FACTORS THAT AFFECT THE UTILISATION OF PRIMARY HEALTH CARE SERVICES: PERCEPTION OF COMMUNITY IN SELECTED VILLAGES OF SEKHUKHUNE DISTRICT, SOUTH AFRICA

by

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DECLARATION

I, Rammela Mukovhe, of student no: 11620559 hereby declare that the mini dissertation titled ***"Factors affecting the utilisation of primary health care services: perception of community in selected villages of Sekhukhune District, South* Africa"** for Masters of Public Health at the University of Venda, hereby submitted by me, has not been submitted previously for a degree at this or any university. That it is my own work in design and execution and that all reference material contained therein has been duly acknowledged.

Student's signature:  Date: 18/08/2020

DEDICATION

This piece of work is dedicated to

my courageous late dad

Rammela Nthangeni Jerry

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ABSTRACT

Primary Health Care utilisation and the quality of health care delivery globally have recently been regarded as poor, more especially in the developing countries. In South Africa 84% of the population depends on the government health care system. The South African health system has adopted the PHC approach because it is believed to be the most acceptable, cost-effective means of improving the health status of South Africans. However, there has not been significant improvements in the health of the South African population. The purpose of this study was to explore and describe factors affecting the utilisation of primary health care services at selected villages of Sekhukhune District. A qualitative, exploratory, descriptive and contextual design was used. A non-probability approach, purposive sampling method was used to select the district and villages; namely Ga-Mashishi and Dithamaga in the Tubaste Sub-District. A probability approach, simple random sampling was used to select 50 participants using set criteria. Data obtained from interviews was analysed thematically. Results: The following themes emerged from data analysis: Socio-cultural factors, Availability of resources, Organisational factors, Environmental, Economic and Physical factors. The study reveals that community members are not accessing quality Primary health care services. Recommendations that are made include: to consider building a centrally located PHC clinic that would ensure equal access to health care services, strengthening the implementation of policies regarding the referral system and ambulance services, ensuring sustainable availability of human and material resources, developing strategies to ensure that the PHC services are delivered in line with the South African Department of Health policies and guidelines.

Keywords: Factors, Health care services, Primary Health Care, Utilisation, Village

Table of Contents

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS:	Acquired immunodeficiency syndrome
CHCs:	Community Health Centers
DAHS:	Demographic and Health Survey
DHB:	District Health Barometer
DHS:	District Health System
DoH:	Department of Health
GDP:	Gross Domestic Product
HIV:	Human Immune-deficiency Virus
HIV/AIDS:	Human Immune-deficiency Virus/ Acquired immunodeficiency syndrome
IDP:	Integrated Development Planning
IMR:	Infant Mortality Rate
KZN:	Kwazulu Natal
MCHC:	Maternal and Child Health Care
MMR:	Maternal Mortality Rate
NGOs:	Non-Governmental Organisations
PHC:	Primary Health Care
STATS SA:	Statistics South Africa
STI:	Sexually Transmitted Infection
TB:	Tuberculosis
UNICEF:	United Nations Children's Fund
WHO:	World Health Organisation

LIST OF FIGURES

LIST OF TABLES

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 Introduction and background of the study

Primary Health Care (PHC) utilisation and the quality of health care delivery globally has been regarded as poor, more especially in developing countries (WHO, 2016). This has been happening as a result of multiple factors emanating from the fact that primary health care does not rely on advanced technology. Besides the poor PHC facilities, every individual perceives good health as a need which makes healthcare utilisation superior (Adam & Awunor, 2014). As a result of underutilisation of PHC services, the principles of PHC need to be strengthened for quality service delivery globally, more especially in the rural areas. According to Visagie and Schneider (2014) the principles of PHC include the following: community contribution, sufficient health resources, communal and financial growth, interventions purposeful on the determinants of underprivileged health, promotion of health, prevention, treatment and remedy, an incorporated referral method to facilitate and a variety of care and equity.

Sharing cultures and languages facilitates information sharing and influence PHC service utilisation within communities. On the other hand, different languages in a multi-ethnic setting affect the utilisation of PHC services in Canada due to the migrant population (Moore, Alex-Hart & George, 2011). Communication between the patients and the provider is an important element in determining satisfaction with primary health care services provided in Uganda (Oyekale, 2017). Furthermore, the educational status of community members has a direct correlation with the utilisation of PHC services, especially for child care and antenatal care services. In the Myanmar study, mothers with higher education levels took their children for care more readily, compared to those with lower education levels (Sein & KyiKyi, 2012).

In other countries, home deliveries are encouraged due to the beliefs, perceptions and cultures of certain communities. On the other hand, in maternal and child health care (MCHC) services in PHC centres in a rural village of Ogun State Nigeria; Agbede, Aja and Owolabi (2015) observed an increasing tendency for persons living with extended family members having a higher rate of home delivery. Although these women attend antenatal clinics and they bring back their children for immunisation, they still prefer to give birth at home.

Although in the Northern Nigeria there are essential problems of PHC such as lack of facilities, shortage of staff in the facilities and lack of equipment to maintain proper hygiene to the surrounding communities of the clinics, PHC is been acknowledged and appreciated in almost all the countries (Titus, Adebisola & Adeniji, 2015). In Southern Nigeria, the other

problem is lack of nursing staff in PHC which has been worsened by the challenge of many nurses were unwilling to work in rural areas (Ijeoma, Obinna & Franas, 2014). According to Oyekale (2017) in Nigerian communities there are several factors that determine the utilisation of health care services within PHC facility, when majority of community members have accessibility immunisation, Human Immune Virus (HIV) treatment and tuberculosis health screening and education, antenatal care, outpatient medical treatment, diagnostic and pharmaceutical services.

Adam and Awunor (2014) also indicated that in Southern Nigeria the factors which significantly contribute to under-utilisation of health care facilities are as follows: underprivileged education and insufficient knowledge about when to look for health care, poverty, insufficiency of available health services (that is lack of drugs, necessary laboratory services; insufficient number of healthcare workers and nearness to the health care facility). Another study in Uganda Wakiso district indicates that poor staff attitude at the PHC clinics are one of the barriers to utilisation of health services at PHC facilities (David, 2014). However, in Malawi Dullie, Meland and Mildestvedt (2018) indicate that technical competence of the health care personnel, interpersonal relationship between patient and provider, availability of services and effectiveness of clinic personnel are important determinants of PHC utilisation.

Transport facilities are an important indicator of the mobility of a particular community. The members of the community should be able to travel from their respective homes to a health care facility when they seek medical attention (Hampton & Nagy, 2016). In the Chipinge village of Zimbabwe, Gore, Muza and Mukanangana (2014) indicated that shortage of transport seriously affects the provision of health care services and outreach programmes, including mother and child services, expanded programme of immunisation, and the supervision of health care services provided. Thus, nurses in the rural areas, in particular, are unable to move from one point to another due to lack of transport. This problem affects nurses who do not live near the clinics.

South Africa has a population of 57.4 million people, with the average age of 26 years (STATSSA, 2016). Furthermore 84% of the population depend on the government health care system and only 16% depend on the private sectors. Thus, the public health system serves the vast majority of the population but is chronically underfunded and understaffed. PHC, therefore serves as a basic mechanism to promote health care to the population of South Africa. The South African health system adopted the PHC approach because it is believed to be the most acceptable and the most cost-effective means of improving the health status. This system brings health care as close as possible to where people live and it

establishes the first element of a continuing health care process. It was formally introduced in South Africa in April 1994 and the government is the main service provider of PHC and the remainder is the responsibility of the private sector and Non-Government Organisations (NGOs). Therefore, it is vital that all community members, more especially in the rural areas, have access and utilise PHC services without any difficulties (Zeluwa, 2011).

South Africa is experiencing major health determinants that result in a neonatal mortality rate of 34 per 1000 live births and a Maternal Mortality Rate(MMR) of 310 per 100 000 live births (WHO, 2016). Most causes of maternal mortality are preventable. For example, more than 60 000 children younger than five years of age die each year mainly due to lack of access to quality child health care services and poor child care in homes and within communities (WHO, 2016). Access to mental health care in South Africa remains a challenge, despite the right to health including both physical and mental health. People with disabilities who live in disadvantaged families experience a number of barriers associated with individual and societal poverty and it may inhibit their capacity to seek health care even when the need is there (Adam & Awunor, 2015).

In Kwazulu Natal (KZN), Sibiya and Gwele (2013) indicated that at the PHC centres there is a shortage of staff which is one of the major problems hindering the efficient delivery of PHC services. Mukiapini, Bresick and Sayed (2018) stated that shortage of staff leads to PHC nurses having excessive workload, which impairs them from mastering the computerised patient record information system. Overall, PHC nurses are expected to cope with increasing workload, executing tasks normally done by doctors, and adjusting to the new technological system which all makes patients wait longer than usual before getting the required services. The PHC nurses do not only perform their traditional duties, they are doing the work that should be done by administrative personnel as well.

PHC access and utilisation plays a significant role in rural community growth, as it is imperative for the wellbeing of a person, mechanism of human principal and to maintain a healthy lifestyle for all (Titus, Adebisola & Adeniji, 2015; Veillard, Cowling & Bitton, 2017). PHC is defined as the fundamental health care which is based on technically sound and communally acceptable system and technology, made available across the world to individuals and families in the community (Muhammad, Umen & Suleiman, 2013). PHC tracks the most common diseases and the outbreak of communicable diseases in the country, provides a system of referral for serious cases, and promotes health care services and prevention of diseases where possible. This is done through community involvement and at an expenditure that the community can afford to sustain at every step of their growth in the spirit of self-confidence and determination (Adam & Awunor, 2015; Oyekale, 2017).

The elementary aim of PHC is to make sure that there is worldwide access to available resources, in order to offer sufficient coverage of the most significant health care needs of the people, more especially in the rural communities (Zeluwa, 2011). Effective PHC encompasses preventive programs, curative services and health education.

According to the Provincial Integrated Development Plan (IDP) (2017/2018) there are disparities in PHC delivery in South Africa between rural and urban areas. To enhance the utilisation of PHC services, the South African government has established various health care improvements and has been periodically revising the National Health Policy. PHC in South Africa currently focuses on mother and child health, control and management of communicable diseases, such as malaria, Tuberculosis (TB) Sexually Transmitted Infections (STIs), HIV/AIDS, mental health, control and management of non-communicable diseases, epidemic and disaster prevention, preparedness and response, school health and oral health. To foster PHC utilisation in South Africa, especially in rural areas, various interventions have been put in place, such as setting up health care posters in public areas and training of traditional healers in the communities.

However, there has not been a significant improvement in the health of the South African population. Many rural areas remain unchanged, people still walk long distances, up to 40 kilometres (km), to reach the nearest rural health care facility. Overall mortality rates are high and life expectancy has dropped to 50 years from 61 years (STATSSA, 2018). Furthermore, there has been an increasing toll of the spread of the HIV/AIDS epidemic in South Africa, which accounts for more than 40% of the deaths (STATSSA, 2016) To explore these, the study will use the selected villages under Tubatse sub-district, due to their reported low utilisation of PHC in Sekhukhune District among other districts of Limpopo province in South Africa (IDP, 2016/17).

According to Hunter, Chandran and Asmall (2017) the introduction of free health care services is causing an increase in the number of consultations and overcrowding of health care facilities in South Africa. Overcrowding is also experienced in health care facilities around the Bronkhorstspruit area (now called Kungwini Local Municipality) after the implementation of free health care services (Nteta, Mokgatle-Nthabu, & Oguntibeju, 2010). Overcrowding at clinics has also increased since the implementation of free PHC, and has contributed to the deterioration of clinic management due to PHC nurses “strain, stress and burnout” (Sibiya & Gwele, 2013). In the Bronkhorstspruit area, free health care services resulted in complaints about long waiting hours, congested waiting areas and shortage of staff, which affect the accessibility of district health care services of the area (Nteta et al, 2010).This study focuses on the issues faced by the community members in the rural areas

regarding the utilisation of PHC services when they have medical problems. The main point being to explore the factors contributing to underutilization of PHC services in rural villages and how these challenges can be overcomed.

1.2 Problem statement

The researcher is a professional nurse working at Toitskraal Clinic, surrounded by farms at Ga-Matlala Ramoshebo village in Sekhukhune District in Limpopo Province. Nurses frequently provide mobile health care services once a month to the nearest villages. However, during the IDP review (2016/2017), the PHC utilisation rate of Sekhukhune District was found to be comparatively low at 1, 5 visits per person annually (compared to the national average of 2, 1 visits per person annually) while the expected rate is 3,2 visits per person annually.

The table below indicates the PHC utilisation rate per sub-district of Sekhukhune District. The Greater Tubatse/Fetakgomo were found to have the lowest utilisation rate in the district. This is an indication that people in these communities are not utilising PHC services when they have medical problems. Therefore it was imperative to conduct a study on factors affecting the utilisation of PHC services at the selected rural villages. The purpose of this study was to explore and describe factors affecting the utilisation of PHC services.

Table 1.1: PHC utilisation rate per sub-district

Municipality	Number of clinics	Number of mobile clinics	Number of population	Number of households	People who utilised PHC services (%)
Greater Tubatse/Fetakgomo	37	7	490 381	125 454	44%
Ephraim Mogale	15	3	127 168	33 936	48%
Elias Motsoaledi	15	3	268 256	66 330	52%
Makhuduthamaga	21	4	283 956	64 769	47%

Source: (Department of Health 2015), Community Survey (2016)

1.3 Rationale of the study

Studies have been conducted in African countries such as Nigeria, Uganda and Rwanda providing evidence of low utilisation of PHC services (Zeluwa, 2011; Ulise & Carina, 2012;

Otieno & Macharia, 2014). Many other studies have been conducted on the factors affecting the utilisation rate of PHC services in South Africa (Nteta, Nthabu & Onguntibeju, 2010; Ngomane & Mulaudzi, 2010). However, few studies have been conducted in Limpopo province (Bresick, von Pressentin & Mash, 2019) and there are no known studies on factors affecting utilisation rate of PHC services conducted in Sekhukhune District.

1.4 Significance of the study

Undertaking this study will help with provision for quality health care facilities and adequate resources to the community members and health care professionals around Sekhukhune District. The outcomes of this study might also help policy makers to review these factors from the perspective of community members and update their policy. They may also inform the state, to develop mitigation strategies and action plans that will improve the utilisation of provided services at the PHC level. These activities will help initiate the process of improving access to health care services, thereby improving the overall health outcome for every individual in the state.

1.5 Study purpose and objectives

1.5.1 Purpose

The purpose of this study was to explore and describe factors affecting the utilisation rate of PHC services at selected rural villages of Sekhukhune District.

1.5.2 Objectives

The objectives of this study were:

- To explore the factors that influences the utilisation of PHC services at the selected rural communities of Sekhukhune District.
- To describe factors affecting utilisation of PHC services within the selected rural communities of Sekhukhune District.

1.6 Definition of terms

1.6.1 Primary Health Care (PHC)

Primary Health Care is defined as the fundamental health care which is based on technically sound and communally acceptable system and technology made available across the world to individuals and families in the community (Muhammad et al., 2013).

In this study PHC is health care provided by a qualified health care provider, such as a nurse at the clinic attending to people with clinical problems and in need of advice or treatment.

1.6.2 Utilisation

WHO (2010) defined utilisation as the quantity of health care services used by the patients.

In this study utilisation refers to sufficient action of making practical and effective use of PHC services by the community members of Sekhukhune District.

1.6.3 Health care

Health care is the protection or enhancement of health through the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in human beings (Titus et al., 2015).

In this study health care is the service provided to the community members of Sekhukhune District through clinical medical assessment, providing medication; if necessary, and health education to maintain or improve the health of every individual seeking health care.

1.6.4 Village

A small community or group of houses and associated buildings, larger than a hamlet and smaller than a town, situated in a rural area, with a population ranging from a few hundreds to few thousands, though often located in rural areas, villages are normally permanent, with fixed dwellings (Adam & Awunor, 2014).

In this study a village refers to a place where community members of Sekhukhune live or are located based on their cultural beliefs and/or practices.

1.7 Outline of the study

Chapter 1: Provided the background to the study, problem statement, purpose and objectives of the study. The chapter also gave an overview of the significance of the study, theoretical framework of the study and defined key terms.

Chapter 2: Discusses the literature review aligned with the study. The literature reviewed focused on factors that affect utilisation rate of PHC services by the community members and nurses rendering PHC services.

Chapter 3: Outlines the research methodology. It provides a road-map, as well as the methods with which the research was scientifically carried out to achieve the objectives of the study.

Chapter 4: Provides discussions of data analysis and interpretation.

Chapter 5: Presents the study conclusion, summary of the findings, discussion of limitations, and recommendations for practice and further research.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter will discuss the literature review for the study. The discussions are limited to literature relevant to the research topic; factors that affect utilisation rate of PHC service. Numerous scholars have conducted studies on the factors that affect utilisation rate of PHC services in the rural villages. Those findings are factored in this chapter. Sources that were used include scholarly articles in journals, e-books, books and book chapters.

During the International Conference on PHC, WHO (1978) defined PHC as an essential health care service based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and their families in the community through their full participation and at a cost that community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. PHC is the first level of contact for individuals, family and community with the national health system. Hampton and Nagy (2016) indicated that for PHC to be more effective to the community, sound policies and good infrastructure should be in place. Lack of a sound policy, good resources and infrastructure hinders the PHC service providers from rendering services effectively. It is very crucial for the national health system to provide adequate PHC services to their communities. Sound health care is a fundamental requirement for living a socially and economically productive life.

Service utilisation refers to the extent to which people are making use of whatever services are already available in the community or at their organisation mostly provided by the government for free. Therefore, health care service utilisation is the extent to which people make use of the health care services available to them in their community (Hampton & Nagy, 2016). The extent to which these health care services are utilised in developing countries is still very low resulting in many different negative consequences. There are many determinants of health care seeking. Although the determinants are similar across populations, their interaction and influence on people's actions are unique to a population based on the environment they live in (Obiechina & Ekenedo, 2013). Utilisation of health care services refers to the use of health services by the people. Therefore, physical accessibility to a facility, its ability to provide required health care services and the patient's ability to pay, are all essential determinants of utilisation of health care services in case of an occurrence of a disease.

The PHC services comprise of education about prevailing health problems and the methods of preventing and controlling them, promotion of food supply and proper nutrition; family planning; immunisation against the major infectious diseases; prevention and control of locally endemic and epidemic diseases; and provision of essential drugs and supplies. However, PHC, which is supposed to be the bedrock of the country's health care policy, is currently catering for less than 20% of the potential patients. Human resources are vital in arrangement of health care systems and health care systems strategies should make provision for a large number of people (Sibiya & Gwele, 2013).

PHC providers need support from the members of the community and other stakeholders for them to provide quality and equal treatment to all patients. However, Fana and Felix (2014) emphasise that good infrastructures and enough funds that can cover a large number of patients for adequate drug supplies; necessary trainings of the health care workers; proper transport for referral system and communications within the facilities are a necessity. Majority of the developing countries are still lagging behind in utilisation of health care services. According to Mills, Taguba, Akazili, Borghi, Garshong and Makawia (2012) the health care services in Tanzania, Ghana, Kenya, and South Africa favour the better-off whilst those people with low income are experiencing the highest burden of illnesses.

PHC services form part of a comprehensive health care service and have been described by the WHO (2010) as an “essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford”. Following the Alma Ata Primary Health Care World Conference WHO had to lay down certain basic principles for the organisation of PHC services:

• PHC should be shaped around life patterns of the population and should meet all the daily needs of the community;

• It should form an integral part of the National Health Care Service, and other levels of health care services should be designed to support the PHC services;

• PHC services should be integrated with other services concerned with community development, such as Agriculture, education and communications;

• The local population must be actively involved in all health care activities. Community participation plays a very important role in addressing health related issues, hence the formation of PHC Facility Committees;

• PHC should offer a comprehensive approach of promotive, preventive, curative and rehabilitative services.

2.2 Theoretical framework

The theoretical framework applied in this study was developed by Andersen (1973) which mostly commenced based on the health-seeking/utilisation behavior model by the individuals in the community (Andersen & Newman, 2005). Andersen's Behavioral Model of Health Care Utilisation, initially developed in the late 1960s, suggests that people's use of health care services is a function of their predisposition to use services, factors which enable or impede use, and their need for care, hence it is providing a way to conceptualise these variations in PHC utilisation rates. Andersen and Newman (2005) indicate that this framework explains PHC utilisation by looking at the following three elements: need, enabling, and predisposing factors.

The study uses these elements to understand the factors which affect utilisation of PHC services in Sekhukhune District, South Africa. Need factors such as an individual's perception of health care need, attitude and knowledge towards health care use and other indicators of their health status. Enabling factors include items such as available health care personnel and facilities, waiting time and access to a source of regular care. Need factors are vital in the community and mostly focus on the individual's health problems and functional state of the person. Andersen and Newman's model of health care utilisation has been mainly used for explaining health care utilisation patterns by the general population. The model will also be applied to explore the factors affecting utilisation rate of PHC services in Sekhukhune District, South Africa.

- Predisposing features category: these are the socio-cultural characteristics of an individual that influence their propensity to seek for health care services (Andersen & Newman, 2005). The individual must act wisely when it comes to health care choices and all people with the same features have to act the same way in their search for health care services. These influential predisposing factors are individual's perception of health care need, attitude, values and knowledge towards health care use and other indicators of their health status.
- The enabling features category: is based on assumptions of accessibility, which assumes the possibility of accessing the health facilities is one of the determinants of community member to utilization PHC services. In other words, the utilisation of PHC facility by community members depends on its availability and accessibility.
- The last category is illness level and general health status needs category, which will indicates that the use of PHC services depends on how community members

perceive the necessity of health care services. The theory explores the effect of an individual's perception on the utilisation of PHC services (Andersen & Newman, 2005).

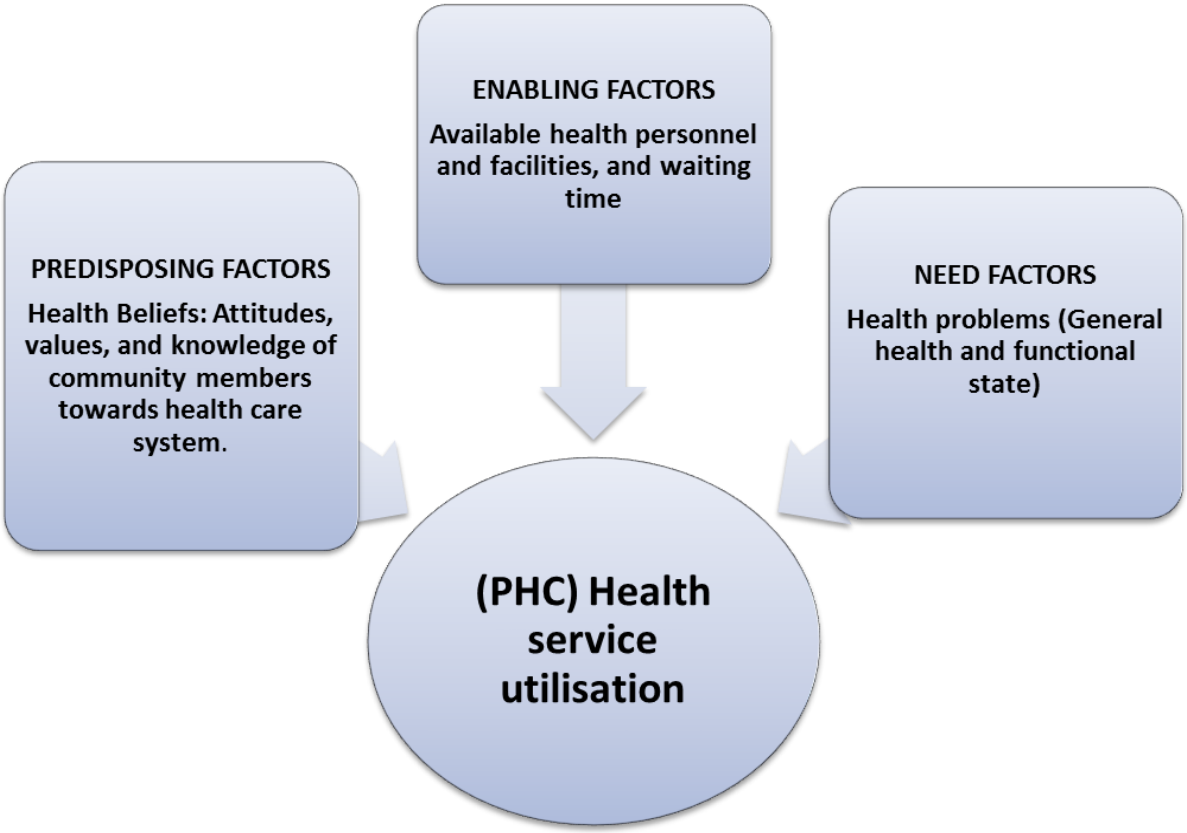

Figure 1: Theoretical Framework (Andersen & Newman, 2005)

2.3 Health care systems in Africa

The health care systems of African countries cannot always be categorized easily as those in developed countries (Chinawa & Chinawa, 2015). Ulise and Carina (2012) state that in the Western Province of Rwanda, health care systems vary with dominant political-economic systems, spanning the entire spectrum from predominantly socialist through socialised, to strongly inclined free-market dispensations. Otieno and Macharia (2014) argue that most African countries are challenged by a double crisis of fragile health care systems and weak human resources. According to the World Health Organisation Report (2016) there are 57 countries that face crippling health care workforce shortages and of those, 36 are located in Africa. WHO estimates that over 4 million health workers are needed to fill the gap and the global deficit of doctors, nurses and midwives in particular is no less than 2, 4 million.

According to Renggli, Mayumana and Mboya (2019) there are clear indications of growing discriminations and inequalities in the health care sector and health care system in African countries. According to Rebhun (2015) one of the criticisms of PHC as a route to achieving the affordable universal coverage is that it provides little attention to people's demands for health care. Shortage of human resources is one of the key structural obstacles facing not only the war against AIDS pandemic, but also the more general health care crisis of which it is the most visible indicator. The human resource problem in the health sector in sub-Saharan Africa has reached crisis proportions in many countries. Although the gravity of the problem varies across the region, the situation in some countries is so grave that urgent action is needed (Oladipo, 2014).

Health care systems in Africa are being drained by an emigration of health care personnel to wealthy countries. According to WHO (2014) the outflow of skilled health care personnel from Africa has reached rates whereby there are more health workers from African countries overseas than in their countries of origin. Rates of health workers migration range from 10% to 60% in some African countries. Gore and Muza (2014) State that many health workers in Zimbabwe are unmotivated to stay because they are poorly paid, poorly equipped, infrequently supervised and informed, and they have limited career opportunities within the civil service. Ulise and Carina (2012) indicated that the health of people in sub-Saharan African countries such as Rwanda is being compromised by disaster, while the health care systems of the continent are not responding adequately and effectively to this predicament.

2.4 Health care system in South Africa

South Africa's health care system comprises of a large public sector, a smaller but fast growing private sector and an NGO sector. The foundation of the PHC system is the PHC clinics that are the first line of access for people needing health care services. This clinics provide their services for free and very few of them are operating for 24hours daily. In South Africa, public sector funding for health care equals 14% of the total government budget and 4% of Gross Domestic Product (GDP) (National Treasury, 2010). Blecher et al., (2011) characterise South Africa's health care system as 'dichotomised', in the sense that it comprises of public and private sectors. However, the public sector is characterised by insufficient resources and systems to deliver adequate health care services to the majority of the population, while in parallel competition with highly resourced private sector that serves a relatively small population of South Africans including the foreigners.

Even though a significant budget is distributed to the PHC sector, the quality of health care services is poor and lack of correspondence in health care access has widened (Blecher et al., 2011). There are 4200 PHC facilities in South Africa with each clinic providing on

average for 13 718 persons. Since 1994, more than 1600 clinics have been built or upgraded (Department of Health, 2015). For 2.5 million South Africans, their nearest clinic is more than 5 kilometres away from their homes. There are 165 371 qualified health care practitioners in both public and private sectors, registered with the Health Professions Council of South Africa. Access to clinics has improved significantly since 1994 but in many instances, the quality of the health care services provided at PHC level has fallen.

2.5 Health care status of South Africa

A major challenge for the PHC services has been the burden of the HIV/AIDS pandemic with more than 6.19 million South Africans, 11.2% of the population of 57.7 million, living with the disease (DoH, 2015). Life expectancy has significantly declined amongst the 15-49 years age group, whereby young women between the ages of 20-30 have the highest prevalence rates and women under 20 years have the highest percentage increase. In 2015, Stats SA reported that 531 965 people died, with 162 455 or 30,5% of these deaths being AIDS-related. This translate into early death amongst youth and economically active people which impact negatively on the economy of South Africa.

South Africa is experiencing major health determinants that results in neonatal mortality rate of 14 per 1000 live births and a maternal mortality ratio of 310 per 100 000 live births. Most causes of maternal mortality are preventable. More than 60 000 children younger than five years of age die each year due to lack of access to quality child health care services and poor child care in homes and within communities. Also, access to mental health care in South Africa remains a challenge, despite the right to health including both physical and mental health. People with disabilities who live in disadvantaged families experience a number of barriers associated with individual and societal poverty and it inhibit their capacity to seek health care even when the needs arises.

There is therefore, a need to re-organise the South African health system so that it addresses the problems of the past. This is supported by the current mission and vision statement of the National Health Act of 2003 which states that: “The vision is a caring and human society in which all South Africans have access to affordable, good quality health care. The mission is to consolidate and build on the achievements of the past five years in improving access to health care for all and reducing inequity, and to focus on working in partnership with other stakeholders to improve the quality of care on all levels of the health care system, especially preventive and promote health, and to improve the overall efficiency of the health care delivery system” (Health System Trust, 2015).

2.6 A comprehensive PHC service package for South Africa

The National Department of Health introduced a comprehensive PHC core package which presents the services that should be rendered for PHC services to be regarded as fully comprehensive or ideal clinic (National Department of Health, 2015). The package attempts to define services in terms of both level of care and approach. Services at the clinics were defined, not by size of the facility, but by the level of skills of the staff. As such, they include services which can be delivered by a professional nurse as part of the common package. Additional services could be delivered if regular visits by doctors or other specialists are organised. For the organisation of clinics, the comprehensive PHC core package suggests three service points, namely children, adults and fast queue, although local clinics may choose different types of organisation (National Department of Health, 2015). The interventions that can be delivered together are clustered in the PHC package in an effort to make the service congruent with the infrastructure and the model of care functioning at the district level (See Figure 2). The PHC package helps to identify shortcomings in both equipment and training needs. It serves as a planning and prioritisation tool focusing on equity, efficiency and cost-effectiveness. In terms of the PHC service package, the following core norms are applicable to all PHC facilities:

- The ideal clinic renders comprehensive integrated PHC services using a one-stop approach for at least 8 hours a day, five days a week.
- Access as measured by the proportion of people living within 5km of a clinic, is improved.
- The ideal clinic receives a supportive monitoring visit at least once a month to support personnel, monitor the quality of service and identify needs and priorities.
- The ideal clinic has at least one member of staff who has completed a recognised PHC course including Nimart.
- Doctors and other specialised professionals are accessible for consultation, support and referral and provide periodic visits.
- Ideal clinic managers receive training in facilitation skills and PHC management.
- There is an annual evaluation of the provision of the PHC services to reduce the gap between needs and service provision using a situation analysis of the community's health needs and the regular health information data collected at the clinic.
- There is annual plan based on this evaluation.
- The ideal clinic has a mechanism for monitoring services and quality assurance; at least one annual service audit.

The core standards for PHC service provisioning amount to the presence of the following (National Department of Health, 2015).

- References, prints and educational resources.
- List of tools that should be available in a PHC setting.
- Medicines and supplies as per the essential drug list for PHC as well as methods for ordering and control of supplies.
- Competencies of health care staff, amongst others the ability to organise and run the facility and to reduce patients' waiting time.
- Patient education where the emphasis is on community participation to improve health awareness.
- Records specifically allied to an integrated standard health information system that facilitates the collecting and utilisation of data.
- Community and home base activities where the importance is on the participation of community stakeholders for support.
- Referral of patients to the next level of care for further management.
- Association with other sectors to improve the promotion of health.

The main framework for the implementation of the package is Demographic and Health Survey (DHS). Due to resource and capacity constraints, it is taken into account that not all districts and local municipalities will be in a position to provide the entire package immediately. The intention was to implement the package incrementally in all provinces, with 2004 being set as the target for full provision and availability of the package in all PHC facilities. However, it soon turned out that the dates set for the implementation of core programmes of the package were unrealistic and overambitious and as a result, materialised only partially. This is further supported by the Sekhukhune District Health Plan which stated that the utilisation of clinics in the district is lower than expected and that clinics will be monitored to ensure 80% implementation of the PHC package (IDP, 2017/18).

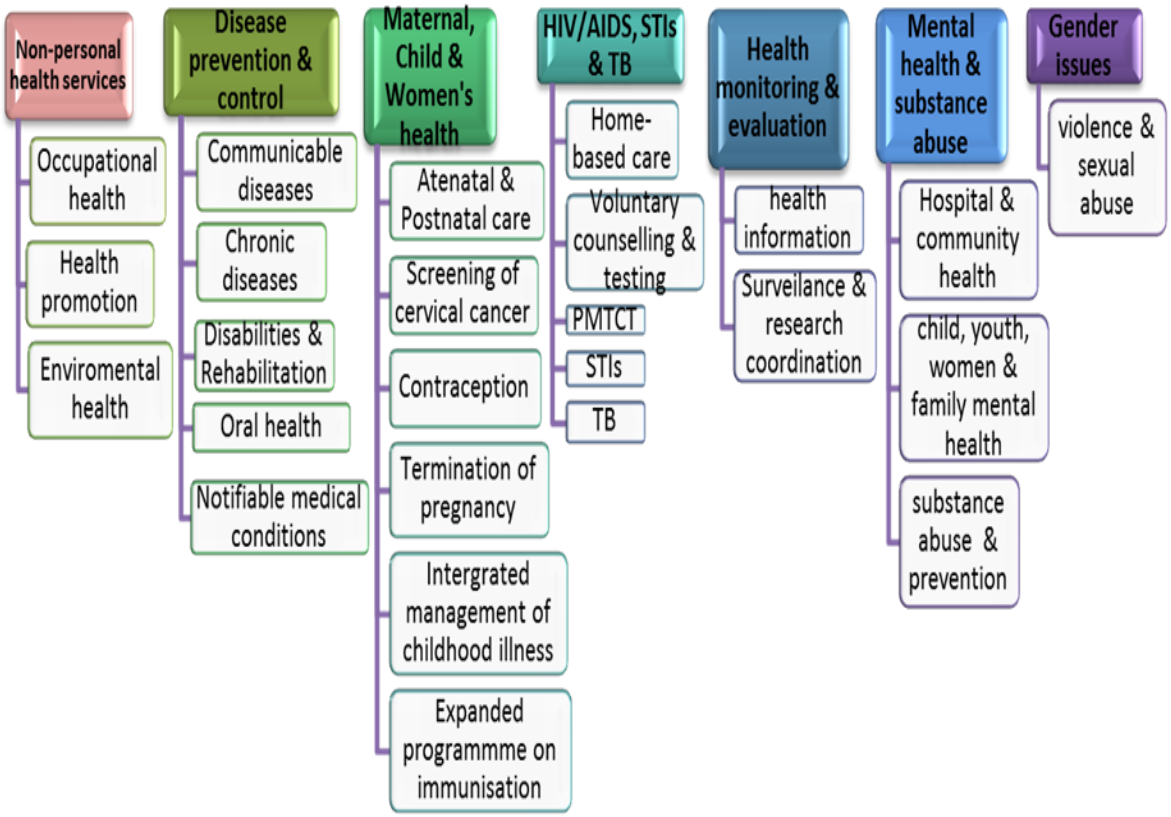

Figure 2: The core PHC programmes and clusters of programmes for Ideal clinic (WHO, 2016).

2.7 Problems within the PHC services

2.7.1 Shortage of nursing staff at the PHC facility

In the Ogun state of South-Western Nigeria, the problem regarding lack of nursing staff in the PHC facilities was worsened by the fact that most nurses were unwilling to work in rural areas (Agbede, Aja & Owolabi, 2015). However, in the Wakiso District of Uganda, shortage of staff was one of the major problems that hindered the efficient delivery of PHC services (David, 2014). In Dekinal local area of Kogi State, Gabriel (2014) found that shortage of staff left PHC nurses with excessive workload, which is impaired by having to master a computerised patient record information system. Having to cope with the new experience, added to their increasing workload puts additional pressure on the already stressed and overworked nurses, and impacted on patients' waiting time. The PHC nurses were expected to cope not only with the increasing workload and their traditional duties, but had to execute tasks normally done by the doctor, and now work that should have been done by administrative personnel.

Umunna (2013) identifies several factors hindering the utilisation of health care services in Nasarawa state. These include institutional factors like infrastructure, staffing constraints and equipment. Others are household factors such as cost of service delivery, stigmatisation and beliefs. In another study conducted in a higher institution in South-West Nigeria, Obiechina and Ekenedo (2013) claim that high cost of drugs, time spent waiting for treatment, inadequate referral service and non-availability of some essential drugs were some of the factors identified as hindering the utilisation of healthcare services. In Odetola (2015) the level of education, nearness to residence, affordability of health care services and quality of services rendered are among other influences that predominantly determine pregnant women's utilisation of health care services in Nigeria.

2.7.2 Poor infrastructures

While most PHC facilities are in various states of disrepair, with equipment and infrastructure being either absent or obsolete, the referral system is almost non-existent (Odetola, 2015). This state of most PHC facilities does not only pose danger to the nation but also affects the rate of utilisation of PHC services. For health outcomes and utilisation of health care services in Nigeria has been found to be low but vary across regions with the Northeast and Northwest regions and rural areas faring considerably worse off than the rest of the country, a pattern largely attributed to the high levels of poverty in the north (Rebhan, 2015).

Renggli et al, (2019) found that regardless of a shortage of health care providers, most rural clinics in Tanzania appeared to be too small for the provision of health care services required. Schoevers and Jenkins (2015) found clinics in the southern Cape/Karoo region too small for the number of patients who visited them on a daily basis. Some clinics in the KwaZulu-Natal (KZN) Province, and North-West Province had inadequate waiting and consulting rooms in their facilities, which resulted in dissatisfaction amongst patients. Moreover, patients' dissatisfaction affected the PHC nurses negatively (Sibiya & Gwele, 2013). Nurses who provide PHC services need isolated working areas to enable them to take patients' history and conduct physical examinations (Austin, Fapohunda, Langer & Orobaton, 2015).

Ibor and Atomode (2014) found that some clinics did not have sufficient consulting rooms and used alternative buildings to provide health care services. Existing clinic buildings in some areas needed urgent renovation, as the buildings were not properly maintained. This problem impacted negatively on the delivery of PHC services.

2.7.3 Shortage of resources such as medical equipment and medication

The shortage of medicine in the clinics contributed to some patients‟ health-seeking behaviour. An organisation that functions without the required supplies poses a problem to

those providing the service. This applies to health care services, especially at PHC level where a PHC nurse is obstructed from delivering services efficiently. Onyenebo, Amazigo, Njepuome, Mwaorgu and Okeibunor (2016) found that shortage of supplies and equipment as well as the poor state of available equipment in some clinics act as an obstacle to the delivery of quality health care services.

As a results of underutilisation of PHC due to poor supply of medical resources, Nigeria has the second largest incidence of maternal deaths globally. Nigeria records about 14% of global maternal deaths, with an estimated 36 698 maternal deaths in 2013 (Gabriel, 2014). In addition, poor utilisation of health care services leads to infant mortality. Although recent estimates show that the under-five mortality rate has declined from 213 per 1000 live births in 1990 to 128 per 1000 live births in 2013 (UNICEF, 2014).

Shortage of equipment also affected the quality of follow-up of patients diagnosed with diabetes. Some of the specific procedures that could not be done were checking of weight and blood pressure (Dominic, Oluyemi & Lady, 2015). Even though some nurses were well trained, it was difficult for them to make a difference due to shortage of equipment. Some of the problems that patients present, cannot be managed successfully without the availability of the relevant equipment. PHC nurses need equipment to properly assess patients.

Bresick et al, (2019) found that in Limpopo Province also experienced problems with the availability of equipment and supplies, particularly emergency equipment like suction machines and oxygen, which could not only prevent quality PHC services but also put patients' lives at risk. Emergency equipment must always be available and be in good working condition as emergencies can occur at any time in a PHC setting.

However, Mukiapini et al, (2018) found that the situation had not improved. There were no thermometers in some clinics in Du noon, which is a basic but important piece of equipment in any PHC clinic, as well as glucometers and ophthalmoscopes (Mukiapini et al, 2018). Early diagnosis of chronic diseases such as diabetes mellitus requires the appropriate equipment followed by proper monitoring. Therefore, shortage of equipment is a major problem that negatively impacts and results in poor or inadequate health care that the community receives, especially the disadvantaged families who depend on public service only (Mamunur & Diddy, 2014).

2.7.4 Poor road infrastructures and transport problems

Transport facilities are an important indicator of the mobility of a particular community. The members of the community should be able to travel from their respective homes to a health facility when they seek medical attention (Musah & Kayode, 2014). In Chipinge South district

of Zimbabwe, Gore, Muza and Mukanangana (2014) found that a shortage of transport seriously affected the provision of health care services and outreach programmes, including mother and child services, expanded programme of immunisation, and the supervision of health care services provided. Nurses in the rural areas in particular, could not move from one point to another due to lack of transport. This affected nurses who did not live near the clinics. These were among the problems encountered by the public sector in relation to PHC services after the introduction of free health care services in Zimbabwe.

However in the Eden and Central Karoo district of Western Cape Province, South Africa; Schoevers and Jenkins (2015), found that transport problems prevented nurses from doing home or school health care visits. Sibiya and Gwele (2013) found that nursing students experienced serious transport problems when they had to do their practical training in rural areas in particular.

The success of PHC services depends on a good referral system that also includes reliable transport (Mamunur & Diddy, 2014). Patients need to be transferred to referral hospitals when referred for more specialised treatment. Gabriel (2014) found that ambulances were only called for emergencies and maternity patients while other referrals either had to use their own transport or resort to public transport due to shortage of an ambulance in the clinic.

2.7.5 Lack of support from the community members and other stakeholders

Some communities in Tanga region of Tanzania did not accept the professional nurses and did not take part in community health care projects (Stefan, Battazar & Steffen, 2015). For instance, instead of supporting the clinics, some community members stole equipment and medicines from them. Heavily populated areas where there is high rate of theft, hindered the provision of quality PHC services (Musah & Kayode, 2014). Frustration and unhappiness in the workplace could hinder the effective rendering of health care services. In Australia, Kafferi (2011) found that nurses were frustrated when the organisation did not support them in their quest for a holistic approach to nursing services. It is important to support PHC nurses to prevent frustration at functional level by doing everything possible at managerial level.

Effective leadership is vital for quality PHC services. Applying their knowledge and experience, and supporting nurses would limit frustration in the workplace, which would have a positive effect on health care services (Fana & Felix, 2014). Less frustrating situations improve productivity and ultimately benefit patients. Lack of support has a negative impact especially on nurses who are determined to work in disadvantaged and rural areas. Lack of managerial support for PHC nurses is a problem (Egbewale & Odu, 2013). For example, Muriithi (2013) found inadequate coordination in PHC services of the Nairobi Slum local

authority in Kenya and Zyaambo, Siziya and Fylkeshes (2012) found limited collaboration between community health care services in the Zambia.

Van Pressentin et al, (2018) found no support and guidance from district managers in the community health centres of the Gauteng province. Moreover, planning by senior nurses at functional level was sometimes discouraged and did not motivate the staff providing PHC services (Gakii, 2013). A further cause for concern was problems in the formation of health care committees in the central area of the Gauteng province (Van Pressentin et al, 2018). Since health care committees take part in the planning and smooth running of clinics, it is important that such committees be formed. One of their functions is to support nurses and mediate issues in the community. Communication is an essential requirement for effective patient care (Obiechina & Ekenedo, 2013). There are numerous barriers to communication in institutions including personal prejudice, language, cultural issues or ignorance (Oladipo, 2014). Language, gender stereotypes, group identity, social background and culture are some of the issues that cause misunderstanding and confusion; ultimately poor relationships between health workers and patients (Kimani, Mugo & Kioko, 2016). Intercultural communication is very important in health care centers of Kenya (Otieno & Macharia, 2014).

2.7.6 Safety problems

Onyenebo et al., (2016) emphasises that every health care provider needs to work in a safe environment as safety is a basic human need and right. This right should be afforded any health worker, irrespective of the environment where the service is provided. A safe environment ensures free movement and execution of tasks in a relaxed atmosphere. A stable community is the one that is “safe and healthy” (Rajendra & Jhaika, 2013). PHC nurses need safe environments to deliver quality health care.

The safety of PHC nurses “whilst on duty has recently become a serious concern” (Musah & Kayode, 2014). Safety of PHC personnel is of particular importance as they are mostly female and only a few nurses are on duty at certain times of the day and/or night. The lack of safety for PHC nurses in PHC settings exacerbates the shortage of staff. PHC nurses on night shift may be more at risk of thugs threatening them, especially if security personnel are few and not well armed.

2.7.7 Migration and long queues

Some years back the Zimbabwean government introduced programmes to provide free health care to communities with a limited income (Gore et al, 2014). This strategy was also used in South Africa to redress the inequalities that existed in health care services (Sibiya & Gwele, 2013). In Zimbabwe it was however proved to be unsuccessful and health care services were affected negatively due to the financial burden on the government and the

increasing level of poverty in communities (Gore et al., 2014). Health care services were fragmented before independence and then centralised. During this period there were serious shortages of resources especially human resources (Awiti, 2014).

2.8 Conclusion

The literature review focused on problems that made it difficult for community members to access quality PHC services. The problems included shortage of nursing staff/health providers at the PHC facility, inadequate clinic buildings or poor infrastructures, shortage of resources such as medical equipment's and medication, transport problem, lack of support from the community members and other stakeholders, safety problems, and migration and long queuing.

CHAPTER 3

METHODOLOGY

3.1 Introduction

This chapter details the research methodology. It provides a road-map, as well as the methods with which the research was scientifically carried out to achieve the objectives. The topics covered are the study design, study setting, the population and sampling, pre-test, plan for data collection and data management and analysis, issues of trustworthiness, ethical considerations, and lastly, the plan for dissemination and implementation of the results.

3.2 Study design

Research design is a structure or plan of the research which provides the glue that holds a project together, groups or samples, observations or measures, programmes or treatments and other aspects of the methodology (Patten, 2016). Burns and Groove (2013) describe research design as “a plan that describes how, when and where data will be collected and analysed”.

3.2.1 Qualitative research approach

Kumar (2014) states that qualitative research focuses on the experiences of people and stresses the uniqueness of the individuals. Burns and Grove (2013) describe a qualitative approach as “a systematic subjective approach used to describe life experiences and situations to give them meaning”. This research used the qualitative approach, to explore the behaviors, perspectives and experiences of the community members in the selected rural villages of Sekhukhune District regarding the factors affecting the utilisation rate of PHC services. Subsequently, Patten (2016) describes qualitative research as “a form of social enquiry that focuses on the way people interpret and make sense of their experiences and the environment in which they live”. The qualitative research methodology helps the researcher understand the population’s unique dynamics and effectively obtain culturally specific information (Nieswiadomy & Bailey, 2017).

The primary reason for using qualitative approach in this study was to explore and describe the opinions of community members on factors affecting utilisation rate of PHC services. A qualitative approach was appropriate to accurately capture the opinions of the community members. The research was concerned with providing more insights into how the low utilisation rate of PHC services leads to high HIV, TB and mortality rate in the selected villages, and how it negatively affects community members’ health.

3.2.2 Exploratory approach

Polit and Beck (2014) state that explorative studies are undertaken when a new area is being investigated or when little is known about an area of interest. It is used to investigate the full nature of the phenomenon and other factors related to it. In this study, the opinions of the community members regarding factors affecting utilisation rate of PHC services was explored through one-on-one interviews. Although the research was conducted to unearth the factors affecting utilisation of PHC services, the little that was known about the opinion of community members regarding the topic was brought forth.

3.2.3 Descriptive approach

According to Burns and Grove (2013) descriptive research "is designed to provide a picture of a situation as it naturally happens". It may be used to justify current practice, make judgment and also to develop theories. For the purpose of this study, descriptive research was used to obtain a picture of community members' opinions on factors affecting the utilisation rate of PHC services, with a view to eliminate those factors in their community.

3.2.4 Contextual approach

Context is vital in qualitative research. According to LoBiondo-wood and Haber (2017) context includes the "environment and conditions in which the study takes place as well as the culture of the participants and location''. The participants in this study were community members' aged between 18 and 70 years in the selected rural villages. The setting was Dithamaga and Ga-Mashishi villages in Tubatse Sub-district under Sekhukhune District. The opinions of community members regarding the factors affecting utilisation rate of PHC services cannot be studied outside their context and therefore, dependent on the context and the time.

3.3 Study setting

Burns and Grove (2013) state that a research setting is an environment in which the research takes place and can be a natural or controlled environment. Natural settings are real-life study environments without any changes made for the purpose of the study. The study was conducted at selected villages of Sekhukhune district in Limpopo province South Africa. Sekhukhune District Municipality is a typical rural municipality consisting of five sub-districts namely: Greater Tubatse, Ephraim Mogale, Elias Motsoaledi, Fetakgomo and Makhuduthamaga, with 764 villages, 263 802 households and 1, 169 762 people (STATSSA, 2016).

Greater Sekhukhune District Municipality is located about 261 kilometers from Polokwane, 123 kilometers from Pretoria. It is characterized by a scattered pattern of human settlement. The road network links most areas, but the quality of the roads is poor, which impedes

development in many other areas. The Greater Sekhukhune Municipality has the lowest access to infrastructure amongst the districts in the province, where 234 095 households are living in formal dwellings and more than 10 107 households still reside in traditional dwellings such as mud houses. In a province which is regarded as one of the poorest in the country, Sekhukhune District can be regarded as the 'poorest of the poor'. Visagie and Schneider (2014) state that poverty has been recognised as a major cause of ill-health and as a barrier to accessing health care services in the rural areas of South Africa. According to STATSSA (2016) 23 million people in South Africa were reported to be living in poverty, including 6, 7 million people from Limpopo, of whom 4,2 million people experienced difficulties in accessing health care services.

The Tubatse Local Municipality is found in the North-eastern part of the District *see* Figure 3 below. Tubatse Municipality is located on the North of the N4 highway to/from Middleburg, Belfast and Mbombela; and East of the N1 highway to/from Groblersdal and Polokwane. According to STASSA (2016), the total population of this municipality is approximately 335 767, with 83 199 households and 210 villages; these makes Greater Tubatse Local Municipality a municipality with the highest population in the Sekhukhune District. Due to its rural nature; the municipality is confronted with a high service delivery backlog. Furthermore, the majority of the settlements are far apart, which makes the provision and maintenance of services very costly. In addition, some of these areas are too small to attain the economic threshold required to provide social facilities in a cost-effective manner.

In Sekhukhune District, there is one provincial hospital, five community hospitals, 43 clinics and eight mobile clinics. In 394 of the villages, including Dithamaga and Ga-Mashishi, there are no health care facilities or even mobile health care facilities, due to shortage of staff and other resources; such as emergency vehicles. However, accessibility to PHC remains a challenge due to poor roads and inadequate transportation. On average there is one clinic for every 17 000 people within the district and approximately 97 500 people per hospital (Ngomane & Mulaudzi, 2010).

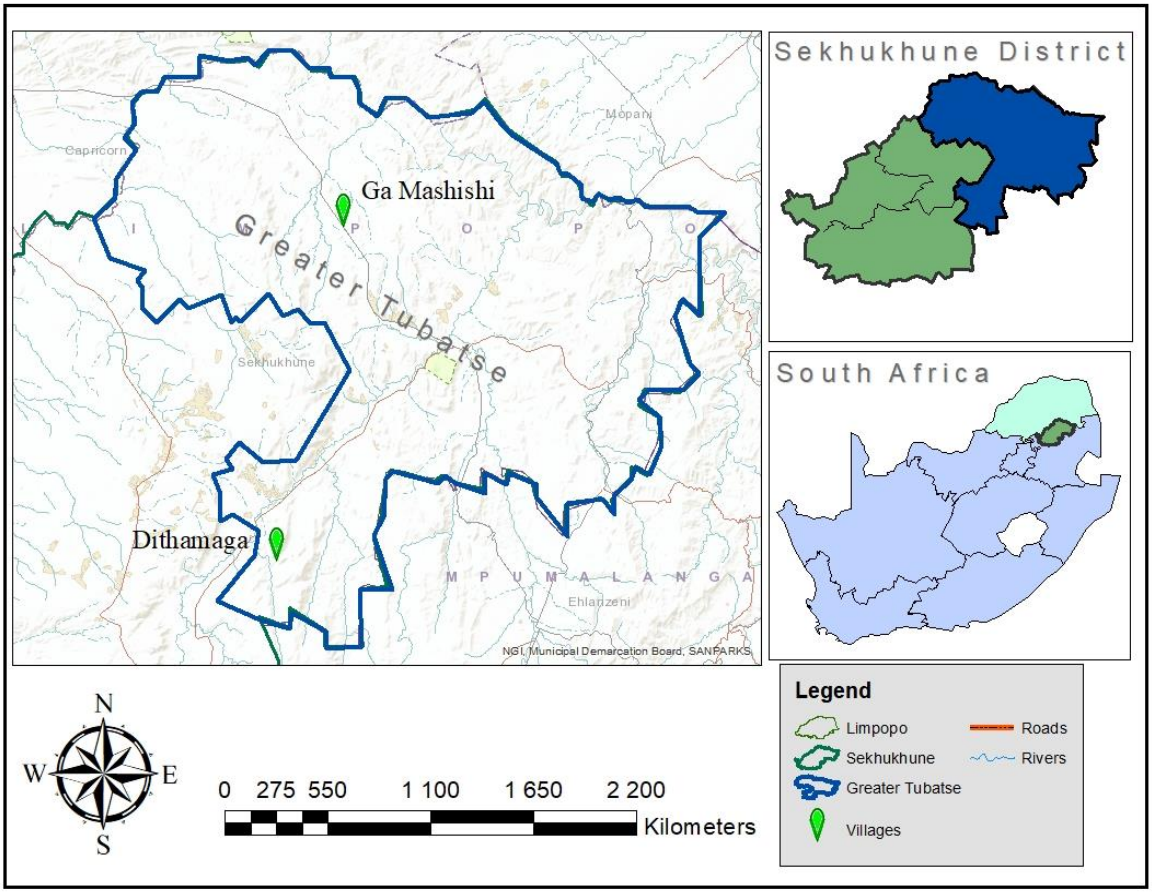

Figure 3: Map of Greater Tubatse Municipality (ESRI, 2018)

3.4 Study population and sampling

3.4.1 Study population

The research focuses on the different cultures and religions of individuals that are gathered within the same village. According to Polit and Beck (2014) a population is the number of possible elements that can be included in the study. Population of this study are all the community members utilising the PHC facilities within the selected villages of Sekhukhune District.

3.4.2 Sampling

The need for sampling is something that is almost invariably encountered in most health-related research. Sampling is a process of choosing elements which are the basic units from which data and information was collected, to represent the entire population (LoBiondo & Haber, 2017). Multistage sampling was used to sample a district, sub-district, villages and participants.

3.4.2.1 Sampling of district

The districts with low PHC utilisation rate were sampled purposefully out of all the districts in Limpopo Province; namely Vhembe, Capricorn, Mopani, Waterberg and Sekhukhune. During the Integrated Development Plan(IDP) review (2015/2016), PHC utilisation rate of Sekhukhune District was found to be comparatively low, at 1,5 visits per person annually (compared to the national average of 2,1 visits), while the expected rate is 3,2 visits per person annually.

3.4.2.2 Sampling of sub-districts and villages

The Sekhukhune District consists of five sub-districts; namely Greater Tubatse, Ephraim Mogale, Elias Motsoaledi, Fetakgomo and Makhuduthamaga. The sub-districts and villages with low utilisation rate were sampled purposefully. A non-probability, purposive sampling method depends on the researcher's judgement in selecting the participants (Patten, 2016). The Tubatse sub-district consists of 192 villages and only two villages (Dithamaga and Ga-Mashishi) were sampled purposively due to their low utilisation rate of PHC among other villages.

3.4.2.3 Sampling of participants

Before conducting interviews, participants were selected using a probability approach guided by the simple random sampling technique. The researcher used a table of random numbers consisting of households stand number (Polit & Beck, 2014). Therefore, simple random sampling technique was used to select a participant in each household. The researcher generated a table of random numbers by computer, this was effective enough for the researcher because there were 20 households selected out of 54 780 households in Dithamaga village and 30 other households were selected out of 64 769 households in Ga-Mashishi village (Census, 2016; Community Survey, 2016). One participant was selected per household. In Dithamaga village 20 participants were selected and another 30 participants were selected in Ga-Mashishi village. Home visits were done by the researcher to the selected households.

3.5 Data collection tools

The researcher used the unstructured interview guide (annexure A) to acquire the information. The researcher chose the unstructured interview as a tool because it was appropriate for the topic and it allows the participants to produce more information by sharing their knowledge of life and conditions (Newton, 2010). An opening question, "How do you utilise the PHC services?" was used to start the interview and additional questions were asked to probe deeper. The questions were translated into Sepedi by Mafeye Morapedi of Bangwadi Consultant, as the language is used primarily in these villages.

3.6 Pre-test

Pre-testing refers to a small study conducted prior to the main research, to determine whether the methodology, sampling method, data collection instrument and analysis are adequate and appropriate for the study to be conducted (Bryman, 2016). In this study the researcher did a pre-test to check if the data collection technique was appropriate. The researcher also wanted to check whether participants had some difficulties in answering questions. Pre-testing helped the researcher to make some few adjustments before collecting the final data, such as deserting emotional questions. After pre-testing, the data collection technique was improved and modified to be friendly with the participants (LoBiondo-Wood & Haber, 2014). The pre-testing was conducted at Dithamaga village with 6 participants, sampled through simple random sampling using set criteria, and located in Tubatse sub-district. This village forms part of the study (Goodman & Moule, 2014).

3.7 Plan for data collection

The researcher engaged with the community members when she visited the tribal office to request permission from the headman. As most of the community members were there for chief's kraal meeting, the researcher passed the information to the community members about the research project and its purpose. When the researcher did home visits to each household, they re-explained the purpose of the research to the potential participants. The researcher arranged with the home-based care givers to make appointments with the selected household prior to each visit.

The researcher interviewed the participants in their households. Brink, van der Walt and van Rensburg (2012), defines an interview as a method of data collection through which an interviewer obtains responses from a participant in a face-to-face situation. An in-depth interview was conducted in Swati and/or Sepedi as these are the languages spoken by the participants. The interview was conducted one-on-one in each selected household. Each interview lasted for approximately 45 minutes to allow the participant to speak his/her heart out, with no rush. Before interviews all participants were informed about the process of collecting data through an information sheet (Annexure B) and they signed a consent form (Annexure C) prior to commencement of interviews. The researcher explained and got consent from the participants regarding the use of an audio recorder to record each interview and document all the fields' notes. Data saturation was reached after interviewing 50 participants.

3.8 Plan for data management and analysis

Data analysis is the systematic organisation and synthesis of research data (LoBiondo-Wood & Haber, 2017). The collected data was analysed using thematic analysis method.

Data analysis thus entails categorising, manipulating, ordering and summarising the data and describing it in a meaningful way. The data obtained from the interviews was analysed through the following steps:

- **Transcribing data**

  The researcher transcribed the data from the audiotapes and in correspondence with field notes, to ensure that the transcripts are accurate. To ensure the reliability of data coding, the researcher got an assistant who verified the data from the audiotape (Newton, 2010). To ensure quality and accuracy of the transcribed data, the researcher transcribed the data on her own (Polit & Beck, 2014). This brought the researcher closer and familiar with the data.

- **Developing a category**

  After transcribing the data, the researcher read and organise it carefully, identifying underlying and clustering concepts. This assisted in forming a strategy for classifying and indexing the data, as well as developing category themes. The researcher also converted the data into smaller and more manageable units that can be reviewed and retrieved. The category themes were developed based on the scrutiny of the actual data.

- **Coding data**

  After developing the category themes, the researcher read the data and the assistant coded it for correspondence with the categories. To fully comprehend the underlying meaning of some aspect of the data, the researcher read the categories several times. The researcher also coded the entire data set to achieve the highest possible coding consistency of the interviews (Polit & Beck, 2014).

The data was grouped according to the findings from the different interviews. Then the results of the study was described in detail in chapter five of the study. Final checking of original transcripts was done to ensure that all the information that needs to be categorised was attended to (Bryman, 2016)

3.9 Trustworthiness

3.9.1 Credibility

Creswell (2013) defined credibility as the confidence that can be placed in the truth of the research findings by a researcher and other readers. Credibility establishes whether or not the research findings represent credible information drawn from the participants' original data and is a correct interpretation of the participants' original views (Brink et al., 2012). Credibility exists when the research findings reflect the perceptions of the people under

study. In this study to establish the rigour of the inquiry the researcher adopted the following credibility strategies:

- **Prolonged engagement:** This refers to investment of sufficient time to learn the culture, to test for misinformation, and build trust with the participants (Burns & Grove, 2011). During data collection the researcher stayed with the participants until data saturation.
- **Persistent observation**: This involves identification of characteristics and elements in a situation that are most relevant to the research problem. Specific situations regarding the phenomenon under study will be observed over a sufficient period, to identify specific aspects relevant to it. Persistent observation provides depth to the study. In this study, the researcher wrote down field notes, observed, identified and assessed the participants' behaviours during the interview.
- **Member checking**: One of the purposes of conducting member checking is to give the participants the opportunity to correct errors and challenge interpretations. According to Creswell (2013) member checking requires the researcher to return to the participants who participated during the study and discuss the interpretation of the collected data. The researcher made appointments with the participants and requested them to listen to the audio recordings. The researcher also discussed the interpretation with the participants after each interview, in order to verify the overall interpretation and meaning towards the final conclusion of the study. Member checks also provided an opportunity to summarise the collected data. This is regarded as the first step towards data analysis (Burns & Grove, 2013).
- **The peer debriefing**: Is defined as the process of exposing oneself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the researcher's mind. In this study, the researcher presented the collected data to other experienced researchers to ensure honesty.

3.9.2 Transferability

According to Polit and Beck (2014) transferability refers to the ability to apply the findings of the qualitative research to other contexts with other participants. However, Creswell (2013) believes that the researcher facilitates the transferability judgment by a potential user through a thick description and purposeful sampling. Therefore, in this study the researcher ensured that the collection and provision of detailed description data within the given context was accurately done and a purposive sampling technique was adopted to sample.

3.9.3 Dependability

According Babbie (2010) dependability refers to the provision of the evidence, such that if it were to be repeated with the same or similar participants in the same or similar context, its findings would be similar. It involves participants evaluating the findings and the interpretation and recommendations of the study, to make sure that they are all supported by the data received from the informants of the study (Cohen, Manion & Morrison, 2011). Therefore, in this study the researcher ensured dependability by using an enquiry audit that was performed by an external auditor, to examine the documentation. Stepwise replication was done by an independent coder and then compared with the findings (Ary, Jacobs, Razavieh & Sorensen, 2010).

- **Stepwise replication**: This approach involves several researchers who can be divided into two teams, to conduct separate inquiries with a view to comparing data as well as conclusions. Data and conclusions were compared by the research supervisors.
- **Inquiry audit**: This refers to data and relevant supporting documents being scrutinised by a peer reviewer. The supervisors of this research audited the research project.

3.9.4 Confirmability

Brink et al., (2012) stated that confirmability refers to the potential for congruency of data in terms of accuracy, relevance or meaning, and it can be confirmed or corroborated by other researchers. Confirmability is “concerned with establishing whether data and interpretations of the findings are not figments of the researcher’s imagination, but are clearly derived from the data that is provided by the participants” (Creswell, 2013). In this study, confirmability was achieved through reflexivity and triangulation.

- **Reflexive:** Reflexivity is a continuous process whereby researchers reflect on their preconceived values and those of the participants, such as reflecting on how data collected will be influenced by how the participants perceive the researcher (Creswell, 2013). However, Patten (2016) state that researchers should reflect on their own actions, feelings, conflicts and experiences they encountered during the research. To achieve credibility of the study, the researcher adopted a self-critical stance to the study, the participants, their roles, relationships and assumptions.
- **Triangulation**: was used to improve the probability that the findings and interpretations can be credible.

3.10 Ethical considerations

3.10.1 Permission

Code of ethics must be followed when conducting a research to avoid human rights violations that might occur during the process of conducting a research (Streubert & Carpenter, 2011). The researcher maintained the research ethics when conducting the research, to avoid violation or contravention of human rights. The ethics that were followed in the study are concisely presented below. Furthermore, the research proposal was presented to the Higher Degrees Committee of the School of Health Sciences, University of Venda and submitted to the University Higher Degree Committee for quality control. Then it was reviewed by the University Research Ethics Committee.The researcher also requested permission to collect data from the chief of the selected villages. The ethical clearance letter was issued by University of Venda Research Ethics Committee.

3.10.2 Ethical principles observed

3.10.2.1 Informed consent

Streubert and Carpenter (2011) argue that whatever the case, when subjects are involved without their consent, the right to self-determination is impaired because informed consent means that the participants must have all the required information regarding the study, and have the power of free choice, enabling them to consent voluntarily to participate in research or to withdraw from participating. The participants were informed about the study before they participated. They were briefed on what the researcher wants, who's going to benefit, and what is expected from them, that their participation is voluntary and should participants feel unable to continue with the study, they were free to withdraw. Therefore the information was given through a participant information sheet (Annexure B), each participant willing to participate was given a consent form to sign (Annexure C).

3.10.2.2 Confidentiality and anonymity

The information obtained by the researcher remained confidential at all times. However, the supervisors and the research assistant had access to the information that was given by the participants during data collection. Polit and Beck (2014) defined anonymity as a state whereby a participant's data should not be associated obviously with his or her name or any other identity. Participants' name did not appear on any of the documents used and the data recorded did not identify the participants' in any form. The data was kept confidential all the time and was discarded upon completion of the study.

3.10.2.3 No harm to the participant

Streubert and Carpenter (2011) stated that the code of ethics have been established for conducting research, to guard the participants' human rights against violations that have

occurred in the past. The study should not injure or damage the object/person participating in it, regardless of whether they volunteer for the study or not. Therefore, in this study, the interview was done in the participant's house. All the participants' decisions were respected, to avoid violation of their human rights.

3.11 Plan for dissemination and implementation of results

A copy of the report is submitted to University of Venda. The results of the study will be published in accredited journals and a copy will be kept at different libraries. A copy will be submitted to the Department of Health, Limpopo Province, and the information will be presented orally at Provincial Research Day; workshops, national and international conference, and/or published in peer-reviewed journals.

3.12 Conclusion

This chapter covered the research design and methodology, including the population, sample, data collection and research instrument, data analysis, ethical principles and plan for dissemination and implementation of results.

CHAPTER 4

RESULTS, INTERPRETATION AND DISCUSSION

4.1 Introduction

This chapter discusses data analysis and interpretation. In this section five major themes derived from the data are discussed.

4.2 Characteristics of participants

Data was collected in two selected rural villages (Dithamaga and Ga-Mashishi) between May and June 2019. There were 50 participants who were interviewed for data collection.

Table 4.1 below depicts the demographic information, gender, age, marital status, occupation and clinic attendance status of community members residing in Dithamaga and Ga-Mashishi who participated in the study.

Table 4.1: Demographic information of participants

Characteristics	Dithamaga	Ga-Mahishi	Total
Gender			
Male	06 (12%)	11 (22%)	17 (34%)
Female	14 (28%)	19 (38%)	33 (66%)
Age			
18-19	02 (04%)	01 (02%)	03 (06%)
20-29	05 (10%)	13 (26%)	18 (36%)
30-39	05 (10%)	08 (16%)	13 (26%)
40-49	05 (10%)	03 (06%)	08 (16%)
50-59	01 (02%)	02 (04%)	03 (06%)
60-69	02 (04%)	02 (04%)	04 (08%)
70-79	0 (0%)	01 (02%)	01 (02%)
Marital status			
Single	05 (10%)	08 (16%)	13 (26%)
Married	14 (28%)	20 (40%)	34 (68%)
Widow/widower	01 (02%)	02 (04%)	03 (06%)
Occupation			
Employed	05 (10%)	10 (20%)	15 (30%)
Unemployed	15 (30%)	20 (40%)	35 (70%)
No of visits			
None	11 (22%)	13 (26%)	24 (48%)

Once	03 (06%)	07 (14%)	10 (20%)
Twice	03 (06%)	04 (08%)	07 (14%)
Thrice and above	03 (06%)	06 (12%)	09 (18%)

Table 4.1 shows that 50 participants were interviewed, 30 participants (60%) were from Ga-Mashishi village and 20 participants (40%) were from Dithamaga village. Majority of the participants were unemployed 35 (70%) and very few were employed 15 (30%) in both villages. Gender distribution of the 50 participants revealed that 17 of the respondents were males (34%), and 33 were females (66%). These findings are in line with the predominance of females attending PHC more than males in South Africa (Demographic and Health Survey, 2016; STASSA, 2017).

The findings further showed that the majority 34 (68%) of the participants were married, then 13 (26%) were single and very few 3 (6%) were widows. Subsequently, the findings revealed that 24 (48%) participants were not visiting PHC facilities at all throughout the year and about 10 (20%) participants visited only once a year. Those who visited PHC facilities twice a year were 7 (14%), those who visited three times a year were 5 (10%), and those who visited the PHC facilities four times a year were 9 (18%).

4.3. Presentation of findings of the study

The data was presented according to two constructs, namely predisposing and enabling factors (Anderson, 1973), as theoretical framework used to guide the study, see the table below (Table 4.2). The findings of this study are presented with direct quotations of participants alongside the themes and categories. Similar information emerged and data was presented concurrently only highlighting where datum complement or contradict each other. Table 4.2 shows five major categories, one under predisposing and four under enabling factors that emerged from the study.

Table 4.2: Factors affecting utilisation rate of PHC services within the community.

Themes	Categories	Sub-categories
Predisposing factors	Socio-Cultural factors	• Traditional, cultural norms and beliefs regarding PHC services. • Attitudes of professional nurses towards community members.
Enabling factors	Availability of resources	• Insufficient material resources. • Shortage of health care providers • Health care infrastructure.

		• Delivery of primary health care services.
	Organisational factors	• Average waiting time to see a nurse or a doctor. • Operational time for PHC facility
	Environmental and economic factors	• Transport and financial issues.
	Physical factor	• Personal limitations

4.3.1 Theme 1: Predisposing factors

These are the socio-cultural characteristics of an individual that influence their propensity to seek for health care services (Anderson & Newman, 2005). The individual must act wisely when it comes to health care choices and all people with the same features have to act the same way in their search for health care services. These influential predisposing factors are an individual's perception of health care need, attitude, values and knowledge towards health care use and other indicators of their health status. One category emerged during analysis under this main theme. The following is the tale that emerged; socio-cultural factors.

4.3.1.1 Category 1: Socio-cultural factors

The study reveals that there are some socio-cultural challenges faced by community members residing in Dithamaga and Ga-Mashishi villages when they need to utilise PHC services. The sub-categories that emerged were; traditional and cultural norms and beliefs regarding PHC services and attitudes of professional nurses towards community members.

4.3.1.1.1 Sub-category: Traditional, cultural norms and beliefs regarding PHC services

The study participants reported a number of social and cultural issues prohibiting community members when deciding to seek and reach health care facility. Amongst these factors were: traditional, cultural norms and beliefs regarding PHC attendance.

Participant G47: *"After we have buried my mother I was instructed by elders to stay indoors for 6months without going outside the gate of the yard due to cultural believe in the family. Due to respect that cultural practice I ended up defaulting my Hypertensive treatment for that 6months because I was not allowed to go to place where there is a lot of people"*

Participant D3: "*I have seven children and I was supposed to have eight children by now but my first born died at the clinic because he breathed infected/contaminated air*

of the people I delivered with them same time in the clinic. So because of that I decided to deliver the rest of my children at home because it is safe for my babies and they are all alive and healthy now".

Understanding social and cultural issues is necessary to recognise 'seeking care' behaviours of the population or communities. Participants indicated that culture played different roles in health care seeking behaviour. Culture was said to influence the way in which participants utilise PHC services. Previous studies show that sharing cultures and languages facilitate information sharing and influence PHC service utilisation within communities. On the other hand, different languages in a multi-ethnic setting affect the utilisation of PHC services in Canada due to the migrant population (Moore, Alex-Hart & George, 2011).

In other countries home deliveries are encouraged due to the beliefs, perceptions and culture of certain communities. While on the other hand, in maternal and child services in PHC centres in rural of Ogun State Nigeria, Agbede, Aja and Owolabi (2015) observed that an increased tendency for persons living with extended family members has a higher rate of home delivery.

4.3.1.1.2 Sub-category: Attitudes of professional nurses towards community members.

In the study participants expressed different views regarding the attitude of health care providers when seeking the service rendered in the PHC facility. Most of the participants confirmed that young nurses don't help them with respect despite being qualified professionals.

Participant G39: "*I don't feel comfortable to go the clinic when I'm sick anymore, because last time I visited the clinic there was this other young nurse who was assisting me in a very shouting manner. Other patients who were sitting in the waiting area could hear everything because she was not showing some respect towards me as patient".*

Participant G34: *"I no longer go to the clinic because nurses they don't care about our lives. Two my sisters delivered their babies at the gate of the clinic in the two different occasions, while nurses are inside the nurses' house in the clinic and they refused to come out".*

Participants feel that they still deserve respect and privacy when they visit the clinic for consultation even if there is shortage of health care providers. Another study in Uganda Wakiso district indicates that poor staff attitude at the PHC clinics is one of the barriers to

utilisation of health care services at PHC facilities (David, 2014). These study findings were further supported by Renggli et al, (2019) who argue that a bad experience with the health care system has an influence on deciding when to seek care.

4.3.2 Theme 2: Enabling factors

The enabling factors are based on assumptions of accessibility, which assumes the possibility of accessing the health care facilities, as one of the determinants of community member to utilisation PHC services. In other words, the utilisation of PHC facility by community members depends on its availability and accessibility. Four categories emerged during analysis under this main theme. The following are the tales that emerged: availability of resources, organisational factors, environmental and economic factors and physical factors.

4.3.2.1 Category 2: Availability of resources

The study shows availability of resources has effects the utilisation rate of PHC services on the in Dithamaga and Ga-Mashishi villages. The contributory factors to underutilisation rate of PHC services which were identified included: Material resources, Health providers, Health care infrastructure and Organisation of health care services.

4.3.2.1.1 Sub-category: Insufficient material resources

The current study findings revealed that most participants were defaulting treatment due to the unavailability material resources such as treatment and other supplies; as well as a lack of resources relating to infrastructure and equipment. The other participant verbalised that community members had limited access to health care and emergency services. The other participants confirmed that having just one mobile clinic in the area was responsible for the limited access to health care by community members.

Participant G35*: "I have spent three months without my chronic treatment because they are not available at the clinic and I can't afford to buy them. Now I have been collecting large amount of lemons from my uncle's yard because I depend on lemons to neutralize my high blood pressure".*

Participant G27: "*I got returned several time from the clinic with my baby not being immunised because they didn't have immunisation vaccines in the clinic".*

Participant G24*: "The doctor said nurses must collect my blood for monitoring my blood sugar level in order to confirm my diagnosis of Diabetes mellitus, but nurses failed to take my bloods because they didn't have the blood collecting bottle (specimen bottle)".*

Another participant added D11*: "I was once returned from the clinic because they didn't have HIV testing kit. They only give me counselling and told me to come back next"*

Shortage of equipment also affected the quality of follow-up of patients diagnosed with diabetes and some of the specific procedures that could not be done were checking of weight and blood pressure (Dominic, Oluyemi & Lady, 2015). Even though some nurses are well trained it is still difficult for them to make a difference due to shortage of equipment. Some of the problems that patients present with cannot be managed successfully without the availability of the relevant equipment. PHC nurses need equipment to properly assess patients. Onyenebo, Amazigo, Njepuome, Mwaorgu and Okeibunor (2016) found that a shortage of supplies and equipment as well as the poor state of available equipment in some clinics act as an obstacle to the delivery of quality health care services.

The shortage of medicine in the clinics contributed to some patients' health-seeking behaviour. An organisation that functions without the required supplies poses a problem to those providing the service. Adam and Awunor (2015) also indicated that in Southern Nigeria the factors which significantly contribute to under-utilisation of health facilities are as follows: underprivileged education and insufficient knowledge about when to look for health care, poverty, insufficiency of available health services (that is lack of drugs, necessary laboratory services; insufficient number of health care workers and nearness to the health facility). Material resources is a marker of health care access to and utilisation of PHC services.

4.3.2.1.2 Sub-category: Shortage of health care providers

The community member's participants reported that they attended PHC services elsewhere, based on the fact that the nearest community health care facility only had one or two nurses attending to all clients including emergencies. The utilisation of PHC services mostly depended on the availability of staff and required material resources. This was supported by the Department of Health (2016a), in that well-resourced and accessible health care facilities include the availability of human and material resources.

One participant said G42: *"I so wish that there was enough nurses and doctors in the health care facilities to help us when we go to the clinic; this could reduce the rate of disease incidents such HIV/AIDS and TB in our community. Sometimes I go the clinic and they cut the line before I consult, I end up coming back without being seen by the nurse or doctor."*

Participant D19: "*Last week I went to the clinic after getting burned by the water while I wanted to cook. When I arrive at the clinic they sent me to other clinic because they didn't bandage to cover my wound and there was only two nurses who were busy with the patient who were giving birth at the clinic. They couldn't help me because they were very busy with the other patient and all they could was to refer me to the other clinic."*

In the current study, delays in receiving care resulted when community members were referred to other health care facilities or booked for the next available date to access PHC services. In the Kwazulu natal, Sibiya and Gwele (2013) indicated that at the PHC centres there is a shortage of staff which is one of the major problems hindering the efficient delivery of PHC services. Additionally, other PHC related services such as cervical, breast and prostate cancer screening to every patient above 40 years old who visited the clinic were not offered due to the health care facilities being understaffed, existing nurses overworked and poor clinic infrastructure.

4.3.2.1.3 Sub-category: Health care infrastructure

The community members concurred that the major contributory factors such as poor infrastructure became a deciding factor of when to seek health care, thus leading to utilisation of PHC services elsewhere outside the community.

Participant G32: "*The nearest clinic to my village is very small to accommodate all the patients visiting the clinic per day. Some patients they sit outside the clinic while waiting to be seen by the nurse because the reception will be full with no space. If I want to sit in the reception bench during the time of Morning Prayer in the clinic I should at least arrive at 05h00am for me to get the space."*

Participant D11: "*I took my son to the clinic for circumcision as per scheduled day by the health care provider. When I get to the clinic it was difficult for my son to agree to be circumcised because three children were circumcised in the same room at the same time due to small place in the clinic with many patients and my son didn't want to cry in front of other children".*

Renggli et al, (2019) found that regardless of a shortage of health care providers, most rural clinics in Tanzania appeared to be too small for the provision of health care that is required. Schoevers and Jenkins (2015) found clinics in the southern Cape/Karoo region too small for the number of patients who visited them on a daily basis. Some clinics in the KwaZulu-Natal Province, North-West province had inadequate waiting rooms and consulting room facilities,

which resulted in dissatisfaction amongst patients. Moreover, patients" dissatisfaction affected the PHC nurses negatively (Sibiya & Gwele, 2013). Nurses who provide PHC need isolated working areas to enable them to take patients" history and conduct physical examinations (Austin, Fapohunda, Langer and Orobaton, 2015). Furthermore, other PHC related services were not offered due to the poor clinic infrastructure.

4.3.2.1.4 Sub-category: Delivery of PHC services

The findings of the study revealed that PHC services delivered in the mobile and health care facilities are not user friendly to them.

Participant D6: *"Last week when the mobile clinic came in my village they said they won't be able to help me because we were many and they have to help a limited number of patients per day and they want to knock off. I was one of the patients whom were requested to go to the nearest clinic.*

The observations were made by participants from both facilities. The PHC services rendered were inadequate, inefficient and sometimes do not satisfy them or are not as patient's expected. In the PHC Service Package, the services of the mobile clinics were well-defined using the level of skills of staff and not the facility size. Common services can be delivered by professional nurses, which is important for rural areas when accessing health care services because CHCs and hospitals were distant (Department of Health, 2001). The findings of the study showed that although the mobile clinics were established in order to bring access to health care services closer to the people, health care access remains limited and inaccessible. The implementation of effective and comprehensive health care programmes in the district is dependent on the availability of adequate resources.

4.3.2.3 Category 3: Organisational factors

The study revealed that there are some organisational challenges faced by community members residing in Dithamaga and Ga-Mashishi villages when they need to utilise PHC services.

4.3.2.3.1 Sub-category: Average waiting time to see a nurse or a doctor

The current study findings relate to the delays or long queues for receiving health care being connected to poor communication and lack of transparency with regards to information about PHC service's access and utilisation.

Participant G47: "*Last week while I was at the clinic two patients fainted while sitting in the bench waiting to be seen by a nurse due to long queue and there was only*

one nurse taking vital signs and one in the consulting room for the whole day."

Several studies identified a number of variable factors and different indicators determining health care service access respectively (Arthur, 2012). In the Bronkhorstspruit area, free health care services resulted in complaints about long waiting hours, congested waiting areas and shortage of staff, which affect the accessibility of district health care services in the area (Nteta et al., 2010).

4.3.2.3.2 Sub-category: Operational times for PHC facility

The study showed that the factors that prohibit access to health care and emergency services were inaccessibility of health care services due to the clinics' operation times and operation days; transport unavailability and other financial issues. The number of clients accepted per clinic session and the provision of services per clinic session were also mentioned.

Participant D17*: "I went to clinic for an emergency pill after the condom ruptured while I was busy with my husband, when I arrive at the clinic gate the security guards told me that I can't access the clinic service because it is holiday and the clinic is not working then I should go home. I ended up having unwanted pregnancy".*

Lévesque, Harris, and Russell (2013), define health care access as access to a service, a provider or health care facility, whereby there is an opportunity for health care customers to use suitable services relating to their health needs. Most participants agreed that the health care facilities in the community were inaccessible due to clinic operational times and operational days, which contributes immensely to under-utilisation of PHC services.

4.3.2.4 Category 4: Environmental and economic factors

The study revealed that there are some environmental and economic challenges faced by community members residing in Dithamaga and Ga-Mashishi villages when they need to utilise PHC services.

4.3.2.4.1 Sub-category: Transport and financial issues

Data from this study showed that most of the participants did not access the health care services provided in the PHC facilities due to lack of transport and poor road infrastructure to the clinic.

Participant D13: "*Last year during rainy season my uncle died in the house after being sick for three days and were unable to take him to hospital because the roads were full of water (floods) and there was no network to call ambulance"*

Another participant added G42: *"I decided to give birth at home assisted by my mother because I didn't have enough money to hire a private car to take me to hospital after many hours of waiting for ambulance that finally did not show up to my house"*

In the Chipinge village of Zimbabwe, Gore, Muza and Mukanangana (2014) indicated that shortage of transport seriously affects the provision of health care services and outreach programmes, including mother and child services, expanded programme of immunisation, and the supervision of health care services provided. Awoyeni, Obayau and Opaluwa (2011) stated that the effect of distance on utilisation of health care services remain a challenge in rural Kogi State, Nigeria.

4.3.2.5 Category 5: Physical factors

The study revealed that there are some physical challenges faced by community members residing in Dithamaga and Ga-Mashishi villages when they need to utilise PHC services.

4.3.2.5.1 Sub-category: Personal limitations

The participant in this study reported that it was difficult for him to access the PHC services by himself due to disability.

Participant G45: "*Sometimes when I'm sick I don't go to the clinic if my grandson is not around because, I'm blind and I need someone to assist to get there for the health services. My wife she's unable to take me to the clinic anymore because she's too old. Without my grandson since he's the only person responsible for taking us to the clinic we don't go to the clinic and we end up defaulting treatment. Sometimes he spend most of his time at school studying and fail to take to us to the clinic"*

Previous studies show that health status analysis indicates that individuals with a good health status are more likely to seek health care services. A good health status indicates that they are more comfortable with the health care that they receive which could be an incentive for them to regularly visit the health care facilities and those who do not have a good health status are more discouraged to seek health care services (Dullie, Meland & Hetlevik 2018). PHC access and utilisation is a significant role to rural growth, as it is imperative for the wellbeing of a person, mechanism of human principal and to maintain a healthy lifestyle for all (Aghion, Peter & Fabrice, 2010; Titus, Adebisola & Adeniji, 2015).

4.4 Conclusion

This chapter presented the data collected from the participants through interviews. Demographic information was presented and themes and sub-themes emerged on factors affecting utilisation rate of PHC services within the community. The next chapter will focus on conclusion and recommendations of the study.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter concludes the study, summarises the findings, discusses the limitations, and makes recommendations for practice and further research.

5.2 Background of the Study

PHC service delivery is the key element of South African health care provision, especially the District Health System (DHS). PHC services should be available, accessible and acceptable to consumers as well as affordable for them and the country as a whole. PHC should be provided properly and to the benefit of the user according to the South African guideline. The delivery of quality PHC services is vital, particularly for communities in rural areas such as Sekhukhune district in Limpopo province. These patients are far from medical doctors, academic hospitals and other health care facilities and have to rely on the health care services offered by registered PHC nurses at their local clinics.

5.2.1 Health System in South Africa

South Africa's health care system comprises of a large public sector, a smaller but fast growing private sector and an NGO sector. The foundation of the PHC system are the clinics which are the elementary point of access for people needing healthcare services. The clinics provide their services for free and very few of them operate for 24hours daily.

5.3 Summary of the study and discussion

The aim of this research was to determine the factors that affect the utilisation rate of the PHC services at the selected villages of Sekhukhune District in Limpopo Province. The objectives of the study were to:

- To explore the factors that influence the utilisation rate of PHC services at the selected rural communities of Sekhukhune District.
- To describe factors affecting utilisation rate of PHC services within the selected rural communities of Sekhukhune District.

A qualitative, descriptive, contextual and exploratory research approach was employed in this study. The target population were community members of the age between 18 and 75 years, residing in Dithamaga and Ga-Mashishi in Sekhukhune District. The researcher used probability approach random sampling and data saturation was reached after 50 participants were interviewed. The data collection instrument was a semi-structured interview guide. Data analysis was done using Phenomenological Analysis Approach. Emerging themes and sub-themes were discussed using literature control.

The discussion of results is based on the health-seeking/utilisation behavior model by the individuals in the community as a theoretical framework used to guide the study (Anderson & Newman, 2005). The study discovered that the three factors/elements described by Anderson and Newman (2005) as the determinants in seeking health care and delays in receiving care also prevailed in Sekhukhune and interfered with the community members accessing and utilising PHC services. The six major themes that emerged during data presentation became the principal factors affecting access to PHC services and utilisation of PHC services in the community. The results are discussed according to the phases of factors as outlined by the Three Elements Model.

5.3.1 Factors affecting utilisation rate of PHC services

Cultural values and norms were said to be the reason for underutilisation of PHC services. The findings of the study revealed that PHC services delivered in the mobile clinics and health care facilities are disorganised and non-comprehensive. The observations were made by participants from both elements. The PHC services rendered were inadequate, inefficient and sometimes not according to the specified guidelines. There is a dissimilar situation in the rural community of Sekhukhune, where community members do not receive PHC services in line with the guidelines because they were referred to other health care facilities for PHC services. Additionally, other PHC related services were not offered due to the health care facilities being understaffed, existing nurses overworked and poor clinic infrastructure.

These factors brought about an under-utilisation of PHC services within this rural community. In relation to the Constitution of the Republic of South Africa, the rural community of Greater Tubatse of Sekhukhune District has a fundamental right to access health care services as Chapter 2 section 27(1a) of the Constitution affirms that everyone has a right to access health care services (Gov.za, 2018). Community members in this rural community therefore, needed to benefit fully from the constitutional right by obtaining accessible health care and emergency services.

The Batho Pele principles pinpoint accurate information for citizens about the use of the available PHC services as vital (DOH, 2003). These authors further stated that the public believes that nurses as professionals provide appropriate information regarding health care issues and health care services. Additionally, nurses have the responsibility to notify patients about changes and new developments in the health care. Lack of information regarding service days and operational hours for services prohibits a patient's right to health care and the importance of PHC attendance. The study findings combined poor and lack of transparency regarding PHC service delivery as one of the factors prohibiting community members from accessing and utilising PHC services within this rural community.

5.3.2 Factors that influence utilisation of PHC services

In the PHC Service Package, the services of the mobile clinics were well defined using the level of skills of staff and not the facility size. Common services can be delivered by professional nurses, which is important for rural areas to access health care because CHCs and hospitals were distant (Department of Health, 2001). The findings of the study showed that the mobile clinics were established to make health care accessible when hospitals are far. The implementation of effective and comprehensive health care programmes in a district is dependent on the availability of adequate resources. Being able to provide transport to a referral centre for emergencies that occur during normal working hours, as well as after-hours, is vital for a well-functioning health service. In the study on developing a model for the integration of PHC services in KZN, Sibiya and Gwele (2013) argued that the implementation of effective and comprehensive health programmes in a district is dependent on the availability of adequate resources.

5.4 Study strength and limitations

This study has provided some important information on the barriers and enablers to access and utilisation of PHC services in the Sekhukhune District of Limpopo Province. The research was conducted in the selected villages of Sekhukhune District; therefore the findings, cannot be generalised to other villages in Limpopo Province. The research data was collected in the community members' households and the language used was Sepedi. One participant refused to be recorded because of their position at the tribal office, even though the researcher explained the anonymity and confidentiality of participants of the study.

5.5 Study recommendations

The study of factors affecting utilisation rate of PHC services, has offered important insights into areas that seek attention. PHC should focus more on prevention of diseases and promotion of health. These and other noted imperatives form the basis of the recommendations being made.

5.5.1 Recommendations for Department of health

The recommendations that are made include:

- To consider building a centrally located PHC clinic that would ensure equal access to health care services.
- Strengthening the implementation of policies regarding the referral system and ambulance services.

- Ensuring sustainable availability of human and material resources.
- Developing strategies to ensure that the PHC services are delivered in line with the South African Department of Health policies and guidelines.
- The health promoter's role should be well clarified and their capacity to give health education at the clinics and the community should be noticeable. Currently the health promoters are providing and being used as administrative staff at the facilities. There is lack of sufficient information on health care and diseases, it is important for community members in particular to get information on PHC aspects.
- Collaborative efforts, engaging and interacting with other members of the multidisciplinary sector such as home-based care givers and social workers is necessary to stimulate support and to harmonise the use of resources in the facilities.
- Within current services designs, Sekhukhune District should conduct yearly evaluations of service performance and manage the relevant impacts that health promotion activities are having on the health of the community.

5.5.2 Recommendations for community

- Strengthening community education and awareness as well as school health at Sekhukhune villages in order for community members to be knowledgeable on the importance of utilising PHC services to improve their health status.
- Develop and utilise more comprehensive empowerment models that invite real community participation at all levels of service development. Exploration of existing community participation drives within Sekhukhune District villages showed a need for more profound engagement with the community such as the use of suggestion boxes in the facilities. There is a need for more explicit community engagement efforts that engage the extensive community in all areas of service delivery.

5.5.3 Recommendations for further research

- Further studies on utilisation rate of PHC services in this area are recommended, in order to uncover more gaps that might have been missed through this study.
- After a period of three years, another study will be needed to determine whether the challenges in this present study are still prevalent.

5.6 Conclusion

There are more challenges encountered by members of Sekhukhune District communities when accessing and utilising PHC services offered. There is limited access to health care

services. Staff shortage was identified as one of the factors that prohibit community members' access and utilisation of PHC services. Another contributing factor is the failure of nurses to adhere to essential guidelines, sometimes deciding to postpone patients due date of collection of chronic treatment and displaying a negative attitude towards PHC clients.

The unavailability of treatment and other resources also contributed to underutilisation of available services. Lastly, the community challenges were that the access and use the PHC was difficult due to poverty (finance) and lack of proper roads to the clinics. The study findings could help improve accessibility, utilisation and equal distribution of health care facilities whereby the health outcomes of the Sekhukhune community may improve. Improved access to and utilisation of PHC services may contribute to positive health outcomes, making it achievable to reduce high incidence of diseases and mortality rate. The findings of the study will not only benefit the Sekhukhune District only, it could also be useful to policy makers at provincial and national levels and therefore be of benefit to the whole country.

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7. ANNEXURES

Annexure A: Ethical Clearance

1

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms M Rammela

Student No:
11620559

PROJECT TITLE:**Factors affecting the utilisation rate of primary health care services in selected villages of Sekhukhune district, South Africa.**

PROJECT NO: **SHS/19/PH/09/2304**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr JT Mabunda	University of Venda	Supervisor
Dr SA Mulondo	University of Venda	Co - Supervisor
Ms M Rammela	University of Venda	Investigator – Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: April 2019
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Senior Prof. G.E. Ekosse

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION
2019 -04- 25
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"A quality driven financially sustainable, rural-based Comprehensive University"

Annexure B: Information sheet (English)

LETTER OF INFORMATION

Title of the Research Study **:** Factors affecting the utilisation of Primary Health Care services: perception of community in selected villages of Sekhukhune District, Limpopo Province.

Researcher : Rammela Mukovhe

Qualification **:** Masters of Public Health (MPH)

Supervisor **:** Dr Mabunda J.T.

Co-Supervisor : Dr Mulondo S.A.

Brief introduction and Purpose of the Study **:** According to the District Health Barometer (2016/17) of Limpopo Province, Sekhukhune District was reported to have the lowest rate of Primary health care utilization accompanied by high maternal and infant mortality rate and a high HIV/TB rate. Hence during the Integrated Development Plan (2016\17) of Sekhukhune District, the selected villages had the highest rate of HIV/TB disease and maternal and infant mortality rate. The aim of this study is to find out the factors affecting the utilisation of the primary health care services at the household level in the villages of Sekhukhune District.

Outline of the Procedures **:** The researcher will interview the participants using their home language. A semi-structured interview guide will be used to collect data. The interview will be conducted one on one in each household, to available participants. The interview will last for 30 to 45minuntes in order to allow the participants to speak their hearts out, with no rush.

Risks or Discomforts to the Participants **:** your participation in this study will have no negative impact on your life or health including your family. However the researcher will look at potential dangers that the participants might encounter and protected against them before they occur by carefully structuring the questions and monitoring the participants for a sign of distress. Should distress occur, the researcher will facilitate debriefing by giving participants the opportunity to ask questions or raise complain, and if necessary, by referring them for counselling.

Benefits **:** The findings of this research will benefit you or have positive impacts on the host and/or neighbouring communities, policy makers and the state, as they will inform the formulation of mitigation strategies to reduce

aspects or the factors that lead to under-utilisation of the primary health care services at the household level.

Reasons why the Participants May Withdraw from the study: If the participants experience some conflicts during the interview or show any feelings of discomfort, they can withdraw from the study.

Remuneration : Nothing will be paid to participants for being part of the study. Their participation in this study is voluntary and their decision to take part in this study will have no negative impact on their life or health.

Costs of the study : Be aware that to be part of this study you don't have to pay anything. In other words, participation is free.

Confidentiality **:** Please note that the Information obtained from you will be treated as confidential. Only the researcher will have access to the responses given by the participants. In addition, participants' name will not appear on any of the documents to be used and the data recorded will not identify the participants' names. The data will be kept confidential all the time and will be discarded immediately on completion of the study.

Research-related injury **:** No injury or damage will occur from participating in this study.

Annexure B: Letlakala La Tsebo (Sepedi)

LENGWALO LA TSEBO

Hlogo ya nyakišišo **:** Dintlha tšeo di amago dipalopalo tša tšhomišo ya dikabelo tša thušo ya tša maphelo ya tlase metsaneng yeo ekgethilwego ya tikologo ya ga Sekhukhune, porofenseng ya Limpopo

Leina la monyakišiši **:** Rammela Mukovhe

Leina la mphato wa boithutelo **:** Masters of Public Health (MPH)

Mofahluši **:** Dr Mabunda J.T.

Mofahluši wa mothuši **:** Dr Mulondo S.A.

Setsopolwa sa matseno le maikemišetšo a nyakišišo: Go ya ka Barometer (2016/17) ya tsa maphelo ya ditikologo mo porofenseng ya Limpopo, tikologo ya Sekhukhune e begilwe go ba le tšhomišo ya fasefase ya dikabelo tša tlase tša thušo ya tša maphelo e sepela le dipalopalo tša godimo tša go ima le go hlokofala ga bana gammogo le dipalopalo tša godimo tša HIV/TB. Ke ka fao ka nako ya Integrated Development Plan (2016/17) ya tikologo ya Sekhukhune, metsana yeo e kgethilwego ebe ena le dipalopalo tša godimodimo tša malwetši a HIV/TB le go ima le go hlokofala ga bana. Maikemišetšo a nyakišišo ye ke go humana dintlha tšeo di amago dipalopalo tša tšhomišo ya dikabelo tša thušo ya tša maphelo ya tlase go ya ka motse ka motse mo metsaneng ya tikologo ya Sekhukhune.

Tlhathollo ya tshepedišo: Monyakišiši otlo boledišana le batšeakarolo ka leleme la bona la segae. Tshepedišo ya poledišano yeo e beyakantšwego etla berekišwa go kgoboketša dintla. Poledišano etla swarelwa ka motseng omongwe le omongwe le batšeakarolo bao ba lego gona ka o tee ka o tee, metsotso ye 30 go iša go ye 45 ele gofa batšeakarolo sebaka sa gore ba ntšhe sa mafahleng ntle le go felelwa pelo.

Dikotsi goba Ditšhitišo go Batšeakarolo: Go tšeakarolo ga gago mo nyakišišong ye, go kase ame bophelo bja gago le ba lapa la gago ka mokgwa ofe kapa ofe goba gona go fetola seemo sa tša maphelo a gago. Efela monyakišiši otlo lebelela dikotsi tšeo motšeakarolo akabago a lebane le tšona gomme amo eletša ka mehuta ya mekgwa ya tšhireletšo go efoga ona mathata ao amo lebanego.

Mehola: Dipoelo tša nyakišišo ye di tlo hola wena goba tša tliša diphetogo tša mehola go motse yoo nyakišišo e dirwago gona le metsana mabapi, go ba dira melao le go mmušo.

Ebile etlo thuša go tla ka mekgwanakgwana ya go tliša thušo ya go fokotša mabaka ao a tlholago goba thibelago batho go šomiša dikabelo tša tlase tša thušo ya tša maphelo ka motse ka motse.

Mabaka ao aka dirago gore motšeakarolo a ikgogele morago mo nyakišišong: Ge motšeakarolo aka itemogela maikutlo a dithulagano ka nako ya poledišano goba abontšha go se ikwe gabotse, ba dumeletšwi go ka ikgogela morago go nyakišišo ye.

Moputso (Tefo): Agona motšeakarolo yoo a ilego go putswa goba go lefelwa go tšeakarolo. Go tšeakarolo mo nyakišišong ye, ke ga boithaopi fela. Ebile le sephetho sa go tšeakarolo mo nyakišišong se ka se ame maphelo goba boeme bja tša maphelo a bona ka selo.

Tefelelo ya nyakišišo: Ela hloko gore go tšeakarolo mo nyakišišong ye ago lefelelwi (patelelwi). Ka mantšu a mangwe go tšeakarolo ke mahala.

Go fihla boitsebišo bja batšeakarolo: Tseba gore dintlha ka boitsebišo bja gago di tla šomišwa le go beiwa bjalo ka sephiri ka nako tšohle. Monyakišiši ale tee otlaba le phitlhelelo ya dikarabo godimo ga lengwalo la tsebo leo letladitšwego ge go thongwa ka poledišano ya nyakišišo ye. Sengwe gape ke gore maina a batšeakarolo kamoka ga bona akase tšwelele felo mo nyakišišong. Dipoelo tša nyakišišo ditlo šomišwa le go beiwa ka mokgwa wa sephiri go fihlela di fetša mošomo wa tšona gomme tša senywa morago ga fao.

Dikgobalo tša go amana le nyakišišo: A gona dikgobalo tšeo di tla bago gona go tšeyeng karolo mo nyakišišong ye.

Annexure C: Consent Form (English)

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher,(**Rammela Mukovhe**), about the nature, conduct, benefits and risks of this study: Research Ethics Clearance Number: SHS/19/PH/09/2304
- I have also received, read and understood the above written information on participant letter of information regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in this study.
- I have had sufficient opportunity to ask questions and of my own free will) declare myself prepared to participate in this study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant	Date	Time	Signature
……	……..	……..	……

I **Rammela Mukovhe** herewith confirm that the above participant has been fully informed about the nature, conduct and risks of this study.

Full Name of Researcher	Date	Time	Signature
……	……..	……	……..

Full Name of Witness (if applicable)

Full Name of Witness	Date	Time	Signature
……	……..	……	……..

Full Name of Legal Guardian (if applicable)

Full Name of Legal Guardian	Date	Time	Signature

…… …….. …… ……..

Annexure C: Letlakala La Tumelelano (Sepedi**)**

Taetšo ya kwano ya go tšeakarolo go nyakišišo:

- Ke mo kase go hlatsela gore ke tsebišitšwe ke monyakišiši, (**Rammela Mukovhe**), mabapi le mohuta, tshepedišo, mohola le dikotsi tša nyakišišo ye – SHS/19/PH/09/2304
- Gape ke hweditše, ka bala le go kwišiša temošo yeo e ngwadilwego ka godimo go letlakala la tsebo la motšeakarolo mabapi le nyakišišo.
- Kea tseba gore dipoelo tša nyakišišo, gammogo le tsebo ka bong, mengwaga, tšatši la matswalo, hlaka tša maina le dipoelo tša tshekatsheko ya mmele waka di tla khutišwa ge go ngwalwa ka gare ga pego ya nyakišišo.
- Goya ka dinyakwa tša nyakišišo, ke fana ka tumelelo ya gore tsebo yeo ekgobokeditšwego ka nako ya nyakišišo eka ahlaahliwa ka mokgwa wa khomphuthara ke monyakišiši.
- Nakong efe kapa efe, ntle le go ahlolwa, nka tloša tumelelano kabe ka ikgogela morago mo go tšeyeng karolo go nyakišišo.
- Ke bile le sebaka seo se lekanego gore ke botšiše dipotšišo ke be ke ikane ka bo nna gore ke lokile go ka tšea karolo mo nyakišišong yee.
- Kea kwišiša gore dintlha tše diswa tšeo di tlo tšwelelago mo nyakišišong ke tlo tsebišwa ka be ka fiwa tšona.

Maina ka Botlalo a Motšeakarolo	Letšatši	Nako	Mosaeno
_____	_____	_____	_____

Nna, **Rammela Mukovhe**, kase ke tlhatsela gore motšeakarolo yoo o tsebišitšwe ka botlalo maikemišetšo, tshepidišo le dikotsi tša nyakišišo.

Maina ka Botlalo a Monyakišiši	Letšatši	Nako	Mosaeno
_____	_____	_____	_____

Maina ka Botlalo a Tlhatse (ge go hlokega)

Maina ka Botlalo a Tlhatse	Letšatši	Nako	Mosaeno
_____	_____	_____	_____

Maina ka Botlalo a Mohlokomedi wase Molao (ge go hlokega)

Annexure D: Letters of permission (English)

Letter to the Tribal Office\Chief

University of Venda
P. Bag X5050
Thohoyandou 0950
South Africa
22/06/2018

Dithamaga/Ga-Mashishi Traditional Council

Dear Sir/Madam

RE: REQUEST FOR PERMISSION TO ACCESS INFORMATION FROM THE DITHAMAGA AND GA-MASHISHI COMMUNITY MEMBERS

My name is Rammela Mukovhe, a Master's degree student at the Department of Public Health at the University of Venda. As a requirement for the partial fulfilment of my degree of Masters in Public Health, I am conducting a study entitled: **Factors affecting the utilisation of Primary Health Care services: perception of community in selected villages of Sekhukhune District, Limpopo Province.** I would like to conduct this study in Dithamaga and Ga-Mashishi villages situated in the Greater-Tubatse Municipality. This study has been prompted by the low utilisation rate of primary health care services in the selected villages of Sekhukhune as well as the high rate of maternal & infant mortality and the HIV and TB burden high rate reported in the Department of health in 2016. I therefore kindly request your permission to access required information for my study.

The study will involve the following:

Seeking permission from the participants to conduct the study and giving all the information to the participants regarding the aim of the study before interviewing them individually. All the information gathered in this study will be kept strictly confidential, and no information will be used for purposes other than intended for this study. A participant's decision to be part of the study will be voluntary and withdrawal from the study at any time will be allowed.

Anonymity will be assured by not taking the names of the participants. The ethical clearance letter from the University of Venda will be submitted.

I trust that my request will be granted. Your assistance in facilitating the research will be highly appreciated.

Thank you in advance

Sincerely

Rammela Mukovhe

(Student number: 11620559, mukovherammela038@gmail.com, cell: 0715084594)

Annexure D: Lengwalo La Tumelelo (Sepedi)

Lengwalo La Goya Kgorong/Ga Kgoši

University of Venda
P. Bag X5050
Thohoyandou 0950
South Africa
22/06/2018

Dithamaga/Ga-Mashishi Traditional Council

Mmadi yoo a Hlomphegago

RE: KGOPELO YA TUMELELO YA GO HWETŠA TSEBO GO TŠWA GO BADUDI LE MALOKO A MOTSE WA DITHAMAGA/GA-MASHISHI

Leina la ka ke Rammela Mukovhe, moithuti wa Master's Degree lefapheng la tša maphelo yunibesithi ya Venda. Bjalo ka se sengwe sa dinyakwa tša go tšwelela mo dithutong tša Masters in Public Health, ke dira nyakišišo yeo e bitšwago: **Dintlha tšeo di amago dipalopalo tša tšhomišo ya dikabelo tša thušo ya tša maphelo ya tlase metsaneng yeo ekgethilwego ya tikologo ya ga Sekhukhune, porofenseng ya Limpopo**. Nka thabela go dira nyakišišo ye metsaneng ya Dithamaga le Ga-Mashishi yeo elego ka tlase ga mmasepala wa Greater-Tubatse. Nyakišišo ye ehlohleleditšwe ke dipalopalo tša tlase tša tšhomišo ya dikabelo tša thušo ya tša maphelo ya tlase mo mafelong ao a kgethilwego gape le dipalopalo tša godimo boimana le go hlokofala ga bana gammogo le matshwenyego a dipalopalo tša godimo tša HIV le TB tšeo di begilwego ke lefapha le tša maphelo ka 2016. Ke ka fao ke kgopelago tumelelo ya lena ka boikokobetšo gore ke humane tsebo le dintlha tša go sepedišana le nyakišišo yaka.

Nyakišišo etla ama tše di latelago:

Kgopelo ya tumelelo go tšwa go batšeakarolo go nyakišišo le go fana ka tsebo le dintlha kamoka tša maikemišetšo a nyakišišo pele go ka ba le poledišano le mongwe le mongwe wa bona. Tsebo le dintlha kamoka tšeo di hwetšwago mo nyakišišong di tla dula di bolokilwe ka sephiring ebile agona le mošomo omongwe ka tšona ntle le go phethagatša maikemišetšo a nyakišišo fela. Sephetho sa goba motšeakarolo mo nyakišišong ke sa boithaupi ebile le go ikgogela morago ga bona go dumeletšwi ka nako efe kapa efe. Maina a batšeakarolo atla dula a fihlilwe ebile akase kgopelwe. Lengwalo la tumelelo goya ka mekgwa le maitswaro a nyakišišo la go tswa yunibesithi ya Venda le tla abelwa batšeakarolo.

Kea tshepha gore kgopelo yaka etla amogelwa ya dumelelwa. Thušo ya lena mo tsamaišong ya nyakišišo ye, etla thabelwa kudu.

Wa lena ka boikokobetšo,

Rammela Mukovhe
(Nomoro ya moithuti: 11620559, mukovherammela038@gmail.com, mogala: 0715084594)

Annexure E: Semi-Structured Face To Face Interview Guide (English)

Name of the village :

Age :

Gender :

Marital status :

Educational level :

Occupation :

Name of the Clinic visited :

Number of visits per year :

When last did you visit a Primary Health Care facility for a service delivered there?

Opening question: How do you utilise the Primary health care services?

Probing questions: What do you do when you require medical attention to get better?

Annexure E: Tlhahlo Ya Poledišano Ya Mahlong Yeo e beakantšwego (Sepedi)

Leina la lefelo :

Mengwaga :

Bong :

Maemo a tša lenyalo :

Maemo a thuto :

Mošomo :

Leina la Kliniki :

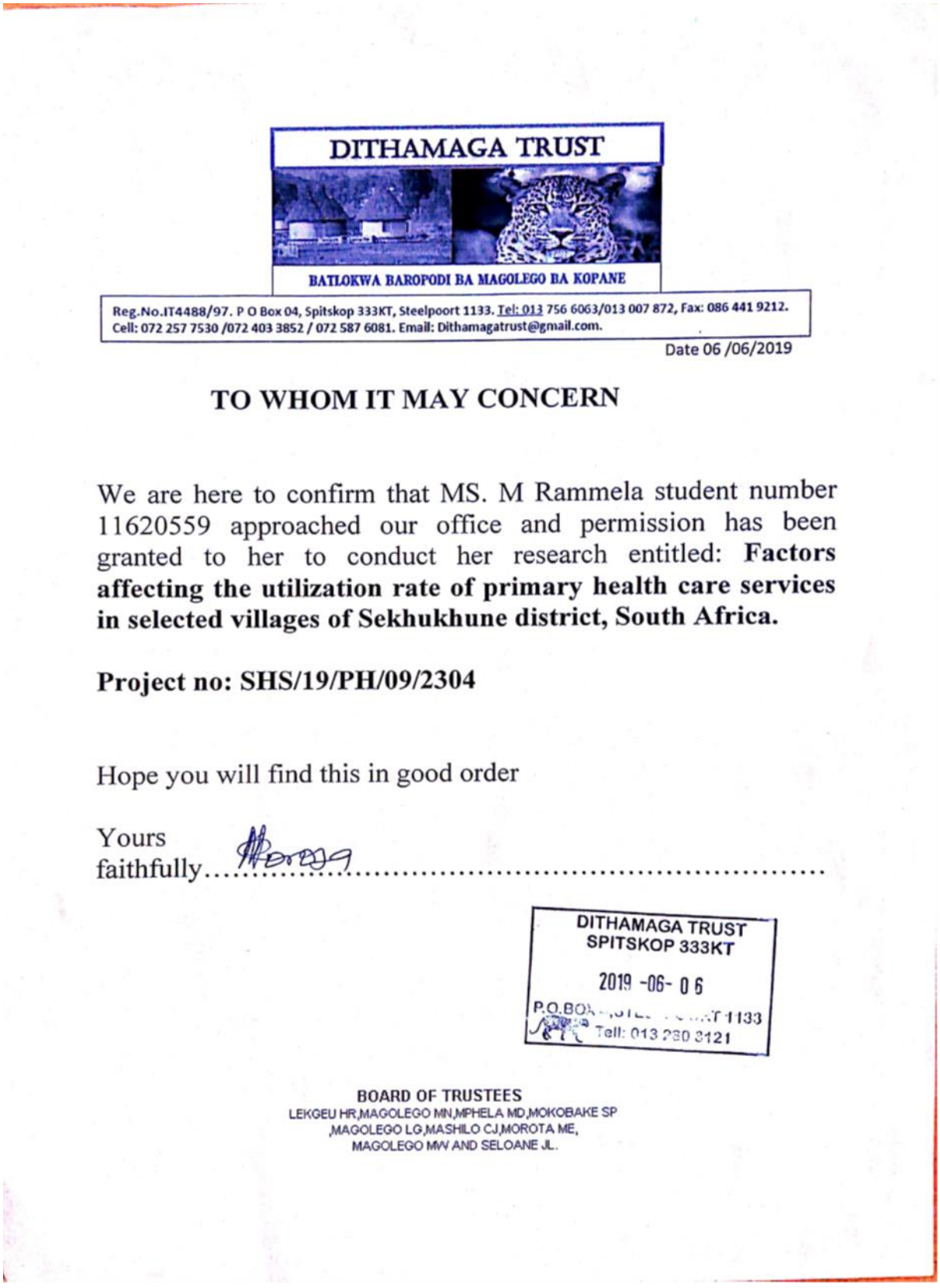
Palo ya diketelo mo ngwageng :

Ke neng la mafelelo fao o ilego wa etela lefelo leo le abago thušo ya tša maphelo ya tlase go hwetša thušo ka engwe ya di kabelo tša lefelo leo?

Potšišo ya go bula poledišano: O šomiši bjang dikabelo tša thušo ya tša maphelo ya tlase?

Potšišo ya go šišinya poledišano: Ke dikgato dife tšeo o di tšeago geo hloka thušo ya hlapetšo ya tša maphelo gore obe kaone?

Annexure F: DITHAMAGA Grant letter from Tribal office



DITHAMAGA TRUST

BATLOKWA BAROPODI BA MAGOLEGO BA KOPANE

Reg.No.IT4488/97. P O Box 04, Spitskop 333KT, Steelpoort 1133. Tel: 013 756 6063/013 007 872, Fax: 086 441 9212.
Cell: 072 257 7530 /072 403 3852 / 072 587 6081. Email: Dithamagatrust@gmail.com.

Date 06 /06/2019

TO WHOM IT MAY CONCERN

We are here to confirm that MS. M Rammela student number 11620559 approached our office and permission has been granted to her to conduct her research entitled: **Factors affecting the utilization rate of primary health care services in selected villages of Sekhukhune district, South Africa.**

Project no: SHS/19/PH/09/2304

Hope you will find this in good order

Yours faithfully.....

DITHAMAGA TRUST
SPITSKOP 333KT
2019 -06- 06
P.O.BOX 1133
Tell: 013 230 3121

BOARD OF TRUSTEES
LEKGEU HR,MAGOLEGO MN,MPHELA MD,MOKOBAKE SP
,MAGOLEGO LG,MASHILO CJ,MOROTA ME,
MAGOLEGO MW AND SELOANE JL.

Annexure G: GA-MASHISHI Grant Letter from Tribal office.

ROKA MASHISHI TRADITIONAL COUNCIL

TO WHOM IT MAY CONCERN.

This is to confirm that Ms. M. Rammela student number 11620559 approached our Office and a permission has been granted to her to conduct her research entitled Factors affecting the utilization rate of Primary Health Care services .

We appeal to all who may be contacted to give her support .

Kind regards .

pp

Mashishi M.S. (Kgoshi)

DEPARTMENT OF CO-OPERATIVE GOVERNANCE
HUMAN SETTLEMENTS & TRADITIONAL AFFAIRS
07 JUN 2019
ROKA MASHISHI TRADITIONAL COUNCIL
P.O. BOX 235, DR. ENOP, 1129
SEKHUKHUNE DISTRICT
SUPPORT CENTRE

Annexure H: Language editing certificate

Address: 624 Pretorius Street, 403 Francisca Flat, Arcadia, Pretoria
Call: +2772 233 9433
Email: info@bangwadi.co.za | Website: www.bangwadi.co.za

BANGWADI CONSULTANT
Context Of Your Contents Is Our Concern

Bancon Independent Editors

REF: EDITING OF MINI-DISSERTATION

DATE: 22 January 2020

TO WHOM IT MAY CONCERN

This letter serves to confirm that Rammela Mukovhe (Student Number: 11620559) submitted her Master of Public Health dissertation entitled "FACTORS AFFECTING THE UTILISATION RATE OF PRIMARY HEALTH CARE SERVICES IN SELECTED VILLAGES OF SEKHUKHUNE DISTRICT, SOUTH AFRICA" for language editing to the undersigned. Hence, the document has been duly proofread and edited for grammatical and technical errors. It is hoped that if all the editorial aspects addressed and recommended therein are to be meticulously attended to, the target readers of this work will find the document free from error, enjoyable to read and easy to understand.

FOR ANY ENQUIRIES RELATING TO THE ABOVE, PLEASE CONTACT ME DURING OFFICE HOURS:

Kind regards,

Mafeye Morapedi (Director of Bangwadi Consultant)
(MA English Studies, Editing: Principles & Practice, BAH Applied Language & Multilingual Studies, BA Contemporary English & Multilingual Studies)

Reg No: (2018/091620/07)