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Exploring Service Delivery of Public Healthcare Facilities in Limpopo, South Africa

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Abstract

The success of achieving health security is dependent on healthcare facilities, thus making comprehensive healthcare service provision fundamental. This study aims to formulate strategies to ease the delivery of quality healthcare in public healthcare facilities in Limpopo Province, South Africa. Qualitative methods were adopted for this study. The study population was constituted by auxiliary nurses, assistant nurses, professional nurses, operational managers, home-based care workers, counsellors, patients, and/or community members. Fieldwork was conducted using observations, semi-structured interviews, and focus group discussions with healthcare workers and patients who were community members. The study area was the Fetakgomo Tubatse Local municipality; however, the research was undertaken only in the Fetakgomo municipal area, excluding the Tubatse municipal area, as the two municipalities are now amalgamated. The study adopted the Batho Pele Principles and Donabedian model to understand and analyse the role public healthcare facilities play in improving healthcare services. By examining how these healthcare facilities contribute to overall health security, the study aimed to acquire knowledge into the efficacy of public

healthcare facilities in achieving health security. Findings show that limited facilities, a shortage of resources, a lack of 24-hour services, and poor infrastructure hinder healthcare access. Despite these challenges, patients are generally satisfied with the healthcare services, although issues such as slow services and medication shortages persist. The study's findings are expected to contribute to the advancement, awareness, and comprehension of the role management of the facilities plays in ensuring effective healthcare provision and that the vulnerable populations have access to public healthcare services. The study concludes that the facilities in the Fetakgomo municipal area contribute to health security; however, they face structural and operational challenges. There is a need for policy interventions in healthcare systems to enable facilities to narrow down the quality care provision gap that already exists. This study contributes to the current policy dialogue and serves as a foundation for proven methods aimed at enhancing healthcare security for the impoverished people and assisting the country to achieve universal health coverage.

Keywords: *Healthcare facilities, public healthcare, health security, service delivery, quality care.*

Introduction

Numerous countries, including South Africa, are working hard to ensure that Universal Health Coverage (UHC) is achieved [1]. In South Africa, affordable healthcare is funded by the government and provided by public healthcare facilities for all citizens [1][2]. Research regarding improvements in health security has been conducted internationally and in South Africa. Health security forms an essential pillar for human security. It is defined by the World Health Organisation as *"the proactive and reactive activities required to reduce vulnerability to severe public health events that put at risk the collective health of populations living across geographical regions and international borders"*[3]. Improved health security is among the most significant goals of the international development agenda. Therefore, enhancing health security is considered important by the Sustainable Development Goals (SDGs), which were adopted by the United Nations General Assembly (UNGA), with specific reference to SDG3: good health and well-being of the people. As such, healthcare facilities play a vital role in achieving these goals [4].

A major hurdle that the public healthcare sector experiences in South Africa is service delivery. For provinces such as Limpopo, health service delivery is prone to be poor, particularly in the local municipalities such as the Fetakgomo Tubatse Municipality. Significant advances in the performance of public healthcare systems and service delivery have been

realised through great efforts since the advent of democracy. However, the outcomes of public healthcare facilities and their programmes remain poor, whilst an increase in demand for healthcare access and services remains high, especially in public hospitals and clinics. This impacts access, timeliness, and quality in care because of the inadequacies of these public healthcare facilities.

Research shows that the majority of South Africans rely upon public healthcare facilities for healthcare services [5]. In support of this, the 2019 Statistics South Africa (Stats SA) report shows that 71 per cent of households in the country utilised public healthcare facilities for healthcare services, and 27 per cent used private healthcare [6]. As such, impoverished people rely on under-resourced health facilities for healthcare. This proves that many people cannot afford private healthcare services, as they come with a high cost.

Therefore, it is fundamental for South Africa to have sufficient public healthcare facilities to accommodate its people, as well as an effective healthcare system that enables people to receive the care they need. Public healthcare facilities supply healthcare, which is affordable to citizens [1], mostly to the impoverished people who rely on free care in public healthcare facilities.

This study focuses on the link between public healthcare facilities in delivering services and health security. The public healthcare facilities in South Africa are under-resourced with respect to healthcare workers (nurses and doctors), medical supplies and instruments, ambulances and buildings need attention. The researcher discovers that impoverished people in rural areas rely on these under-resourced health facilities for healthcare needs. Furthermore, accessing healthcare is a major issue due to limited availability and geographical distribution of healthcare facilities in rural communities. Additionally, health service delivery is poor owing to a shortage of resources. The absence of well-resourced public health facilities is highlighted as a key challenge in achieving health security. This leads to slow progress in accomplishing quality healthcare for the people. Key challenges in Fetakgomo Tubatse include insufficient healthcare facilities, lack of resources, and inadequate quality of care. This results in people receiving poor-quality healthcare. As such, health security is not achieved. Given these challenges, the study was guided by the following objectives:

- To explore and describe the service delivery of public healthcare facilities in Fetakgomo Tubatse Local Municipality.
- To examine the challenges of public health delivery in the Fetakgomo Tubatse Local Municipality.

The South African National Department of Health has demonstrated an unrelenting dedication to raising the standard of healthcare [7]. However, healthcare access remains complex and multi-faceted, and, as a basic right, equitable access and services should be available to all user groups [8]. Despite these commitments, access to high-quality healthcare services continues to be is a global issue and a huge problem for over half of the population who live in rural and isolated locations [9]. These accessibility gaps contribute to health inequalities and the burden often borne by socially disadvantaged groups who experience higher levels of disease and have shorter lives [10].

The idea of healthcare access has evolved to consider aspects of healthcare that influence the availability of services and the level of demand [10]. From the 1970s to date, literature has defined access to healthcare in many ways. It is defined as the action of making practical, effective, and efficient service utilisation, as opposed to initiation and continuance, which are the successive uses of healthcare [11]. It is further explained based on the level of healthcare services that are available and easy to access. There are two concepts about healthcare access, which are gaining access and having access. As such, gaining access is the use of healthcare, and having access is the potential to use healthcare [12]. For a public healthcare system to be sufficient, strategic approaches must be applied to ensure coverage, address social factors, and achieve the standard of quality care [13]. Healthcare facilities may be available, but people may still not receive the healthcare they need. As such, *"access includes not only affordability and availability but also acceptability and effectiveness"* [14]

The South African Constitution, section 27, affirms that all individuals in the country have the right to basic healthcare, implying that the health sector cannot deny anyone access to health services, especially in cases of emergencies. According to the Constitution, public healthcare is guaranteed for all individuals in the country, and efforts have been made to fulfil universal health coverage, as well as a unified system that enables people to access medication equitably [15].

Despite South Africa's well-developed Constitution, progress on human rights issues, such as access to high-quality healthcare, is still slow [16]. Research indicates that regarding public health care access hurdles in South Africa, little is known regarding care for the general population [17]. Understanding access barriers from the user perspective is important for expanding healthcare coverage, both in South Africa and in other low- and middle-income countries [17]. It is imperative to work toward achieving universal access to basic healthcare [18]. It is also important to investigate the appropriateness and efficacy of other levels of care, such as ambulatory

care (community-based, home-based), in ensuring continuity of medical care [19].

In March 2021, the Minister of Health reported that 84% of the citizens in South Africa utilise public health, whereas 16% opt for private healthcare [20]. While healthcare access cannot be completely denied, it is significantly limited as a consequence of resource scarcity. Access to healthcare can also be dependent on money and time [21][22][23][24]. Disadvantaged people tend to struggle to access healthcare because of not having the financial means and time; these are based on the socio-economic status of individuals and the geographical setting of the healthcare facilities. The term "affordable healthcare" refers to the expenditures that patients must pay, such as travel expenses and even lost wages from attending medical appointments [13]. The National Department of Health considers a distance of 5km to primary healthcare facilities acceptable [25] However, in most cases, people who live in isolated areas travel or walk more than 5km to local clinics or a healthcare centre.

As the nation strives toward the objective of universal and equal access to healthcare for all residents, these difficulties have a significant impact on the health of the South African populace [26].*Achieving universal access remains one of the government's key health priorities as it endeavors to rectify healthcare-related market failures* [27].

Furthermore, the expanding scope of services supplied by public healthcare institutions as a result of South Africa's shifting epidemiological profile has placed tremendous pressure on existing resources, contributing to a shortage of medicines and issues with the quality of care delivered. [15]

The NDoH note:

South Africa is at the brink of effecting significant and much-needed changes to its health system financing mechanisms. The changes are based on the principles of ensuring the right to health for all, entrenching equity, social solidarity, and efficiency and effectiveness in the health system to realise Universal Health Coverage. To achieve Universal Health Coverage, institutional and organisational reforms are required to address structural inefficiencies; ensure accountability for the quality of the health services rendered and ultimately to improve health outcomes, particularly focusing on the poor, vulnerable and disadvantaged groups. [28].

To achieve a balanced universal health coverage, all people must have access to essential services without facing an unsustainable financial burden [17].

Data indicate that the use of clinics by South Africans is increasing. However, the challenge that South Africans face regarding healthcare is the lack of healthcare infrastructure, including equipment, and emergency services such as ambulances [29]. Healthcare infrastructure is essential for effective operations of healthcare systems [30]. An 'Ideal Clinic' is defined as a clinic with good infrastructure (i.e., physical condition and spaces, essential equipment, and information and communication tools), adequate staff, adequate medicines and supplies, good administrative processes, and adequate bulk supplies; such a clinic uses applicable clinical policies, protocols, and guidelines, as well as partner and stakeholder support, to ensure the provision of quality health services to the community [29] .

The following areas --- physical accessibility, organisational accessibility, cultural accessibility, and acceptability, as well as access to adequate services of care continue to be a concern. It is significant to note that access alone does not ensure the delivery of respectable services, and the accessibility of resources, supplies, and equipment harms the respectability of services [31].

Methodology

This study was guided by the Batho Pele Principles and the Donabedian Model. The Batho Pele Principles aim to enhance service delivery through consultation, service standards, access, courtesy, information, openness and transparency, redress, and value for money [32]. These principles provide a framework to assess how healthcare services are provided and managed and to address challenges in healthcare facilities [33]. The Donabedian Model evaluates healthcare quality through three components -- structure, process, and outcome -- and identifies gaps for improvement [34].

A qualitative design was employed to explore how participants perceive and experience healthcare services [35]. Participants included primary healthcare providers, patients, and community members. Participants were selected because of their direct involvement with primary healthcare services in the study area. A combination of snowball and purposive sampling was used to choose participants for this study, and this method allowed the sampling process to continue until a sufficient sample size was reached [36]. This allowed the study to capture diverse perspectives on healthcare challenges and service quality.

Data were collected through observations, semi-structured interviews, and focus group discussions. Semi-structured interviews allowed open-ended responses, while focus groups facilitated interactive discussions [37].

Observations focused on facility infrastructure, cleanliness, and resource availability. Thirty-eight participants took part in this study: twenty in interviews (ten patients/community members and ten healthcare workers) and four focus groups with healthcare workers, including nurses, counsellors, and home-based care workers. Data were analysed by organising transcripts and notes into manageable information for interpretation.

Ethical Consideration

Ethical clearance was obtained from UNISA's Research Ethics Committee and the Provincial and District Departments of Health. Participation was voluntary, with informed consent obtained from all participants. Privacy, anonymity, and confidentiality were maintained, and participants were informed of their right to withdraw at any time without consequences.

Data analysis

The data were analysed using thematic analysis. Themes were generated through coding and classification of the data that the participants provided through semi-structured interviews and focus group discussions. Below are the themes:

Healthcare services availability and accessibility

In terms of the physical presence of public healthcare facilities, a major hurdle is the lack of proximity to access healthcare for a large number of the population in the Fetakgomo Municipal area. Observations were conducted during fieldwork and identified that there is one clinic in each village, except for one village that does not have a clinic and another with both a clinic and a community healthcare centre. Given the extensive size and sectional nature of the villages, a single clinic is structurally insufficient to accommodate the healthcare needs of the communities. Those who find healthcare easily accessible live closer to the clinics. They don't have to travel or walk long distances to utilise healthcare services. In an interview with patient #11, when asked whether healthcare is easily accessible, she answered, *"For me, yes, they are accessible, the clinic is not far."*

However, distance is another challenge that prevents the majority of the community members from accessing healthcare services easily. Based on interviews with patients, empirical data indicates that clinic access

necessitates utilising two separate taxi services, with the estimated transportation expense totalling about R80. Patient #10 explained that:

> It's not easily accessible, the clinics are not enough clinics, and in terms of distance, they are far. It takes about 7 km to get to the facility.

This further raises financial barriers patients experience in terms of money for transport, as Patient #8 noted that *"sometimes if you don't have the funds, you have to walk to the clinic."* However, walking is also a barrier for those who are in inadequate health to walk long distances, as stated by patient #7: *"I have a problem with walking because of my legs, even going to the clinic is far for me because of my legs."* Patient #4further highlighted that *"sometimes a child is sick, you don't even have a mere R10, and to get to the clinic you have to travel, you'd find yourself sitting with a sick child at home because there is nothing you can do."* Furthermore, most of the facilities do not have a 24-hour service, which reveals a lack of full access to healthcare. Patient #8 mentioned:

> *"The boring thing is that they don't work on weekends and at night."*

Therefore, this confirms that healthcare is not always available in terms of operating hours. In support of this, Nurse #7 stated that:

> Our patients are not getting all the care they need because there's a shortage of staff, and we don't have a 24-hour service, a person can get injured there on the streets, and when they have to come to the clinic we are closed. Also, we don't work on weekends, because we don't have staff, so we can't rotate. We only do emergency deliveries because there are just two of us who are working, so if an emergency delivery comes in, both of us have to attend to the patient, so the patients outside suffer because of that. For us deliveries, we send them to the hospital. (#7)

Among the seven facilities selected for this study, only two provided a 24-hour service, while three have an on-call system, where the nurses are on standby for emergencies. Nurse #3 explained the on-call system, stating that, *we provide an on-call system, if you come to the clinic at night, you will find a nurse who spends a night at the clinic.*

In the first focus group discussion with nurses, Participant #1 stated that, *even those who work on call during the night they just compromise so that patients do not return home.*

Patient interviews indicated that the clinics serve as the primary source of care for diverse health conditions, ranging from chronic and acute

illnesses to minor ailments, as well as essential maternal and child health services. The main chronic illnesses include diabetes and hypertension.

Therefore, in terms of affordability, nurses highlighted that healthcare is free of charge, and patients don't have to pay for anything. However, Nurse #2 noted that *the ambulance is not free of charge, they think it's free of charge, but it is not.* As such, when patients are transferred to the hospital from the clinics, they are required to pay for ambulance services, which the majority of people are not aware of.

Home-based care and scope of services

While healthcare facilities face challenges in accessibility, home-based care workers play a supporting role in enhancing healthcare access.

In terms of accessibility, Nurse #6 argued that healthcare is easily accessible, stating that *it is easy to access, we also use home-based care workers, and they visit them at home to deliver medication or at a shop, we call them pick-up points, depending on the conditions.* This nurse emphasised that healthcare is accessible, as the patients do not always have to come to the clinic; they can be cared for at home by home-based care workers or get their medication delivered at home.

In Focus Group #2 with home-based care workers, participant #1 explained how patients receive healthcare in the comfort of their homes, stating that they *do "screening, health promotion, referral",* and further explained that: *"We do door-to-door. For chronic illnesses, some we deliver medication for them, some we administer medication at home, like TB patients, and for those that are unable to cook for themselves, we assist them."*

Also, in Focus Group#1, participant #1 highlighted that *we go to creches to check children's clinical cards, to check if they attend their scale appointments properly, they are getting their injections on time, and they receive their vitamins accordingly. When we find that there's a child who did not receive all these services, we refer them to the clinic so that the nurses can provide care for them.*

Participant #2 further emphasised that:

> For our patients, we collect medications and deliver them, especially those with chronic illnesses and the elderly who are unable to come to the clinic every month, and after six months, that's when they come to the clinic and renew their prescription letters. We do assist them at their

> homes, those who are sick and can't bathe themselves, we bathe them, cook for them, give them medication until they improve. (#2).

Even though home-based care personnel improve access to healthcare, they constitute a partial solution, as they are unable to provide the full spectrum of health services necessary for the communities. Their main focus is on chronic patients and TB patients. The researcher probed further, asking how they care for TB patients at home, and Participant #3 explained:

> For TB patients, because they have to take medication every day, we go to them to ensure that they take their medications. Back then, they used to come to the clinic every day to take their medications, but now they come maybe after two weeks., For TB, they don't like chronic patients; we don't deliver medication for them, they come and collect their medication, and we just do follow-ups and make sure they take their medication on time(#3).

Staffing and infrastructure challenges

Shortage of staff has been highlighted as the rationale for the lack of a 24-hour service. Nurse #1 remarked that *We don't provide a 24-hour service simply because we are short-staffed, for a 24-hour service, it needs a certain number of people to be there for day and night, including cleaners and security.* Another Nurse #4 agreed stating:

> We had a 24-hour service a long time ago when we had enough staff and when we were still working in this building that is now cracked, so we were forced to cut the building and use half from 2009 until 2015, but after 2015, calling system had to be cancelled because of the structure and shortage of staff. (#4).

From the perspective of infrastructure quality, out of the seven facilities, three clinics have poor infrastructure. There was one facility that did not have a building. When asked if the buildings are user-friendly, a healthcare worker responded as follows: Nurse #4 *Not per se, first of all, we don't have a structure, we work in containers, there is no privacy, you have to speak lower so that others don't hear you, whereas patients differ with voices, privacy is a big issue. we have been working in these containers for 15 years.*

Patient #8 supported this statement noting that, *The infrastructure. All the buildings have cracks, so we use containers. They are small and there's no privacy.* This

clinic's reliance on only three container units results in insufficient capacity to effectively accommodate the needs of the community, a limitation that has persisted for over a decade. As such, patients who receive care in this facility are more disadvantaged than the rest of the Fetakgomo community. The waiting area is small, and there is not enough shade from the sun. The containers need to be repaired, and as a result, they pose serious health challenges. Nurse #4 noted that:

> The structure is a problem because we'd find that the electricity is not working properly, because in these containers' things shift a lot. Some days one container is not working properly, the next day it's the other one. When it's raining, the water gets inside and damage the cables, and the main switch shuts down. So, a lot of things work electronically so it becomes a problem (#4).

In Focus Group #1 with Nurses, Participant #1 noted that the challenge they face with infrastructure is "space", and she further explained that *the building is no longer user friendly for the community, the community has increased, people are a lot, and we only have 3 consulting rooms.*

Participant #2 added: *A lot of things are damaged, taps, toilets, doors, floors are cracked, the clinic is cracking in half, this clinic will be closed one day because the crack is very huge.*

The Limpopo province government pays no attention to the poor infrastructure in healthcare facilities [38].

Healthcare Emergency Response

According to the World Health Organisation, all populations in the world are at risk of experiencing health emergencies and disasters, along with those related to disease outbreaks, conflicts, natural and technological hazards, and other hazards [39]. As such, public healthcare facilities in rural areas are not well equipped to overcome such cases. This study investigated how the facilities in the Fetakgomo municipal area manage health emergencies, with a focus on "other hazards," which are trauma, injury, accidents, obstetric, and violence-related emergencies. Healthcare workers were asked how they manage such emergencies.

During Focus Group discussion #2 with nurses, Participant #3 explained how they deal with emergencies in their clinic, noting that:

> Once they arrive, they see them outside (she was pointing at the home-based care workers), then they FastTrack them and then get in here and tell us that there's an emergency, we have a room for that, then all the nurses will go there to assess what kind of an emergency is it, and if it needs just two nurses or all of us, it only depends on the severity. If it's an emergency that needs all of us, we stop seeing patients and attend to the emergency until the patients leave to go to the hospital. (#2).

Furthermore, in interviews with nurses, responses were as follows:

> Nurse #6 responded: We have an EDF, we can just say it's our Doctor; it's the one that tells us how to manage our emergencies, and sometimes we use our descriptions, we have an emergency room which has fairly enough equipment, especially medication, and when we do the referral.
>
> Nurse #8 highlighted that according to protocol, it depends on what type of emergency it is, if it something that can be handled in the facility, we manage, stabilize and discharge, but if it's something very major, we manage, stabilize and refer to the next level of healthcare which is Jane Furse hospital.

Jane Furse Hospital is the nearest hospital in the area.

Nurse #4 further explained that *"we deal with them accordingly, it only depends on when it arrives, we attend to it immediately, but we have a challenge with EMS, it takes too long to get here"*

In support of this, Nurse #8 further explained that they experience challenges during the referral processes, stating that *we do have challenges of the ambulance, the system for the ambulance you just don't go there and tell them I have a patient, the call must go via the call centre because that's how they record and then the call centre report and that's how we get the ambulance.*

A probing question followed, asking how long the ambulance takes, and she answered, *"it takes +- 15 minutes"*. This posed a further question about the challenge of ambulances arriving late, and she explained that it depends on the day, and sometimes there's an EMS parked there in the Community Health Centre.

Nurse #7 explained that sometimes the ambulances take long and sometimes they do not, noting that *luckily, if you find that it's been on the road and it's headed to the hospital, it will come on time, but if not, you will wait with the patient until they arrive.*

Nurse #6 explained that the ambulance can sometimes take over *"2/3 hours"* to come, however, she explained that *we have a WhatsApp group where we send messages, so the whole district will know that the clinic has been waiting for an ambulance for over 3 hours and response in the group is faster.*
The participants' viewpoints show that health emergency response in the clinics is moderately effective, as they usually care for minor emergencies. Furthermore, delays in ambulance arrival can critically compromise patient outcomes, especially in emergency situations requiring urgent referral. However, they manage emergencies competently, as highlighted by the Department of Health:

> On arrival of the patient at the accident and emergency department (A&E), clinicians assess the patient's condition in a quick but organised approach utilising a specific method of documenting the patient's health condition, namely, Subjective, Objective, Assessment and Planning (SOAP). Quick assessment of a patient on arrival in A&E is utilised to determine the urgency of intervention and prioritisation. [40]

Satisfaction with Services

In several public healthcare facilities, the demand for healthcare services surpasses the capacity available, and this can be attributed to the long waiting periods that sometimes result in patients returning home without receiving the care they need [40]. The facilities in the study area are not adequate; they are overwhelmed by the large population. Satisfaction with services was investigated by posing key questions to patients regarding the services provided by the clinics, including their overall satisfaction, the competency of the nursing staff, and the perceived alignment of clinic offerings with community requirements. Some patients were on a neutral stance, some replied with 'yes,' whereas others responded with a 'no' and elaborated on their reasons.

Patient #7 best describes his satisfaction with service delivery. He seemed very confident about his response and noted, *yes, I am satisfied, even for us, they are those that get their medication delivered to the residence of the chief and then come to collect them there, it's nearby. It's just that I need to make arrangements so that I can collect them there.* Some patients receive their medication at the

nearest pick-up point instead of travelling long distances to the clinics. He further explained how satisfied he was and also highlighted the issue of queuing for too long:

> The service delivery is right; the only issue is the long queues. I never get confused when I get to the clinic. When I get there, I always find people ready to assist me.
> Patient #2 added that their services are slow, stating that the slow service, and if they don't have medication, if possible they should tell us that they don't have medication for 123 so that we can leave instead of queuing for long hours, that time you are hungry, but they are looking to just check the vitals and fill in the file.

Shortage of medication results in poor service delivery; however, that does not necessarily mean that nurses are not doing their job. The same goes for slow services; shortage of staff has been highlighted as a major issue. Patient #10 noted:

> I believe they are, some of the things are beyond their control, there's the shortage of staff, we can't expect them to be that effective.
> Other patients emphasise that nurses do their job, they are trying their best, and they take care of their patients. Patient #10 highlighted that "the fact that they don't send patients home after their knock-off time, they attend to all of them, that shows that they do compromise."

The participants acknowledge the challenges they experience in healthcare while also recognising the effort and dedication of the healthcare workers in providing care.

Discussion

The service delivery in the seven facilities selected for this study, while remaining effective, shows potential for improvement. One of the challenges that emerged from the interviews was the geographical distance to healthcare services. Travelling to the clinics did pose challenges for the majority of the people. This indicates that there is an sufficient number of facilities in the area, and that there is one clinic in each village and one village without a clinic. The residents of the village without a clinic are required to go to the nearest clinic in another village. Those who are living closer to the clinics have convenient access to healthcare services. Others who live further away incur transport costs. Yet there are others who walk

long distances to access care because they cannot afford the transport costs. This is extremely difficult for those who are not physically well.

Another primary issue is the limited availability of a 24-hour service facility. The majority of the clinics are not operational day and night, on weekends, and during public holidays. The two facilities offering 24-hour services are located in moderate proximity to one another, which creates a disparity in access to continuous healthcare for populations residing in more distant areas. Therefore, this results in a gap in healthcare service delivery. Nonetheless, three facilities have an on-call system where a nurse is on standby in the clinic at night. The principal duty of an on-call nurse implies working after hours, night shifts, and during weekends and public holidays, performing standard responsibilities such as attending to patients and caregivers, referring patients when needed, and responding to injuries. In contrast, based on the findings of this study, the on-call nurses only work at night, and some nurses are requested to work on weekends and public holidays during the day as overtime duty.

In the interviews and focus group discussions, the nurses explained that the staff shortage is the cause of the gap in service delivery because there are not enough nurses to rotate for different shifts. Other reasons include infrastructure challenges, as one nurse explained that in their clinic, they had to reduce operational capacity over the years owing to poor infrastructure.

Despite encountering these challenges, each healthcare facility has a minimum of 15 community workers, known as home-based care workers, to enhance healthcare service delivery. The availability of home-based care workers enhances the accessibility of heart care services, particularly for people living with chronic illnesses. They also play a vital role in child immunisation as they ensure that their records are in order. Despite the limitation of service scope to these specific health issues, these initiatives demonstrably improve access to care for some individuals.

Public healthcare is free of charge; however, it was discovered that there were unforeseen expenses such as ambulance fees. It seems that people are not aware that ambulances are not free, and this is a big, unexpected cost for patients to incur when they need the services.

Conclusion

Service delivery in the seven facilities selected for this study shows potential for improvement but remains effective. One of the factors that arose in interviews was the geographical distance to healthcare services, which poses challenges for the majority of the people, as they have to

travel or walk long distances to access care. This indicates that there are not a sufficient number of facilities in the area, as it was observed that there is one clinic in each village and one village without a clinic.

Another primary issue is the limited availability of a 24-hour service. The majority of the clinics are not operational day and night, on weekends, and during public holidays. Two facilities have a 24-hour service and are moderately close to one another; as such, people from areas that are far from these two facilities do not have easy access to a 24-hour service. Therefore, this results in a gap in healthcare service delivery. However, three facilities have an on-call system where a nurse is on standby in the clinic at night.

In interviews and focus group discussions, the nurses explained that the shortage of staff is the cause of the gap in service delivery because there are not enough nurses to rotate for different shifts. Other reasons include infrastructure challenges, as one nurse explained that in their clinic, they had to reduce operational capacity over the years due to a lack of infrastructure.

Despite encountering these challenges, each healthcare facility has a minimum of fifteen community workers, known as home-based care workers, to enhance healthcare service delivery. The availability of home-based care workers enhances the accessibility of heart care services, particularly for people living with chronic illnesses. They also play a vital role in child immunisation as they ensure that their records are in order. Despite the limitation of service scope to these specific health issues, these initiatives demonstrably improve access to care f for some individuals.

Ethical consideration:

Conflict of Interest: The authors declare that they have no competing interests or other interests that might be perceived to influence the results and/or the discussion reported in this paper.

Data Availability Statements: The data leveraged for this study consisted solely of the primary data collected during the execution of the case study. We have well-organised data, and the corresponding author will make it available upon request.

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Transparency: The authors confirm that the manuscript is an honest, accurate, and transparent account of the study; that no vital features of the study have been omitted; and that any discrepancies from the study as planned have been explained. This study rigorously adhered to all necessary ethical practices throughout its execution and reporting. Publisher: Innovative Research Publishing

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