make sure when someone is sick you go to the clinic and stay at the house with them.” “Just go to the clinic to get treatment.”
Tablets/medicine	2	
Injections/immunizations	2	
Visit dentist	1	

Environmental factors and access to resources were a third component to health maintenance:

Figure 6. Resources and Environment as Prevention

RESOURCE/ENVIRONMENT	FREQUENCY (OUT OF 31 RESPONSES)	KEY COMMENTS
Money	5	“You can’t get veggies if you’re not working.” “You must have money to buy good food: cabbage, spinach, potatoes. You can’t be healthy if you don’t have money.”
Education	3	“I buy healthy food and do education for my family.”
Clean water	1	
Clean environment	2	
No stress	1	[Unclear whether informant viewed stress as a controlled or uncontrolled factor.]

It is important to note that requisite resources were named equally frequently as external support, where money as a means of staying healthy was named five times and education was named twice.

In order to better understand what elements of health are most openly dwelled upon in daily life, we also asked community members whether they discussed health with their neighbors or family members, and what subjects those discussions focus on. Specific topics in **discussions of health** vary, but from most to least frequent they are:

Figure 7. Health in Conversation

SUBJECT	FREQUENCY (OUT OF 15 RESPONSES)	KEY COMMENTS
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Cleanliness	8	“I talk to my family. I tell them to be clean and to keep everything here clean.” “Hand-washing, clean dishes, protecting from flies, sweeping floors and outside the house.”
Diet	6	“I have conversations at home primarily about diet and which food to select.” “Discuss vegetables, health food, balanced diet.”
HIV	4	“There is HIV, TB. We just talk about that.”
TB	3	
Prevention	3	“We talk about prevention and HIV/AIDS.”
Safe sex/protection	2	“We discuss safe sex, HIV and safety.”
Medicine	1	
ANC	1	“I tell the community that the ANC is the only party that will bring health to the community.”
Exercise	1	
Safety	1	
Gardening	1	

Topics discussed clearly varied, but diet and cleanliness were again the most frequent responses, identified eight and six times respectively. One community member discussed her efforts to educate her neighbors about vegetables, healthy foods and balanced diets. She discussed casual gardening training that she provides in her neighborhood, but expressed concern about the lack of arable land in the area. Following diet and cleanliness, HIV, TB, and protection against STIs were the next most frequent topics of conversation.

Our final inquiry relating to conceptions of health was simple: why do people get sick? Again, responses were divided between controlled personal behaviors and uncontrolled external factors—environment, the behaviors of others, and access to resources.

Figure 8. External Factors Causing Illness

EXTERNAL FACTOR	FREQUENCY (OUT OF 20 RESPONSES)	KEY COMMENTS
Overcrowding	9	“We live so close to everyone. So close.” “Houses are small and overcrowded.” “It’s overcrowded and the houses are very small.”
Toilets/drains	8	“People get sick because of the way we’re living. Toilets and drains are in front of us.” “There are no toilets. Many

		people use the bucket system and drop waste in drains or leave it outside the house for days.”
“Dirty,” unclean environment	9	“Most places are dirty and others also complain of sanitation.” “They are very dirty.”
Trash	2	
Cold/weather	2	“Congestion of houses, cold houses. People get wet when it rains because houses flood, leak, then mold.” “At Cape Town it is always wet.” “The wetness of Cape Town causes TB and other sicknesses.”
Smell	2	“There is a smelling that comes in our houses. We can clean our houses, but the smelling is still there.”
Unclean water	2	
Pollution	1	“Asthma comes from bad air and living conditions.”
Neighbors	1	“If you clean and your neighbor doesn’t, you still get sick.”
Other children	1	

These resource challenges, ultimately leading to illness, are heavily inter-related: unemployment causes lack of food; unemployment and lack of food are both indicators of poverty. It is useful, though, to note that community members most frequently identified unemployment as the overriding resource challenge, and the cause of subsequent challenges.

Figure 9. Resource Challenges Causing Illness

RESOURCE CHALLENGE	FREQUENCY (OUT OF 20 RESPONSES)	KEY COMMENTS
Unemployment	6	“Unemployment leads to lack of food and poor nutrition.” “People are not working, so they have no good food and live in informal settlements.”
Lack of food	4	“HIV is caused by unemployment, lack of food, and an unhealthy lifestyle.”
Poverty	2	“Poverty and malnutrition lead to lower immune systems.”

Figure 10. Personal Behaviors Causing Illness

PERSONAL BEHAVIORS	FREQUENCY (OUT OF 20 RESPONSES)	KEY COMMENTS
Alcohol	3	“Some of them are drinkers without eating before.”
Unclean houses/shacks	2	“The people are living in shacks and they are very unclean. They do not practice good hygiene and

		it is very dirty.”
Too many relationships (multiple partners)	2	“People sleep around.”
Unhealthy food	2	“Because they don’t eat healthy food; they drink.” “People don’t eat healthy food.”
Unhealthy lifestyle	2	
Children don’t cover themselves	1	
Smoking	1	
Stress	1	

General dirtiness (as a result of personal behavior), mentioned seven times, was the most commonly cited environmental factor causing sickness. More specific issues—smell, trash, unclean water, unclean environment and pollution—were also named. Others expressed views that people get sick because of the behaviors of others—neighbors and other children. A final group of community members blamed peoples’ illnesses on their personal behaviors including alcohol use, unclean houses/shacks, too many relationships, poor covering, unhealthy food, unhealthy lifestyle, smoking and stress. There is no general consensus on what causes illness, but environmental factors were mentioned most frequently, followed by resource challenges, and finally personal behaviors.

B. HEALTH STATUS:

What is the health status of Khayelitsha residents?

In order to understand the health status of Site B residents in their own eyes, in focus groups, door-to-door interviews, and waiting-room interviews, we asked, “What is the biggest health problem in Site B?” The way the question was framed or asked varied from interview to interview in an attempt to communicate most effectively with the given participant. Our results from door-to-doors and waiting rooms were more reliable than results from the focus groups because they had included responses to different ways of asking the question. That so many answers were so similar gives us more confidence that our question was effectively communicated. The results from door-to-doors and waiting rooms will be discussed below.

We tallied responses by subject. Community informants gave multiple answers, and all of their answers were tallied. Their challenges, in their own words, follow. Challenges are listed by frequency, and then alphabetically:

“What are the biggest health problems in Site B?”

Responses from Door-to-door and Waiting-room Interviews

PROBLEM	FREQUENCY
HIV/AIDS	17
TB	14
Diarrhea	6
Asthma	5
Diabetes	5
Dirty/poor sanitation	5
High blood	4
Informal settlements	3

No toilets	3
Poverty	3
Unemployment	3
Arthritis	2
Lack of clean water	2
Rash	2
Cancer	1
Child illness	1
Child vomiting	1
Clogged drains	1
Crime	1
Electricity	1
Flies	1
Infections	1
Lack of food	1
Overcrowding	1
People don't know status	1
Rape	1
Stitches after stabbing	1
Standing water after rain	1
Teen pregnancy	1
Too many children	1

It is useful to more deeply assess the responses articulating the most-frequently mentioned subjects: HIV, TB, diarrhea, diabetes, asthma, high blood, and dirtiness.

With 17 mentions, HIV was the most frequently cited health challenge in Site B. Of these, many respondents described HIV as a challenge specific to young people. Many indicated a wider community sentiment that HIV is caused by unsafe sex, and sex with multiple partners. Some respondents also stated that lack of nutrition is related to HIV and can cause increased susceptibility to the virus. Community members also pointed to insufficient knowledge regarding HIV in their neighborhoods; both a lack of education and a tendency to ignore education were discussed. Some described a general community reluctance to learn one's HIV status, with a greater unwillingness among men. Although the gender gap in willingness to test is influenced by common MTCT testing for mothers, this gap has resulted in a general perception that men are spreaders of the disease. Sources that work on the issue of community health report that HIV stigma still exists. A few youth sources reported that other youth are no longer scared of HIV; because they can easily obtain and "be healthy" on ARVs, there is reduced incentive for them to practice safe sex. One source even indicated that youth may intentionally try to contract the disease to get grants from the government. The prevalence of this practice is unknown, but regardless it indicates a need for improved/altered education in the community.

TB was the second-most frequently identified health challenge for the community (mentioned 14 times). Residents identified several factors that they believe to be

responsible for contraction of TB. To those interviewed, the most important factor was environmental: TB as a result of living conditions like over-crowdedness and uncleanliness. Smoking, alcohol, and lack of nutrition were also named as contributing factors. TB is clearly understood to be contagious, and its natural contagion is exacerbated by small house size and crowded living conditions. Opinions of TB stigma were contradictory: some described a stigma due to its correlation with HIV/AIDS, but others described an increased awareness about the disease.

Although diabetes was mentioned with greater frequency, diabetes and high blood are seen as related, and both are associated with old age. Respondents also perceived them as problems affecting women more than men. A link is perceived between diet and both diabetes and high blood. Some respondents attributed dietary problems to “cultural practices.” In general, though, there seems to be a lack of education about the specific cause of diabetes. A mental correlation between current behavior and future disease status was not indicated.

Respondents also discussed diarrhea and dirtiness/poor sanitation as closely related health challenges. Interviewees attributed problems with diarrhea to a lack of education about hygiene. Asthma was also perceived as related to environmental factors—specifically the living conditions that are beyond the control of individual Site B residents. For example, air quality was often identified as a contributor to asthma. Factors identified as negatively impacting air quality include burning trash, paraffin flame stoves, over-crowdedness, and dampness of homes.

Throughout the comments of our community informants, problems and causes seem intertwined. Their words indicate significant interchangeability between disease status and environmental conditions, but ultimately both are seen as health concerns. The community’s conception of health seems to automatically take behavior, resource challenges, and environmental factors into consideration.

A discussion of the causes of these challenges was an unsolicited undercurrent in responder’s comments. Unemployment and poverty were frequently identified as the base-level causes of general community health challenges. The financial difficulty inherent to unemployment was described as often causing an inability to purchase nutritional foods and obtain medications. Environmental factors, symptoms of poverty—including problems with toilets, trash, drains, and over-crowdedness—were also described as base causes of shared health challenges.

C. HEALTH SERVICES:

How do community members perceive Site B Day Hospital and Clinic, and other sources for health-care in Site B?

Of those interviewed, the vast majority (51 respondents total) go to the day hospital for health care. Eight (some of whom also use the services of the day hospital) visit private doctors. Four (again with some overlap) also use the services of other Cape Town area public clinics. Respondents go to the following outlets for care:

LOCATION	FREQUENCY
Site B Day Hospital	51
Private doctor	8
Traditional healer (additional)	5
Greenpoint	2
Michael Maphongwana	1
Hospital in Cape Town	1

With only a few exceptions, all of those who are listed as receiving healthcare from locations other than Site B hospital also seek care at the hospital. Many who seek care from private doctors attend the day hospital for general care, and visit the private doctor for more serious conditions—when “very sick.” Some perceive the price demanded by the private doctor as an indicator of the superiority of his care. One respondent said, “The private doctor is better because it costs money.” Other respondents systematically divide where they go for care according to the type of care sought. For example, when one patient can’t get her tablets or pain injections from the day hospital, she goes to the private doctor instead. Another patient seeks care for herself at the day hospital while relying on a private doctor for the care of her children. Despite some grievances with the care they receive, most community members choose to seek care from the day hospital because it is located within Site B and it is free.

Our assessment of Site B Day Hospital and Clinic is based on discussions with both community members, hospital staff, and staff of organizations that deal regularly with the hospital. All of these parties identified similar concerns with hospital inefficiency and service delivery. Community members dwelled heavily on complaints regarding patient care, but both community members and hospital staff expressed a desire for improved communication with one another in order to cooperatively address perceived problems and complaints about service delivery. It is important to note that for this portion of our study, we documented only the comments of those with direct experience with the day hospital.

The most common complaints received were length of waiting time and crowded conditions. Many respondents also emphasized their disappointment with the quality of interactions between hospital staff and patients, specifically noting a lack of empathy and inefficiency of the hospital staff. Patients also indicated frustration about the sometimes limited stock of medications in the hospital pharmacy (especially cough syrup); multiple respondents described having to go to the local chemist and pay for medications because they were not in stock. See below a summary of complaints made by community members regarding the day hospital. Extensive comments are included because this is the most actionable data of our project:

Figure 11. Complaints Regarding Health Service Delivery

COMPLAINT	FREQ.	KEY COMMENTS
Long wait	25	“Because I bring my own chair, I can go at 9am and wait in a long queue until 4pm.”

		<p>“The service is not good. Sometimes we go at half past seven and stay there till 5.”</p>
Nurse/staff behavior	25	<p>“When they are talking they are rough with patients.”</p> <p>“They need more qualified nurses. They need more active, concerned nurses.”</p> <p>“I don’t like it. They don’t care about people. My mother came here and they didn’t help her. She died.”</p> <p>“People there don’t care about clients. Even the receptionist—they don’t even take care of people. One time I take my baby there, the receptionist said the two names for the baby are too long and she cannot write them both. I am not satisfied with the way I was treated.”</p> <p>“It is hard when you are sick, you are weak, you are hungry, and you get an attitude from the staff.”</p>
Pharmaceutical service; Medications not in stock	16	<p>“There are limited drugs at the pharmacy. They limit the drugs that doctors can potentially prescribe. The pharmacy is even sometimes short of stock on those medications that are ‘available.’”</p> <p>“Sometimes I have to com back without medication because they run out. Sometimes I just go to buy the pump from the chemist instead of going to the clinic and it is a problem because the chemist is expensive.”</p> <p>“There is no cough medicine. You have to do the cough mixture yourself.”</p> <p>“They don’t give us our medicines, only tablets. They don’t give coughing medicines.”</p> <p>“In the afternoon they tell people there is no medicine, and you have to go home with no medicine.”</p> <p>“Many nurses and pharmacists will tell patients to buy their prescribed medications at the local pharmacy, and pay with a child support grant. Men think this grant should be used for food, and medical care (including medicine) should be free.”</p> <p>“Sometimes they give you the wrong medicine. I have heard of several times when this happened. Even me, I’m asthmatic and they give me totally unrelated medicine.”</p>
Understaffing	15	<p>“There is sometimes a shortage of nurses and doctors... There is no discipline.”</p> <p>“When you come, they say there is only one doctor.”</p> <p>“There’s a big difference now; last year there was a shortage of staff. But it’s still hard.”</p> <p>“There is only one staff person that runs the X-ray. I have to wait, and sometimes I have to come back another day.”</p>
Staff efficiency	13	<p>“They start work at 8:30, but arrive at 7. They have tea, prayer, and watch TV and don’t seem urgent at all about their position. All staff go to tea at once, and the care stops.”</p> <p>“What makes people to get fed up with the clinic is when the nurses are not there. They don’t help people as they come. They take their own time.”</p>

		<p>“They are lazy those people who are checking folders, they are talking always.”</p> <p>“Sometimes a gap between staff shifts increases the time we have to wait.”</p> <p>“Sometimes nurses take a two hour lunch break. Even the head nurse knows about this problem, but it doesn’t change.”</p>
Overcrowded	9	<p>“The chemist usually get very full.”</p> <p>“The hospital is OK, only the over-crowdedness.”</p> <p>“It is small. It is supposed to be bigger.”</p>
Triage	8	<p>“When you visit the day hospital with a very sick patient they don’t care about that. The person is very sick, she will die on that chair.”</p> <p>“The triage system for adults is very bad. One man was stabbed and couldn’t walk. He was taken to the day hospital by the police, but they wouldn’t admit him until he walked to the window to get his folder.”</p> <p>“If children are vomiting they try to go to room 12 and then they are told to go to reception to get their folders, when they have no folder then they go and die at home.”</p> <p>“Patients are turned away even if their condition is urgent.”</p>
Lost folders	8	<p>“I did not get my treatment for high blood last month because my folder is lost.”</p> <p>“Computers should be used so that folders aren’t lost.”</p> <p>“There are a lot of missing folders.”</p> <p>“My folder was lost, but I wrote to Mr. August and they found my folder and now I have care.”</p> <p>“Sometimes you wait the whole day without being told that your folder is lost.”</p>
Wait in morning	7	<p>“Patients must wait for five hours. Sometimes I come at 2 or 3am so that I can see the doctor in the morning.”</p> <p>“Some go very early to the day hospital. Others have been attacked by gangsters.”</p>
Weekend service	4	<p>“During the weekend it is bad. People are stabbed and shot. I do not go to clinic from Friday to Sunday.”</p> <p>“Weekend care is much worse. Non-critical cases aren’t seen, and general care is very bad.”</p>
Accessibility/transport	3	<p>“The problem is now that I can’t get to the day hospital, and I can’t get my pills. I haven’t taken them for two months.”</p> <p>“We lack transport. There is a lack of ambulances and they take a very long time to come.”</p> <p>“There should be transport from home to hospital to other hospitals. They need to have quick response for emergencies.”</p>
Lack of specialists	2	<p>“The hospital needs specialists on site. Most needed are dermatology, neurology, and general practice physicians.”</p> <p>“There is a major need for specialists.”</p>
Hospital resources	1	<p>“There is a lack of money in facilities. The lack of</p>

		equipment leads to limited procedures that can be performed.”
No outlet for feedback	1	“Quality control at the clinic is an issue. They need performance reviews. Since the staff have so much to do, they are not sure just how good or bad the hospital is doing.”
Nutrition	1	“Food isn’t provided with the medications. For many of the serious medications like ARVs and antibiotics, you are supposed to take them with food, but I didn’t have any food and I have to skip my pills some days so I don’t get really sick from the medication.”

It is important to note that 17 respondents stated that in the end, there was no problem with the care they received at the day hospital. One praised, “The clinic is clean. The doctors say the right things and they make you better.” Another stated simply, “It is good.” Also, a few respondents coupled their complaints with recommendations for improvement. Interestingly, several male patients suggested that transitioning to a mixed race staff would lead to more competition between the staff; such a staff would have less to talk about and less excuse to delay their duties. The care, this respondent asserts, would improve greatly.

Staff perspectives regarding the above complaints varied.

In order to allow an unbiased direction to staff interviews, staff members of the day hospital were not asked direct questions about the complaints named above. However, some indicated awareness of these same problems, and elaborated on or responded to them without prompting. Below is a list of the service delivery challenges that staff members also named, the number of staff members who identified them, and their most pertinent comments. Complaints appear in the same order as above:

Figure 12. Staff Perspectives on Complaints Regarding Service Delivery

COMPLAINT	FREQ	COMMENTS/RESPONSES
Long wait	2	“In spite of their long wait, I still find the patients amazingly polite, patient and understanding.”
Staff behavior	3	“This is generally a thankless job. People don’t appreciate how hard the doctors are working, and they only see the slow-moving waiting lines.” “Trained people don’t come here.” “The staff is leaving because they are overworked. There are bad salaries and violence.”
Understaffed	1	“At the TB Clinic there are four nurses, but only one has professional TB training—another example of the human capacity problem of the day hospital. There is a problem getting nurses into specialty training programs, as there is limited availability.” “Doctors see 50-60 patients per day, and average 5-10 minutes per patient (more for serious cases). This leads to an unavoidable decrease in the quality of care. Patients get 30 minutes at private hospitals—automatically better care.” “People here are unhappy because they are stressed. We are understaffed, and there is not proper payment so people are resigning. There is low morale.”

Staff efficiency	1	“The bureaucracy of the day hospital disillusion people so they go slow.”
Overcrowded	3	

Apart from naming specific complaints with service delivery, a number of community informants also indicated that the care they receive varies between hospital departments. Apart from the day hospital, we received specific comments regarding the MOU, the TB/HIV clinic, and the Site B Clinic (children’s side). One patient reported a positive experience at the MOU. She said, “I experienced the clinic is good when I was pregnant. I had pains, but they saw me quickly and told me I’m far away from delivering. They said just to go home and rest.” Meanwhile, another patient stated, “When you are in labor sometimes they stop you. Sometimes the mother gives birth alone. There are no nurses there.”

The TB/HIV clinic, initially established by MSF but now transferring to provincial authority, received overwhelmingly positive reports. In the TB/HIV clinic, according to patients, “They are very good. They care about their clients. They are better than the other side.” One informant explained that the Site B TB/HIV Clinic was one of the first places to offer ARVs in Khayelitsha, with the help of MSF and other NGOs. Extra doctors and a higher level of resources set a high standard for services at the outset.

Comments regarding the children’s side also tended to be more positive than comments about the day hospital. In particular, patients described a better triage system—children with urgent needs receive care immediately. One mother described, “There *is* care on the children’s side. All of my children suffer from asthma and when they go to the hospital while experiencing breathing problems, they are sent directly to Room 40 for oxygen while their folder is located.” Another mother shared a similar experience. “On the children’s side, my daughters receive emergency oxygen for their asthma easily.” Community informants described the children’s side as quicker, and were generally more satisfied with experiences there than in the day hospital.

Patients and staff agreed on the need for increased communication between them. In order to better meet community needs, hospital staff expressed a need for better communication regarding:

- Triage
- General security concerns at the day hospital, including waiting outside the day hospital after dark, and staff safety.
- Folder organization/loss
- The need for on-site specialists

D. SOURCES OF HEALTH INFORMATION:

How do community members learn about health and health services?

The Site B Day Hospital was the most cited source of health information in Site B. However, community members expressed a desire for health educators to be more accessible—their presence is a rarity. Meanwhile, hospital staff discussed the difficulties they encounter in explaining health information to patients. Some of these difficulties

included the illiteracy of many of the patients and the inability of non-Xhosa speaking health educators to communicate with the primarily Xhosa-speaking population. Our team also observed that health education in the day hospital—the majority of health information in the community—happens *after* people are sick and not before. [For further discussion, see “Preventative Health Care” below.]

In order to identify community sources of health information, we counted how many interviewees mentioned where they get health information. We then identified resources and tallied how many people utilize each resource. For deeper analysis, we selected responses that had a frequency of more than three out of 41. (This is not a representative sample, but useful trends can still be identified.) Discussion of those information sources, both by community members and hospital staff, follows.

RESOURCE IDENTIFIED	FREQUENCY (out of 41)
Site B Day Hospital	26
Community Health Workers (CHWs) (unable to differentiate between government and NGO-employed CHWs)	10
Community radio health programming	6
School	4

It is also critical to note that four respondents stated they specifically do *not* get information from the day hospital, and they know of no other free source of health information in their community.

Health Information at Site B Day Hospital

Hospital staff described the system of conveying health information within the hospital. Different staff members interviewed identified different sources of information; summaries of the information system did not correspond. Combining these reports, our understanding of health information sources at the day hospital is as follows. Six “environmental health workers” try to organize all education efforts in the hospital. An additional health educator speaks with parents while they wait for pediatric care for their children; rags and soap are used to demonstrate proper hand washing to mothers. (In contrast, a deputy nurse stated that there is a total of only three health educators at the hospital.) Apart from health educators, on the children’s side, a mother-to-mothers support group is available. There are also clubs for diabetes, hypertension, high blood pressure, asthma and epilepsy.

Of those that identified the day hospital as their main source of information, some expressed complete satisfaction with information received. These respondents described an abundance of information from a forthcoming staff, resulting in full understanding of basic health information. However, more respondents conveyed a negative opinion of delivery of health information. Descriptors of the information include “bad,” “nonexistent,” “unknowledgeable,” and “not factual.” Inconsistency was a major theme of these negative views, both in terms of inconsistent availability of information and in terms of inconsistency between hospital sources of information. One respondent associated the lack of information with hospital staffing issues. She said, “Sometimes

they tell you the right thing, and sometimes they are busy and tell you to come another day.” A group of community health workers also expressed a shared concern about the lack of information about proper child nutrition. A final respondent pointed out that there are many health education posters in the hospital, but “people are too uneducated to understand them.”

Staff members also expressed concerns about the quality of health education at the hospital. Some expressed the difficulty of efficiently conducting education with a highly illiterate client population. Multiple sources stated that educators end up functioning more as Xhosa translators than sources of information; one-on-one education suffers because of the overriding language challenge in delivering healthcare. Educators in the youth clinic said that condom use is the most difficult message to convey, and that condom distribution and education are dropping. Staff members also identified hygiene, alcohol abuse, domestic violence, HIV prevention, and TB diagnosis as specific areas where increased education efforts are needed. Staff members were also troubled that most education occurs after patients are already sick and is focused on the disease that the patient has already contracted; few patients receive comprehensive preventative health education.

Health Information from Community Health Workers (CHWs)

One fourth of those interviewed identified community health workers as another major source of health information in the community. CHWs were described as sources of information about hygiene and referral for relevant health resources. However, some community members expressed concern that CHWs only visit the homes of people who are already sick, again indicating insufficient preventative health education.

CHW descriptions of their work included door-to-door visits, workshops for community members on the health subject of the CHW’s choosing, and education programs in churches, schools, and at the day hospital. CHWs conceded that their selected topics may not result in a comprehensive health education program. Although our study did not obtain a representative sample, the mismatch between community perceptions and CHW reports of their work may indicate a shortage of CHWs or a problem with the geographic scope of education.

Health Information in Radio Programming

Three radio stations were named as sources of health information. Specific subjects of discussion on these stations include HIV/AIDS, asthma, adherence to medication regimes, rape, and government grant programs. One community informant complained that health programming is aired only in the morning when many people are occupied, and he suggested that additional programming be introduced in the evening.

Health Information in Schools

We received only limited information about health education in schools, only that there is “a lot” of information from both city and NGO educators and that the high school program is “quite comprehensive.”

Regardless of its source, many respondents expressed a desire for more information. “I am lacking of everything, and I want to know more,” said one Site B resident. “I don’t know nothing,” said another. One patient stated that she knows the name of the condition she is being treated for, but nothing about it. The need for an improved education system is clearly shared by all parties interviewed, and the consensus of this need indicates potential for cooperation in meeting it.

E. PREVENTATIVE HEALTH CARE:

How does the community approach preventative health care?

Respondents identified potential methods for prevention through two avenues: individual action and community cooperation. For a comprehensive list of specific preventative behaviors identified by community members, see above Section A above (page 14). In Figure 4 of Section A the most commonly cited behavior for illness prevention was maintaining a balanced diet, and participants particularly emphasized the importance of eating fruits and vegetables. The second most commonly cited behavior was maintaining good hygiene. This included activities such as hand-washing as well as keeping the house and living areas clean. Other important preventative behaviors listed included exercise, visiting the doctor, and taking medicine or supplements.

Sources identified education as the most important way the community can work together to prevent sickness—education both through neighborhood conversation and the development of shared community resources (including schools, day hospital, and others). Many respondents voiced the necessity of good information in preventing illness, and many pointed to a specific need of the community to teach children health habits—preventing health challenges from a younger age. Nutrition and money were also identified as key agents for prevention.

VII. DISCUSSION

Major Findings

In addition to identifying the major trends as discussed above, the subjects explored in our study uncovered several specific findings that beg further inquiry:

Conceptions of Health

- Health is not a closed concept in Khayelitsha. Rather, it is thought of in terms of personal behaviors, external support, and environmental factors.

Health Status

- Further investigation of the apparent stigma experienced by TB patients is needed. Informants identified a loose community affiliation between TB and HIV, but more specific inquiry is necessary in order to enable targeted sensitization and education efforts.
- There is an identified need for diabetes education. A focused investigation of current community knowledge of diabetes is warranted. Knowledge about high blood pressure seemed to be better, and a comparison of current education and understanding of the two conditions could help to shape a more effective information campaign about diabetes.
- The prevalence of child diarrhea in Khayelitsha is rising. Further investigation to identify the specific cause of this rise is needed. Community perceptions of hygiene and living conditions as discussed in this study provide a good foundation for that investigation.

Health Information

- Multiple sources identified the language barrier as a major challenge in delivering efficient care at the Site B Day Hospital. One health educator estimated that she spends as much as 85% of her time translating. Further examination of this problem is needed in order to identify effective solutions.
- Although this study identified radio programming as a major source of health information, a closer look at the frequency and nature of the programming could help to further the potential an already-useful source of health education.
- A similar examination of health curricula in schools and churches could identify points for improvement and ultimately further community health awareness.
- Another notable pattern is that health education is generally disease-specific and given to patients after they are already sick. Thus, patients only have health information concerning health issues they are affected by.

Perceptions of Site B Day Hospital

- This study identified triage and waiting room organization as major problems in the current logistics of the day hospital. Closer observation of these problems could help to generate creative solutions.
- The hospital is currently undergoing a transition from shared provincial and city authority to being entirely controlled at the provincial level. The ramifications of

this change need to be assessed and have been incorporated into the recommendations included in the following section of this report.

- Following the transition, an evaluation of staff placement and turnover might help to identify other windows for improvement in clinic functionality.

Prevention

- Site B Day Hospital was identified as the most common agent in preventing illness, but our research did not yield a clear picture of the hospital's approach to preventative care. Further research is needed.
- Our respondents indicate that many community members struggle from the connection between unemployment and poor nutrition. Further thought needs to be given to ways to affordably provide a balanced diet to all community members, regardless of employment status.

Limitations of the Assessment

Due to the limited time period, language barrier, and other challenges, our study has many limitations. These limitations identify points of improvement for future studies and a better understanding of health in Site B.

- **Too little too late?** At their conclusion, studies often feel compromised by what there *wasn't* time to accomplish. This inquiry was severely limited by the short timeline for its execution. However, we believe that it provides a useful and previously nonexistent baseline for future research. Its worth is also confirmed by its locally actionable findings.
- **A negative view of community health status?** Our data seems to reveal an overwhelmingly negative view of the health status of Site B residents. This is not necessarily indicative of the community sentiment. Rather, it is a reflection of our failure to identify a question that would extract positive feelings or pride relating to health in the community. This inability, though, might in turn be a reflection of a lack of existing positivity or pride.
 - Future study should include a deeper examination of this notion.
- **Health in English or Health in isiXhosa?** The scope of our study was severely limited by the ratio of researchers and translators. Nuances in tone and word choice were lost in translation, and conceptually abstract ideas were compromised (both in posing questions and obtaining information. E.g., there is no English equivalent of “Xhosa wounds.”). Future studies should include an increased role for Xhosa speakers on the research team.
- **What does a non-representative sample actually represent?** We acknowledge that our interviewees are not a representative sample of Site B residents. However, the trends and frustrations we have found in their responses are nevertheless important, and represent opportunities for improving the community's health.

VIII. RECOMMENDATIONS

While collecting data in Khayelitsha, we encountered several community recommendations for improving health in Site B. After merging this data and analyzing the trends, our own conclusions also led to a set of recommendations based on the concerns voiced to us by the community. The following are the combined recommendations with respect to (i) improving service delivery at the hospital, (ii) improving the dissemination of health information in Site B, and (iii) approaching prevention.

i. Recommendations for Service Delivery at the Site B Hospital:

The suggestions we obtained from the community were primarily related to service delivery in the Site B Hospital. One of the most common complaints from community members was that they do not understand the bureaucracy of service delivery, for example the triage system and the reason for long wait times. They have also communicated that they are not engaged in an active dialogue with hospital staff and facility managers. One suggestion is to have a Site B Health board where named representatives known throughout the community meet with hospital staff from all wings of the clinic on a regular basis. These representatives can express the community's concerns and they will be able to get responses to these complaints, relay the responses back to the community, and hold hospital officials accountable.

Though this is a potentially effective suggestion, we recognize some logistical limitations that could impede implementation. For example, selection of community members that would represent the diverse concerns of the entire Site B community may prove challenging. Issues also may arise in creating a consistent forum for these representatives to receive suggestions from the broader community and to report back responses from the hospital staff.

Another suggestion from the community was to have daily meetings of all the hospital staff before they go on-duty. They will be able to discuss the specific challenges facing the clinic that day such as how the day's staff shortages might impact waiting times in certain departments of the hospital. They will then be able to prepare the day's strategy to deliver service effectively. When the staff comes out of this meeting they will go directly to patients in the waiting room and inform them about the specific challenges of the day and about the system by which they will be seen.

This strategy was tried in the past and was reported to have positive results for service delivery. However, this strategy was abandoned due to reported lack of staff interest.

The last suggestion is for community volunteers to assist with administrative duties and take an active role in improving hospital service delivery. One limitation introduced by community members is that there is not a culture of volunteerism in the community. Volunteers often expect compensation after working for some period of time. In conditions of extreme monetary strain, resources may not be available for compensating

these community members. Another challenging issue is that there are no current resources for training volunteers. Current hospital staff is unable to take time away from heavy workloads to train volunteers.

The last suggestion is to implement more effective mechanisms for staff appreciation and morale—perhaps through recognizing an employee of the month or introducing an annual staff appreciation day. Both hospital staff and patients could nominate employees of the month.

ii. Recommendations for Health Education in Site B

One community-voiced recommendation to improve the dissemination of information about health is to have volunteers assist with clinical translation for doctors. One of the issues recognized by hospital staff was that health educators at the Day Hospital were spending most of their time translating for doctors instead of educating patients. The introduction of community volunteers will free up time for these educators to more effectively deliver health information.

We recognize that this suggestion carries with it the same limitations as other volunteer initiatives. Additionally volunteers would have to undergo sensitivity training before working with patients.

During our research we also observed the need for more coordination between the efforts of NGOs and hospital staff to educate patients in the waiting room. Currently some NGOs are deploying health educators in the waiting room, however there is little communication between these health educators and the Site B Hospital staff.

We acknowledge that this might partially limit hospital control over the type of information being disseminated to their patients, but we believe that there could be a major net benefit. A basic set of guidelines describing the range of permissible activities and information distributed to patients by NGOs would be necessary.

iii. Recommendations for Prevention in Site B

Additionally, we recommend that the hospital staff consider ways to more emphatically encourage patients to exercise. In researching conceptions of health there seemed to be a gap between identification of exercise as a characteristic of good health and community members actually exercising as a measure for staying healthy. Creating an exercise club organized by the day hospital is one possibility.

Limitations in human resources will pose a challenge to implementing this suggestion. Additionally, rallying interest among community members could prove difficult, as exercise is a secondary priority.

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The Staff of the Site B Day Hospital

University of Cape Town Faculty of Health Sciences

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XI. APPENDICES

Appendix A: Interview Protocol

- 1) Describe your family (who lives in house), demographics, employment, grants background
- 2) Where do you go for healthcare when you are sick?
 - a. Do you ever go to places in Site B? The Day Clinic?
 - b. Have you ever used a traditional healer?
 - c. How do you feel about the place where you go for healthcare?
 - d. What is not provided in Site B that you need for healthcare?
 - i. What do you do while you are waiting? Would you like to get health education while waiting? Do you understand what you are supposed to do for your health when you leave the hospital?
 - ii. Referrals experience? (Groote Schuur, Red Cross?)
 1. Have you been referred? What for? Could you get there? Experience?
 - iii. Have your experiences been different for different units of hospital? MOU, Pediatrics, TB, HIV clinics?
- 3) What does it mean to be healthy? OR How would you describe someone who is “healthy”?
- 4) What is most important for good health?
 - a. (Optional) Tell a story about a good experience of healthcare in your community?
- 5) What are the biggest health problems in Site B?
 - a. Why do you think people in your community get sick?
 - b. Why do people get sick from A, B, C health problems described?
- 6) Are health challenges different for men and women in your community? How?
- 7) Are health challenges different for youth and elderly in your community? How?
- 8) What do you do to keep yourself healthy?
 - a. How does that make you healthy? Who told you to do that?
AND Maybe . . .
 - i. What do you do to prevent yourself and your family from getting sick?
 1. What is important about hygiene? About nutrition? Who told you to do that?
- 9) Where do you get information about health?
 - a. If clinic, ask- “Anywhere else?”
 - b. Do you talk about health with your neighbors? Your family? What do you say?
 - c. Do you have any questions about health?
- 10) People we should talk to who know a lot about health?
- 11) Anything we haven’t asked?

Appendix B: City of Cape Town Department of Health Statistics