

**Barriers to accessing Public Primary Health care among elderly people in Mpheni village,
Limpopo Province.**

Name of student: Netshakhuma Ndaedzo

Student number: 18000050

**A mini-dissertation submitted in partial fulfilment of the requirements for the
degree:**

Master of Public Health (MPH).

Supervisor: Dr. Mudau AG

Co-Supervisor: Prof Makhado L

DECEMBER 2024

DECLARATION

I, Netshakhuma NC, declare that the proposal titled “***Barriers to accessing Public Primary Health care among Older people in Mpheni village, Limpopo Province***” submitted by me has not been submitted previously for a degree at this or any other University that is our work in design and execution and that all reference material contained therein has been duly acknowledged.

Surname and Initials: Netshakhuma NC

Signature 

Date: 20 November 2023

DEDICATION

This study is dedicated to my grandmother, Mabila Tshavhungwe, and my mother, Mabila Joyce, who are also taking medication for chronic diseases at the local clinics every month.

ACKNOWLEDGEMENTS

- My sincere gratitude goes to God, who gave me wisdom and guidance to finish my studies.
- To my supervisors, Dr. Mudau AG, thank you for your guidance and support and for always motivating me in my studies.
- To the chief Mr Davhana M and his committee who allowed me to conduct my study, I say thank you
- To all my participants who took the time to participate in my study, thank you so much.

LIST OF ABBREVIATIONS AND ACRONYMS

COVID-19: Coronavirus Disease 2019

PHC: Primary Health Care

RCT: Randomized Controlled Trial

RSA: Republic of South Africa

SA: South Africa

VDM: Vhembe District Municipality

WHO: World Health Organization

ABSTRACT

Background

As individuals age, their health demands increase compared to younger populations. When these demands are not adequately met by Primary Health Care (PHC) systems, it can lead to the progression of chronic diseases, increased comorbidities, and worsening health outcomes. This, in turn, reduces the overall quality of life for older adults. There is a gap between the ideal PHC policy framework and its practical implementation, especially in rural communities like Mpheni Village, Limpopo Province.

Purpose of the Study

This study aimed to explore and describe the barriers preventing the elderly population of the Mpheni community from accessing and benefiting from PHC services.

Methods

An exploratory qualitative research design was used. Participants were selected through non-probability convenience sampling, focusing on those aged 60 years and above, residing in Mpheni, and self-reporting challenges in accessing PHC services. Data were collected through semi-structured interviews with 10 participants and analysed using thematic content analysis. Ethical principles including informed consent, confidentiality, and trustworthiness were strictly observed.

Results

The study identified several barriers to PHC access, including long waiting times caused by staff shortages, transportation challenges due to poor infrastructure and high costs, and frequent medication shortages. These issues negatively impacted participants' health, exacerbated chronic conditions, and led to psychological distress such as anxiety, depression, and feelings of neglect. While clinics were praised for their cleanliness and free services, participants expressed the need for specialised elderly care, improved communication about medication availability, and mobile clinic services.

Recommendations

To improve PHC service delivery for the elderly in rural areas, the study recommends the introduction of mobile clinics, training of PHC personnel in geriatric care, timely medication supply, and enhanced transport services. Policies must be tailored to ensure accessibility and responsiveness to the needs of the ageing population.

Key Concepts:

Barriers, elderly population, PHC services, accessibility, rural healthcare, Mpheni community

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CHAPTER ONE: OVERVIEW OF THE STUDY

1.1 Introduction

Globally, the population is aging, and the World Health Organization (WHO) estimates that by 2050, the number of individuals aged 60 and older will increase fourfold, with those aged 80 and above reaching 400 million (WHO, 2021). This global trend is mirrored in South Africa, where the estimated population in 2022 included more than five million people aged 60 or older. Stats SA states that this demographic represents 9.2% of the total South African population (Stats SA, 2022). Understanding the implications of an ageing population is crucial, as this age group is particularly vulnerable, requiring support through social assistance programs, accessible cash transfers, food programs, and primary healthcare (PHC) services to ensure their well-being.

Ageing is typically accompanied by deteriorating health, and as individuals grow older, they encounter health issues that necessitate regular check-ups. Despite this need, the challenges faced by the elderly in accessing PHC services are rarely examined in research projects. The recent COVID-19 pandemic has further highlighted the need to protect the elderly, emphasizing the urgency of addressing their healthcare needs. In line with this, the Older Persons Act 13 of 2006, as amended, underscores the government's responsibility to promote the well-being, dignity, and care of older persons by ensuring equitable access to healthcare services tailored to their needs (Republic of South Africa, 2022).

This study aimed to explore and describe the barriers preventing the elderly population of the Mpheni community from accessing and benefiting from PHC services. By bridging the gap between the global context and the specific research focus, this study seeks to contribute valuable insights into providing PHC for the elderly in this region.

1.2 Background of the study

Older adults have unique healthcare needs compared to younger populations. In South Africa, elder care policy prioritizes aging within the community rather than in institutional settings. However, the primary healthcare (PHC) system is not adequately structured to address the specific health requirements of older individuals living in the community (Su, Rao, Caron, D'Arcy and Meng, 2023). Several developing countries, including South Africa, promote older persons staying in community settings due to the high expenses of institutional elder care (WHO, 2021). To preserve the health and intrinsic capacity (encompassing both physical and mental abilities) of older adults living in the community and to minimize frailty and institutionalization, it is crucial to strengthen primary healthcare (PHC), home-based care, and community-level social services (WHO, 2021). However, health and primary care systems are often not adequately designed to meet the unique healthcare needs of older individuals compared to the younger population (Kabir, Karim, Islam, Romero and Billah, 2022).

According to Fulmer, Reuben, Auerbach, Fick, Galambos, and Johnson, (2021), it is challenging for governments and healthcare professionals to create policies and interventions to assist the elderly in improving or maintaining their quality of life. Older people worldwide experience various health issues, including chronic illnesses, injuries, loneliness-related depression, hunger, visual and hearing impairment, and complex dental problems (Garousi, Amirkafi, Mohammadi and Garrusi, 2023). These issues are compounded by social and economic challenges, often more severe in developing countries (Garousi et al., 2023). The wide-ranging global inequalities in older people's quality of life (WHO, 2021) exacerbate these challenges. African governments have a limited response to the economic, health, disability, and living condition challenges faced by older adults compared to governments in other regions (WHO, 2021).

Older individuals often require comprehensive, multidisciplinary healthcare interventions due to their reduced physiological reserves and increased likelihood of complex, long-term multi-system health conditions. These challenges highlight the need to address the biopsychosocial determinants of health; however, many healthcare professionals lack specialized expertise in geriatric care (WHO, 2021). In South Africa, only 22.9% of the elderly population has health insurance, with the lowest coverage rates among Black (6%)

and Coloured (16.6%) populations, compared to 73.5% of the White elderly population who are insured (Stats SA, 2022). As a result, these groups rely heavily on the public healthcare system or must pay out-of-pocket for private care. While older individuals have access to free public primary healthcare (PHC), and recipients of the state's Old Age Grant qualify for free secondary and tertiary care, many community-dwelling older adults may underutilize healthcare services or receive inadequate care due to barriers in accessing appropriate medical support (Vaishnav, Joshi, Joshi and Mehendale, 2022).

The likelihood of obtaining healthcare is influenced by the patient's economic status, social capital, education level, physical and mental capabilities, and supply-side issues within the healthcare system. Supply-side determinants of healthcare access include the availability of facilities, policies, structures, procedures, tools, medications, and skilled labour (Dalinjong et al., 2021). Despite notable progress in improving healthcare accessibility and quality in recent years, the South African healthcare system remains a "stressed institution" burdened by workforce shortages, weak leadership, and inefficient resource allocation. Research on healthcare quality and responsiveness in the public sector indicates that individuals across all age groups encounter difficulties in obtaining adequate care (Filip et al., 2022). Older individuals from disadvantaged social and economic backgrounds are particularly vulnerable to receiving substandard healthcare and experiencing poorer health outcomes. Financial constraints further exacerbate their challenges in accessing healthcare services (Vaishnav et al., 2022). Although policy initiatives emphasize community-based care, older patients do not receive priority services or specialized programs at the primary care level and must compete with other patients for medical attention (Vaishnav et al., 2022).

Although there is limited research on the topic, existing literature generally agrees that health systems in developing countries often fail to meet the needs of older adults. This is largely due to barriers such as poor access to healthcare services and slow, rigid response times (Li, Taeihagh and Tan, 2023). Older adults and other vulnerable populations in South Africa frequently report dissatisfaction with healthcare services, citing poor care quality and a lack of confidence in healthcare personnel in both rural and

urban areas (Li et al., 2023). As the population continues to age, the prevalence of chronic diseases, frailty, and disability increases, intensifying the demand for chronic care within Primary Health Care (PHC), as well as for long-term care and community-based support. This rising demand further exacerbates existing challenges in accessing public primary healthcare services (Wu et al., 2023). The increasing burden of both communicable and non-communicable diseases across all age groups places additional strain on the healthcare system (WHO, 2021). Despite these growing concerns, limited research has been conducted on the gaps in South Africa's healthcare system specifically related to the needs of the elderly, nor older South Africans' perceptions of their health and usage of healthcare services (Smythe, Inglis-Jassiem, Conradie, Kamalakannan, Fernandes, Van-Niekerk, English, Webster, Hameed, and Louw, 2022). Few studies, if any, have examined the problems experienced by community-dwelling individuals, who make up a significant proportion of people older people older people in rural South Africa (Smythe et al., 2022). It is evident from the research that older people's health needs and the extent to which the public and private PHC systems in South Africa meet these requirements require more consideration. This research aims to contribute to the growing body of evidence on healthcare accessibility and quality for older adults. Section 27(1)(a) of the Constitution of the Republic of South Africa (Act 108 of 1996) guarantees the right of access to healthcare for all, while Section 27(3) states that no one should be denied emergency medical treatment (RSA, Constitution, 1996). However, healthcare access in South Africa remains unequal, deepening existing poverty and inequality (Gordon, Booysen and Mbonigaba, 2020). The most disadvantaged populations, particularly those in remote areas like Mpheni village, often have the least access to healthcare services, which frequently fail to meet national standards. Although there have been improvements in healthcare accessibility and quality, these gains have been unevenly distributed, with rural communities continuing to face substantial healthcare challenges (Smythe et al., 2022).

1.3 Problem statement

Despite interventions by the government and non-governmental organisations, older people in South Africa continue to face significant challenges in accessing health services. Reports reveal alarming trends, including increased mortality rates among older adults, a growing burden of diseases in this demographic, barriers to visiting healthcare facilities, instances of being denied hospital treatments, and prolonged waiting times for health services (Ajisegiri et al., 2023). These challenges highlight the vulnerability of the elderly, particularly those from socioeconomically disadvantaged backgrounds, who often experience compounded difficulties due to limited financial resources and declining physical capacities, resulting in inadequate care and poor health outcomes (Ana et al., 2021).

The existing healthcare system primarily emphasises clinic-based approaches targeting acute and severe conditions, leaving older adults underserved. Additionally, healthcare personnel frequently lack the specialised training required to meet the unique needs of the elderly. The absence of geriatric-focused training within medical and nursing curricula, both at undergraduate and postgraduate levels, further exacerbates the issue (Consolo Clark and Lippe, 2024). Consequently, elderly individuals cannot access adequate healthcare and improve their quality of life due to these systemic barriers.

Although policy frameworks promote community-based care, there has been limited translation into dedicated services or programs for the elderly within PHC. This has led to older patients competing for care with younger populations in a healthcare system already burdened by resource constraints. Furthermore, the chronic shortage of healthcare professionals and the absence of patient-centred and age-friendly care models contribute significantly to these access challenges. The issue is particularly pronounced in rural areas where the majority of elderly South Africans reside, and accessing primary health services remains a significant hurdle (Ajisegiri et al., 2023).

Addressing these challenges aligns directly with Sustainable Development Goal 3 (SDG 3), which aims to ensure healthy lives and promote well-being for all ages. To achieve this, innovative healthcare models must prioritize patient-centred and age-friendly approaches. Strengthening community-based healthcare initiatives and task-shifting responsibilities to community health workers could be instrumental in improving health service delivery for older adults (Ajisegiri, Abimbola, Tesema, Odusanya, Peiris, and Joshi 2023).

This study, therefore, seeks to investigate the specific barriers elderly individuals face in accessing primary health services at public health facilities in Mpheni village. By exploring these challenges and identifying potential solutions, the research aims to contribute to more inclusive and effective healthcare services for the elderly, thereby addressing a critical gap in healthcare practice and policy while supporting the achievement of SDG 3.

1.4 Rationale of the study

The total number of aged people is anticipated to increase dramatically over the next few decades, more so in the African region than in any other region of the world; with South Africa having 5.9% of 65 years and above, South Africa's population remains youthful. As a result, the elderly population should receive more primary health care (Gu et al., 2021). Since ageing is a fundamental process in the history of mankind, it is critical to study and understand the demand for PHC for the elderly, more so in rural areas. The recent emergence of the COVID-19 pandemic, with its high mortality risk for older adults, has highlighted critical issues related to ageing and healthcare. The risk factors for COVID-19-related mortality include pre-existing chronic conditions such as hypertension, heart disease, and diabetes mellitus (Zhou et al., 2020), all of which are highly prevalent among the elderly. This has further emphasized the need for improved healthcare services and targeted interventions to address the unique health challenges faced by ageing populations.

To determine whether a similar study has already been done, the researcher looked for background information on the challenges the elderly population faces in receiving primary health care services in Mpheni village, according to Ajisegiri et al., (2023) study, Older People Experiences of PHC. The study has insufficient information related to the challenges faced by the elderly population in rural areas, such as the Vhembe district, in delivering PHC services. There is still a gap in the delivery of PHC services for the elderly population of Mpheni village, Vhembe district. The primary purpose of this study is to explore and describe challenges faced by the elderly population of the Mpheni community regarding the provision of PHC services since no prior research has been done there.

1.5 Significance of the study

This study holds significant potential to impact the field of PHC delivery for the elderly, particularly in rural South Africa. By identifying and addressing the specific challenges that older people face in accessing PHC in Mpheni village, the research aims to improve healthcare delivery and outcomes for this vulnerable group. Addressing these challenges will enable healthcare providers to design more effective and accessible PHC services tailored to the needs of the elderly. This can improve health outcomes by ensuring that older adults receive timeously and appropriate care, reducing the prevalence of untreated conditions, and improving their overall quality of life.

The findings from this study may provide critical data that the Department of Health can use to plan and enhance primary health services. By understanding the barriers faced by the elderly, policymakers can develop targeted interventions that reduce these challenges. Potential improvements include training healthcare workers in geriatric care, increasing the availability of community-based services, and ensuring that PHC facilities are equipped to meet the needs of older patients. The study's findings will thus inform policy decisions, making them more relevant and effective in addressing the healthcare needs of the elderly.

This research can also be vital in raising community awareness about the importance of PHC for the elderly. By highlighting the specific needs and challenges of older adults, the study can foster more excellent community support and involvement in promoting health and well-being among the elderly. Educational strategies could include community workshops, informational campaigns, and local leaders' participation to advocate for better healthcare services for the elderly. Engaging the community in this manner can enhance the overall impact of the study and ensure sustained improvements in elderly care.

The study may add to the existing body of knowledge by providing up-to-date data on the challenges faced by the elderly in accessing PHC services in rural South Africa. This is particularly valuable given the limited contemporary research in this area. The insights gained can inform future research and help build a more comprehensive understanding of elderly healthcare needs in similar contexts. By supplementing existing yet outdated data, this study will offer novel insights and perspectives crucial for developing effective healthcare strategies.

Based on the study's findings, several interventions can be implemented to address the identified issues. These might include training programs for healthcare workers focused on geriatric care to enhance their ability to meet the unique needs of older patients, the development of community-based health initiatives that provide accessible care options within the community, and policy recommendations to ensure that PHC facilities are adequately staffed and equipped to handle the health needs of the elderly. Additionally, task-shifting to community health workers could enable them to provide essential health services and support to the elderly, alleviating the burden on PHC facilities.

1.6 Study purpose and objectives

1.6.1 Purpose

This study aimed to explore and describe the challenges faced by the elderly population of Mpheni village in providing PHC services.

1.6.2 Objectives

Considering the primary purpose of this study, the following specific objectives have been formulated:

- To explore challenges faced by the elderly population of Mpheni village in the provision of PHC services.
- To identify the impact of identified challenges on the health outcomes of the elderly population in Mpheni village.
- To propose recommendations for improving PHC services for the elderly population in Mpheni village.

1.7 Definition of key terms

Elderly population

Most developed countries define an "elderly" or older person as someone aged 65 and above. However, like many Westernized concepts, this classification does not always align with the African context. Although this age threshold is often linked to pension eligibility, there is no universally accepted definition of old age, as different societies and institutions use varying criteria. This study adopts the World Health Organization's (WHO, 2021) definition, which considers individuals aged 60 and above as elderly. This classification is particularly relevant in Africa, where life expectancy, socioeconomic conditions, and healthcare access differ from those in developed nations.

Primary health care

According to the World Health Organization (WHO, 2021), Primary Health Care (PHC) is a fundamental form of medical care that integrates practical, scientifically validated, and socially acceptable technologies. It is designed to be widely accessible to individuals and families within a community through active participation and is provided at a cost that both

the community and the nation can sustain at every stage of development, fostering self-reliance and self-determination. In this study, PHC is defined as a healthcare delivery approach that promotes equitable access to essential health services, enabling individuals to attain a level of well-being that supports their economic and social productivity.

Challenges

Challenges are defined as situations that demand substantial mental or physical effort to be successfully overcome, thereby testing an individual's abilities. In the context of this study, challenges refer to the obstacles and difficulties that elderly individuals encounter in accessing healthcare services and maintaining their overall well-being.

For this study, challenges include any predicaments faced by the elderly population regarding providing PHC services.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The preceding chapter outlined the study's background, identified the research problem, and articulated its objectives. In contrast, this chapter delves into an existing scholarly discussion concerning how load shedding affects the quality of healthcare services in hospital settings.

A literature review systematically compiles and presents academic studies relevant to a particular subject, facilitating the identification of research gaps and contradictions in current knowledge (Chigbu, Atiku, and Du Plessis 2023). Karunarathna, De Alvis, Gunasena, and Dissanayake (2024) highlight that literature reviews are essential in locating, evaluating, and interpreting research findings, ultimately allowing scholars to derive well-informed conclusions.

2.2 Purpose of the Literature Review

According to Chigbu, Atiku, and Du Plessis (2023). researchers conduct the literature review for various reasons, namely to

- To acquire hint on the methodology and instrument.
- Recognising the research problem and sharpen the research question.
- To compare the results of the current study with those from previous research.

A review of pertinent literature on "**Barriers to accessing public primary health care among older people in Mpheni village, Limpopo Province**". The researcher discovered that, although numerous studies have been conducted in various countries, there is a lack of reports, research, or literature specifically addressing this subject in Limpopo Province. This gap highlights the need for further investigation to understand the unique challenges and experiences of elderly individuals in accessing healthcare services within this region.

2.3 The South African public primary health service

After South Africa became democratic in 1994, many began to believe that the provision of public services would improve. However, according to Ajayi and De Vries (2019), service delivery in health departments has typically been highly delayed, even though the government has introduced legislation and addressed historical injustices in South Africa. Recent news reports highlight the health sector's severe difficulties due to the COVID-19 pandemic, including a lack of medical personnel, long workdays, and basic supplies like personal protective equipment (Harrisberg & Khan, 2020).

Pauw, (2022) argues that despite progress since 1994's democratisation, there is still an important barrier to overcome before South Africa's health system can become highly effective. Several initiatives addressing transformation and redress have shaped South Africa's PHC environment (Abrahams, 2021). These include the PHC Package, the Constitution of the Republic of South Africa, 1996, and other legislative frameworks that

form the basis for enhancing South Africa's healthcare systems (Pauw, 2022). The Constitution, which serves as the primary source of national law, assures the right to access public health services delivery through the Bill of Rights and offers legislation on significant issues. According to Abrahams (2021), the state and health service providers are required under the Constitution, particularly section 27, to work towards enhancing the healthcare rights of all residents.

Despite having a highly developed Constitution, South Africa continues to lag behind other countries in ensuring human rights, including access to high-quality healthcare (Maphumulo & Bhengu, 2019). According to Dolamo (2018), adequate healthcare access guarantees that every citizen receives the best possible physical and mental medical care. This obligation is outlined in the National Health Act 61 of 2003, which provides the legal framework for organizing and delivering equitable healthcare services across the country. Recognized as a fundamental human right, access to healthcare should be exercised constructively to ensure that healthcare facilities provide high-quality public services to individuals and communities. To achieve this, the Constitution and other legislative frameworks mandate national, provincial, and local governments to establish a well-structured and consistent healthcare system in South Africa.

2.4 Healthcare Accessibility in Rural Areas

Examining how individuals obtain healthcare is the focus of the multidisciplinary discipline of health services research. Achieving the best possible health outcomes, including maintaining general physical, social, and mental well-being and preventing illness and disability, depends on having optimal access to health services (Pendo, and Iezzoni, 2020). Many factors, including unmet health needs, can be caused by poor access to healthcare services. Growing worries exist in Canada that some geographic regions may be unable to access and use the health system as readily as possible (Marchildon, Allin, S. and Merkur, 2021). For instance, compared to people living in urban areas, many people in rural areas have worse health, and shorter life expectancies. They also have less access to medical services, like physiotherapy (Marchildon et al., 2021).

Long-standing concerns have been raised about the accessibility of healthcare in rural areas (Cordes et al., 2009); rural communities have long struggled to maintain access to quality healthcare services. Having a primary care system in place in a remote location is not sufficient, though; the services must also be easily accessible (Houghton, Bascolo, Cohen, Vilcarromero, Gonzalez, Albrecht, Koller, and Fitzgerald, 2023). It would seem that rural populations would have less access to healthcare services than their urban counterparts, yet contradictory and inconclusive research has been reported by Houghton et al. (2023). According to Marchildon et al. (2021). people living in rural and isolated places encounter obstacles proper medical care. These obstacles to rural residents' access to healthcare have been extensively documented

Rural areas "do without ready access to the dense network of services - including health services - that characterises the urban environments" and share key traits that impact health and health care (Garnelo, Parente, Puchiarelli, Correia, Torres, and Herkrath, 2020). listed the following as some essential traits for rural areas: Fragile and underdeveloped health infrastructures, High rates of chronic illness and disability prevalence, financial difficulties; and, physical obstacles including distance and transportation choices, such as an absence of public transportation (Ezeudu, and Fadeyi, 2024).

2.5 Elderly Healthcare Needs and Challenges

The World Health Organisation (WHO) defines geriatrics as individuals 60 years of age and above. By 2050, there will be 160 million geriatrics in sub-Saharan Africa (SSA), up from 42.6 million in 2010 (Aboderin & Beard, 2020). The effectiveness of initiatives to lower maternal and newborn mortality and improve access to antiviral therapy contributes to the region's fast ageing to contributes population (Audain et al., 2019). By 2040, South Africa's elderly population is expected to outnumber children under the age of five for the first time (Oosthuizen, 2024). Despite the anticipated rise in age-specific health demands, health systems across the continent have made minimal progress in addressing geriatric healthcare needs. This may be partly due to the limited availability of data informing

policymakers about the specific health requirements of older adults in Sub-Saharan Africa (SSA) (Maduna and Loos, 2021). Additionally, most research on the health needs of older adults originates from high-income countries (HICs), making it difficult to generalize findings to the elderly population in SSA, where healthcare access, infrastructure, and social determinants of health differ significantly.

Most elderly persons in SSA receive their medical care via PHC facilities. Most pensioners receive their medical care from community clinics. However, a tiny percentage goes to traditional healers or private general practitioners (Maduna and Loos, 2021). and traditional healers or private general practitioners (Maduna and Loos, 2021). It is uncommon to find specialised geriatricians and specialised care for the elderly. According to data from 2017, there was just one geriatrician for every 275,000 senior citizens in South Africa (Maduna and Loos, 2021). The elderly in South Africa confront several obstacles in receiving the healthcare they require, even with the greater access to essential care services that follow democracy (Naidoo et al., 2019).

The primary barriers that older people have while trying to get health care are accessibility, affordability, and transportation. According to reports, most elderly persons in low- and middle-income nations did not receive healthcare due to transportation or financial concerns (Dabelko-Schoeny, Maleku, Cao, White, and Ozbilen, 2021). High out-of-pocket costs are linked to long-term conditions requiring regular trips to the hospital or clinic (Dabelko-Schoeny et al., 2021). Another significant obstacle to receiving healthcare is transportation, which is particularly problematic for the elderly living in remote areas and those with limited mobility (Naidoo et al., 2019).

Potential consequences of limited access to PHC services for elderly populations Research has indicated that elderly individuals with less access to essential healthcare services tend to have worse health outcomes. For instance, a lack of primary care access can delay the diagnosis and treatment of chronic disorders, including diabetes, hypertension, and cardiovascular diseases, which can worsen the condition's progression, consequences, and mortality (Bazemore et al., 2019).

When older people have trouble getting PHC, they frequently go to hospitals or emergency rooms for urgent care. This puts more burden on the healthcare system and raises expenses (Haraldseide, Sortland, Hunskaar and Morken, 2020). Furthermore, senior populations may often require hospital stays and ER visits without timely access to preventative care and disease management services, which can exacerbate pre-existing medical conditions and create a vicious cycle of episodic care (Parkinson, Meacock, Checkland, and Sutton, 2022).

Older people's overall well-being, including their mental, social, and physical health, can be adversely affected by limited access to essential healthcare services. According to Parkinson, Meacock, Checkland, and Sutton, (2022), older people may have a lower quality of life, more disability, and a worse functional status if they are unable to obtain preventative treatment, health screenings, and chronic illness management services. Furthermore, according to Narayan et al. (2019), the expense of securing healthcare outside of primary care settings might strain household finances and worsen socioeconomic gaps.

2.6 Socioeconomic factors as a barrier that prevents older people from accessing health care in rural areas

Older people, especially those in rural areas with lower income levels, who typically have fewer financial resources, which might make it more difficult for them to access healthcare services. These barriers could include the inability to pay for the costs of getting to medical facilities, prescription medications and other treatments out of pocket, or specialised care outside of the community (Shen et al., 2018).

The excellent excellence, and the ability to effectively navigate the healthcare system and maintain health literacy depends heavily on education and excellence. Excellent knowledge among the elderly increases their likelihood of comprehending health information, practising preventive health behaviours, and advocating for their healthcare requirements. On the other hand, a lack of education can lead to misunderstandings about health, a reduced knowledge of the services offered, and communication problems with medical professionals (Murugesu, Heijmans, Rademakers, and Fransen, 2022).

Older people living in rural locations depend heavily on their social support networks, including friends, community, family, and organisations, to access healthcare services. Strong social networks can offer psychological, practical, and educational support, including help getting to doctor's appointments, assisting with the healthcare system, and motivating people to seek treatment as soon as possible (Dominguez et al., 2019).

2.7 Strategies adopted by the government to improve the quality of healthcare delivery in South Africa

2.7.1 Decentralisation of healthcare system

Like other developing nations, South Africa has embraced a decentralisation strategy for changing its healthcare system (Rapanyane, 2022). The three layers of government that make up South Africa's healthcare system are, which are national, provincial, and local (Winchester & King, 2018). The reviewed literature on the advantages and difficulties of decentralisation, particularly in the health sector (Rapanyane, 2022), finds mixed results.

According to several studies, decentralisation has helped developing nations (Alves et al., 2013). Nevertheless, according to Rapanyane, (2022), decentralisation has made disparities in healthcare delivery worse for vulnerable people. The division of South Africa's policy implementers from policy determinants has resulted in a crisis in the provision of healthcare, claims Michel Kawonga, Muchengeti and Tanner, (2024). Health expenditures have been diverted to other spending with political agendas because policy implementers failed to impose restrictions at the provincial level (Michel, et al., 2024).

2.7.2 Policies and Legislation

The Constitution of the Republic of South Africa (1996), ratified by the Constitutional Court on February 4, 1997, serves as the nation's supreme law, outlining the rights and responsibilities of citizens as well as the structure and functioning of the government. From its provisions, the Patient's Rights Charter was established to create a standardized framework for raising awareness about patients' rights within the healthcare system (Njuguna, 2020). Additionally, the National Health Act (No. 61 of 2003), in conjunction with

the Constitution, provides the legislative foundation for the National Department of Health's mandate, which includes policy oversight and healthcare service coordination across South Africa. Key government initiatives, such as the district-based PHC system and the free health policy, aim to enhance healthcare access and promote equity nationwide (van Praag, Nangawe, Kengia, and Kapologwe, 2023).

2.7.3 Programmes developed to evaluate healthcare delivery

In South Africa, several methods have been implemented to monitor and enhance the provision of high-quality healthcare. One significant approach has been the development of accreditation, initiated by Dr. Whittaker through the 1994 University of Stellenbosch pilot Accreditation Programme for South Africa. This initiative aimed to assess healthcare institutions against minimum quality standards. Findings from the study revealed that many institutions failed to meet these baseline requirements, leading to a renewed emphasis on continuous quality improvement (Malakoane, Heunis, Chikobvu, Kigozi, and Kruger, 2020). This accreditation process has since played a vital role in strengthening healthcare systems, ensuring that facilities uphold safe, effective, and patient-centred care.

According to Malakoane et al., (2020) the National Department of Health has demonstrated a strong commitment to enhancing the quality of healthcare delivery in public health facilities. A key initiative reflecting this commitment is the Hospital Revitalization Programme, aimed at improving hospital infrastructure, health technology, administrative management, and service quality. As part of this effort, the Ten Point Plan Strategic Planning Framework was developed to guide healthcare reforms and ensure that public hospitals deliver efficient, patient-centred care (National Department of Health, 2011).

2.8 Community-based initiatives and interventions designed to address barriers to healthcare access among older people in rural areas

2.8.1 Health Education and Awareness Campaigns

Through community-based health education and awareness initiatives, knowledge of available healthcare services, preventive measures, and healthy behaviours can empower older adults and their caregivers. These messages can be delivered in the local languages through printed materials, radio programmes, workshops, and community gatherings. In South Africa, non-profit organisations and government agencies like the Department of Health frequently work together to carry out health education initiatives specifically designed for rural areas (Kolawole, Mustapha, Mbata, Tomoh, Forkuo, and Kelvin-agwu, 2023).

2.8.2 Community Health Worker Programs

Enhancing healthcare access in rural regions has been demonstrated to be beneficial through the training and deploying of community health workers (CHWs). CHWs offer various services, such as health education, basic healthcare, and chronic disease monitoring, and they help people navigate the healthcare system. They are frequently hired from the local community. These programmes in various rural locations improve the older population's use of healthcare (Banerjee, 2021).

2.8.3 Mobile Clinics and Outreach Programmes

Mobile clinics and outreach programmes are developed in many rural locations, including South Africa, to provide healthcare services directly to communities. These programmes frequently target senior citizens who might have trouble getting to medical facilities. In addition to providing PHC, these mobile clinics provide health education, testing, and referrals. One illustration might be the "Mophela Mobile Clinic" in the South African province of Mpumalanga, which offers medical care to rural residents, particularly the elderly (Lim, Liang, Assantachai, Auyeung, Kang, Lee, Lim, Sugimoto, Akishita, Chia and Chou, 2020).

2.8.4 Programmes for Transportation Assistance

In rural areas, access to healthcare services is severely hampered by a lack of transportation infrastructure. Older people can overcome this challenge by supporting community-based transport assistance programmes, such as volunteer driving or subsidised transport services. These programmes make it easier to go to medical facilities

for appointments, medicine collections, and other healthcare-related needs (Hosford, Pitman, and Winters, 2024).

2.9 Chapter Summary

This chapter examines the South African public health system and its challenges, focusing on rural areas and elderly populations. Despite progress since 1994, the health system struggles with accessibility, resource allocation, and service delivery, exacerbated by socioeconomic disparities and geographic isolation. Rural healthcare accessibility remains limited due to underdeveloped infrastructure, financial constraints, and transportation challenges, leading to poorer health outcomes than urban areas. Elderly individuals face compounded barriers, including affordability and lack of specialised geriatric care, impacting their quality of life and overall well-being.

The chapter also explores government strategies and community-based initiatives to improve healthcare delivery. Decentralisation, legislative reforms, and quality assurance programmes have been implemented to enhance healthcare infrastructure and services. Community health worker programmes, mobile clinics, and health education campaigns also target rural and elderly populations to address access barriers. While these efforts show promise, persistent challenges highlight the need for sustained investment and innovative interventions to achieve equitable healthcare delivery in South Africa.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

Chapter three outlined the research methodology, detailing the study design, research approach, study area, population and sampling techniques, as well as the methods of data collection and analysis employed by the researcher.

3.2 Research methodology

Creswell (2018) defines research methodology as a systematic process for addressing a research topic through data collection, utilizing various approaches, interpreting the gathered data, and drawing conclusions from the study's findings. It encompasses multiple methods that aid in understanding and analysing data. This study adopted a qualitative approach for data collection, analysis, and interpretation.

3.2.1 Study design

Creswell and Creswell (2018) assert that qualitative research emphasizes qualitative phenomena, focusing on aspects related to quality. It follows a logical approach and is characterized by being descriptive, non-numerical, and conversational. The primary aim is to capture the meaning, emotions, and detailed descriptions of a given situation. Adopting an “insider” perspective is essential, as older individuals often engage in lengthy conversations and feel a strong need to express themselves. These research designs are well-suited for the study, benefiting both the researcher and the participants.

3.2.2 Exploratory Research Design

George (2021) defines exploratory research as a methodological approach used to investigate research issues that have not been fully explored. This type of research often relies on qualitative methods to gain deeper insights. In this study, an exploratory

approach was employed to investigate how older individuals in the Mpheni community perceive the accessibility of PHC services.

3.2.3 Descriptive research design

Punch (2013) defines descriptive research as a study that outlines the characteristics of a population or subject under investigation. McCombes (2022) further emphasizes that descriptive research is ideal for identifying attributes, frequencies, trends, and classifications, particularly when the topic remains largely unexplored. This study employed a descriptive approach to collect rich, first-hand information on the challenges affecting the delivery of PHC services for older individuals in Mpheni village.

3.2.4 Qualitative research approach

Bhandari (2023) explains that qualitative research involves gathering and analysing non-numerical data such as text, video, or audio to gain deeper insights into concepts, beliefs, and experiences. Data collection in this study extended beyond just words or text, employing an empirical approach to address the research question (McCombes, 2023). Interviews, literature reviews, and observations provided rich, detailed, and sensitive data essential for the study. An open-ended interviewing method was used to extract the necessary information for this qualitative approach.

3.3 Study setting

According to Brink, Walt, and Rensburg (2018), a study setting refers to the location where data is collected. The study was conducted at Mpheni village (Figure 1). Mpheni is a hill with a rounded elevation of a limited extent that rises above the surrounding land with less than 300m of local relief. Mpheni Village is a rural area in the Vhembe district at Limpopo in South Africa. It is situated northeast of Wolferoode and southwest of Muhovha River, next to Elim. The villagers have farms where they plant vegetables and fruits and keep animals. The Mpheni village has a population of approximately 20 456, of which 2050 are elderly (Stats SA, 2022). The population of Mpheni village consists of black

Africans who speak Tshivenda and Xitsonga. Most people in Mpheni village depend on government social grants to meet their needs. There is a high level of unemployment in the village. The schools at Mpheni village are Muthuhadini Primary School, Ozias Davhana Secondary School, and Mulweli Primary School.

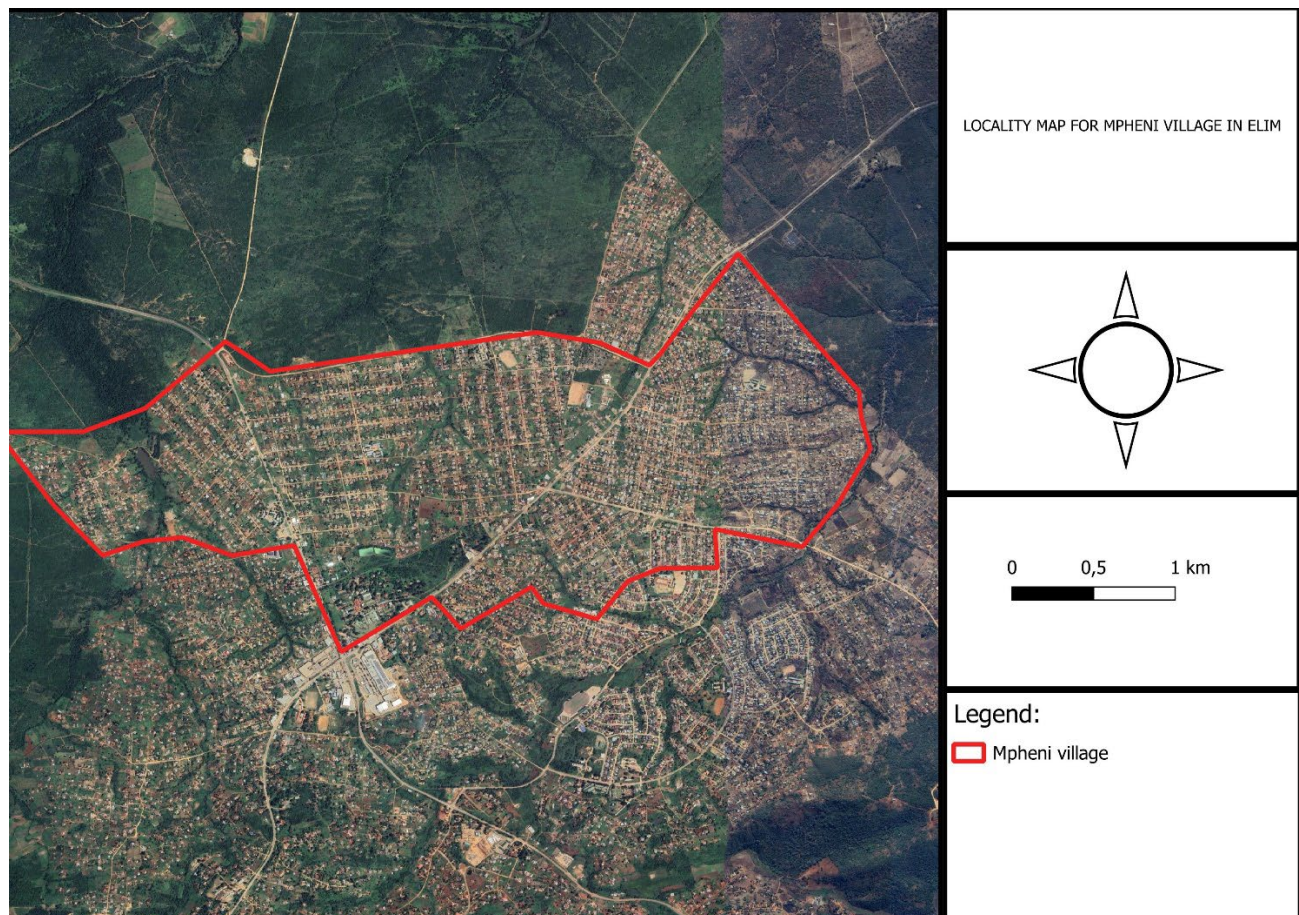


Figure 3.1: Mpheni village Locality Map

The primary health services at Mpheni are rendered at the Mpheni clinic; the district hospital is in a nearby village called Elim Hospital. Mpheni Village has running water and good sanitation. Vhembe District Municipality (VDM) is one of 11 pilot project areas for the National Health Insurance Scheme roll-out. Therefore, this study was conducted in Mpheni village, where Elim Hospital has limited PHC services. The researcher chose

Mpheni village because it has a large population of older people relying on the Mpheni clinic and the Elim hospital, which is far from Mpheni for older people to access. Hence, they need to use transport, compared to the neighbouring village Watervaal, which has a small population.

3.4 Study population and sampling

3.4.1 Target population

A population refers to the complete set of individuals or objects that are of interest to a researcher, provided they meet the specific criteria relevant to the study (George, 2021). In this study, the population consists of community members residing in Mpheni village. The target population represents the broader group of individuals or elements that align with the researcher's sampling criteria and to whom the findings may be generalized. Specifically, this includes both male and female residents of Mpheni village aged 60 years and older who may encounter difficulties in accessing or receiving PHC services. According to Stats SA (2022), Mpheni village has an elderly population (aged 60 and above) exceeding 2050.

3.4.2 Sample and sampling

Creswell (2018) defines a sample as a smaller group derived from a larger population, selected by the researcher for participation in a study. Sampling, in contrast, is the process through which the researcher selects individuals from the population to gather data on a particular phenomenon, ensuring it reflects the broader group of interest. This study will employ a nonprobability convenience sampling approach, where participants are chosen based on their availability and willingness to take part. However, it is essential to recognize the potential biases associated with this method, such as the exclusion of certain demographics or individuals who are less accessible.

While this sampling method may provide valuable insights from a convenience perspective, its limitations in accurately representing the entire population must be recognised. Sample size refers to the number of participants in a study, and in qualitative research, a smaller sample size is often sufficient to achieve data saturation. Data saturation occurs when no new information or themes emerge from the data collection, indicating that theoretical saturation has been reached (Braun and Clarke, 2021). While the anticipated sample size for this study was 15 participants, the researchers remained open to increasing the sample size for data saturation to be achieved within the initial cohort. This flexibility ensures that the study captures a comprehensive range of perspectives and experiences related to the challenges older people face in accessing PHC services in Mpheni village.

3.4.3 Inclusion and exclusion

Inclusion criteria are the characteristics the subject or element must possess to be part of the target population. The study included:

- Participants that are 60 years old and above
- Participants who receive PHC services in Mpheni clinic and Elim hospital.
- Participants who have been residing at Mpheni for 10 years or more.

Exclusion criteria are those characteristics that can cause a person or element to be excluded from the target population. The study excluded:

- Community members who refused to sign the consent form without informed consent, participants may not have a clear understanding of what is expected of them, and their voluntary participation may be compromised.
- Participants who formed part of a pre-test.
- Participants who withdraw from the study
- Residents that do not reside at Mpheni village.
- The study excluded individuals who were not at home during the visits or were uncomfortable participating in interviews, leading to potential biases.

3.5 Data collection

3.5.1 Interview guide

This study used a structured interview guide to solicit data from the participants of the study participants. An interview is a data collection technique through which a researcher obtains information from the participants through verbal interaction. A researcher prepared an interview guide pertinent to the study before meeting the participants to discuss the challenges regarding providing PHC services among the elderly population residing in Mpheni village.

Oben, (2021) state that the questions in an interview guide are designed to align with the research objectives. The initial section of the interview guide included details such as the research topic, study aim, participant demographic information, assigned codes, interview duration, location, and date. The researcher used a structured interview guide (Appendix E) to get information from participants. Validation was ensured by conducting member checks or validation interviews with a subset of participants to verify the accuracy and completeness of the data collected. This step enhanced the credibility and trustworthiness of the findings.

3.6 Pre-test

Bhalla, (2023) describes a pre-test as the process of trialling an interview guide on a small group of participants before conducting the full study. This helps identify potential issues, such as ambiguous wording or excessive time required for administration.

The pre-test for this study involved selecting three elderly participants from Mpheni village, representing 10% of the total participants, these three individuals were chosen to serve as pre-test respondents to help identify and resolve any potential issues with the interview guide before proceeding with the full-scale study. This small sample size was

appropriate for a pre-test as it allowed for a manageable and focused evaluation of the interview guide without overburdening resources. A minimum of 30 or 45 minutes was spent on each interview. Communication abilities were considered to assess the study's feasibility and the questions' quality. Given the age and potential health issues of the elderly participants, the interview length was carefully balanced to avoid causing discomfort or fatigue. The participants and findings for the pre-test were excluded from the main study. The data was only used to help ensure that the data collection runs smoothly.

3.7 Trustworthiness

Trustworthiness refers to the level of confidence in the data, interpretation, and research methods used to ensure the rigor and quality of a study (Adler, 2022). Researchers must establish clear guidelines and criteria to help readers assess the credibility of a study ((Haq, Rasheed, Rashid, and Akhter, 2023). While scholars widely agree on the importance of trustworthiness, there is ongoing debate regarding the specific factors that contribute to it (Adler, 2022). Since qualitative research does not rely on standardized instruments for measuring validity and reliability, it is crucial to demonstrate that findings are credible, transferable, confirmable, and dependable. To uphold trustworthiness, the researcher-maintained honesty, respected participants' privacy, and ensured their anonymity, fostering a sense of security and confidence in the study. These four elements form the foundation of trustworthiness in qualitative research.

3.7.1 Credibility

Credibility measures a qualitative researcher's reliance on the validity of the study's findings. The key question is, "How do you know your findings are true and accurate?" Triangulation is a method employed by qualitative researchers to enhance the validity of their study's findings by using multiple data sources, methods, or perspectives. In this study, the researcher implemented multiple types of triangulations and detailed how conflicting data or perspectives were addressed to ensure the validity of the findings.

Methodological Triangulation:

This approach incorporates various data collection methods to examine the same phenomenon. In this study, both interviews and observations are utilized to enhance the depth and accuracy of the findings. Interviews are conducted with elderly participants to capture their personal experiences and viewpoints, while observations of their daily activities provide contextual data. This combination of methods helps cross-verify the interview findings, offering a more thorough understanding of the studied subject.

3.7.2 Transferability

Transferability refers to the ability of a qualitative researcher to demonstrate that the study's findings are applicable to other situations, including similar contexts, populations, or phenomena. One way to establish transferability is through comprehensive descriptions, which help illustrate how the findings may be relevant in various conditions and settings (Creswell, 2018). In this study, the researcher provided in-depth descriptions of the research context, participants, and processes, enabling readers to assess the applicability of the results to other environments.

3.7.3 Dependability

Dependability refers to the extent to which a study's findings can be consistently replicated by other researchers. This means that if someone were to repeat the study, they should have sufficient data from the research report to follow the same process and arrive at similar conclusions. One way to establish dependability in qualitative research is through an inquiry audit, where an external reviewer examines the research process and data analysis to ensure consistency and reliability (Haq et al., 2023). In this study, the researcher sought an external audit from an independent reviewer. To strengthen the rigor of the methodology, the following details regarding the external audit process were provided.

Selection of the External Reviewer:

The external reviewer will be selected based on their expertise in qualitative research methodologies and familiarity with the study's subject matter. Ideally, the reviewer will have a background in social sciences, particularly in gerontology or community health, to ensure they have the relevant knowledge to assess the study critically.

Criteria for Assessing Dependability:

Audit Trail: The supervisors and research committees examined the documentation of the research process, including research design, data collection methods, data analysis procedures, and decision-making processes. This included checking that all steps were clearly documented and logically consistent.

Data Consistency: The data analysts compared the raw data with the findings to ensure the data supported the conclusions drawn. This involved reviewing the interview transcripts, observation notes, and other data sources used in the study.

Process Adherence: The research committees and supervisors assessed whether the research followed the planned methodology and adhered to ethical guidelines. Any deviations from the initial plan were justified and documented.

3.7.4 Confirmability

Confirmability refers to the degree to which a study's findings are shaped by participants' responses rather than the researcher's biases or personal motivations (Creswell, 2015). This requires ensuring that data interpretation remains objective and is not influenced by the researcher's perspectives. To establish conformability, qualitative researchers can maintain an audit trail that systematically documents each step of data analysis, providing a clear rationale for methodological decisions. This approach helps verify that the study's conclusions accurately reflect participants' responses ((Ashiq, Usmani and Naeem, 2022). In this study, the researcher ensured conformability by detailing the process used to verify

and validate data, as well as by providing a transparent account of data collection methods. The researcher offered credit to all participants in the study, the data was completed, and the data was audited. The researcher acknowledges that potential biases may arise and will take the following steps to mitigate them: The researcher begins by identifying and recognising their own possible biases and assumptions related to the study. This self-awareness is crucial for recognising how personal perspectives might influence the research process. The researcher selected participants from diverse backgrounds within Mpheni village to ensure a broad range of perspectives. This diversity helped mitigate the influence of any viewpoint dominating the findings.

3.8 Plan for Data collection

Qualitative data collection in this study was exploratory, involving in-depth analysis and research. The methods focused on gaining insights, reasoning, and motivations, allowing for a deeper understanding of the subject. Since qualitative data is not measurable in numerical terms, researchers typically use data collection tools that are only partially structured to maintain flexibility (McCombes, 2022). This study made use of structured interview methods to collect data. The researcher was responsible for clearly explaining the interview method to the participants to ensure their full understanding. Additionally, participation was entirely voluntary and uncompensated, ensuring that individuals chose to engage willingly without financial incentives influencing their involvement. Participants were visited in their households for interviews. It was the researcher's responsibility to guarantee that the data collected was relevant to the research topic and that all policies that must be followed during interviews were followed. The researcher guaranteed the data was continuously updated by taking notes during the interviews (McCombes, 2023). Before the interviews began, the participants were informed of the notetaking. The researcher conducted interviews using the participant's native language (i.e., Tshivenda and Xitsonga) with the elders who did not understand English.

3.9 Plan for data management and analysis

3.9.1 Plan for data management.

"Research data management" refers to organising and storing data gathered during a study project (Ashiq et al. (2022). The researcher retained the data obtained throughout the study by developing standardised norms. The researcher employed rigorous data management techniques to ensure secure data sharing, access, preservation, and disposal. In this study, data was stored in a password-protected file accessible only to the researcher, encrypted on a USB drive and SIM card, and regularly backed up for recovery. To maintain confidentiality, participants' questionnaires contained no identifying information; instead, unique hidden codes were used for identification. All responses were securely saved on a USB drive, which was stored in a locked safe accessible only to the researcher. Interviews were conducted using a structured guide with a predetermined order of questions to ensure consistency across all participants. Standardized probing techniques, such as prompts like *"Can you tell me more about that?"* and *"How did that make you feel?"*, were used to encourage detailed responses. With participants' consent, interviews were audio-recorded and transcribed verbatim. Additionally, the researcher took detailed notes to capture non-verbal cues and contextual information, enhancing the depth and accuracy of data analysis.

3.9.2 Data analysis

Texts, images, photographs, videos, and audio qualify as qualitative data forms. For instance, a researcher might use field notes, survey results, transcripts of interviews, or recordings made in the field. TCA, or thematic content analysis, was used in the study. This is the method of classifying verbal or behavioural data to organise, consolidate, and tabulate the data (Roodt, 2020). The steps for qualitative data analysis that were used in this study are as follows:

- Prepare and organise data: This study involved transcribing interviews and documenting field notes in a structured format.

- Review and explore data: The collected data was examined to identify patterns, recurring ideas, or significant insights.
- Develop a data coding system: The researcher established a coding framework based on initial observations to categorize the data effectively.
- Assign codes to the data: Each participant's responses were reviewed and tagged with relevant codes in a spreadsheet. If necessary, new codes were introduced during the analysis process.
- Identify recurring themes: The researcher grouped related codes into overarching themes to create a comprehensive understanding of the data.

3.10 Ethical considerations

Ethics refer to a set of principles established by individuals or groups that outline rules and expectations for appropriate conduct toward research participants, employees, sponsors, researchers, assistants, and students (Sivasubramaniam, Dlabolová, Kralikova, and Khan, 2021). To obtain approval, the research proposal was first submitted through the Head of Department to the Faculty of Health's Higher Degrees Committee for review and presentation. Upon faculty approval, the proposal was forwarded to the University Higher Degrees Committee and subsequently to the University's Research Office for ethical clearance before the study commenced. A gatekeeper letter requesting permission to conduct the study was submitted to the Traditional leaders of Mpheni Village. In the letter, the researcher requested the leaders to communicate with their constituency regarding the proposed study. Once the request was approved, the researcher issued an informed consent form to all the participants, which explained the research intentions and the importance of the respondent's participation in the success of the research.

3.10.1 Informed consent

This makes a participant aware of all aspects of the study (Millum and Bromwich, 2021). Informed consent allows the participant to participate of their own free will. Researchers

thoroughly explained all the information about the study to participants. Participants also received a consent form (**Appendix D**) from the researcher to sign.

Millum, J. and Bromwich, D., 2021. Informed consent: What must be disclosed and what must be understood?. *The American Journal of Bioethics*, 21(5), pp.46-58.

3.10.2 Respect for persons

This principle involves acknowledging each individual as unique and autonomous (Creswell & Creswell, 2018). Researchers recognize that every person has the right to make independent decisions and, as such, respected each participant's religious and cultural beliefs. Additionally, participants were informed of their right to withdraw from the study at any time without facing any form of penalty.

3.10.3 Beneficence

This is all about acting to benefit others (Bhandari, 2023). The researcher carefully structured the interview questions and monitored for any sign of discomfort and stress throughout the data collection process. The researcher allowed participants to ask questions that they did not understand.

3.10.4 Justice

This principle deals with fairness (Bhandari, 2023). The study population was not included because it was easy to access, and the selection of the participants was related to the research problem. The researcher did not manipulate participants to obtain information.

3.10.5 Confidentiality

The data is re-identified, and the participant's identity is kept confidential (Punch, 2013). Researchers did not share information about the participants with other participants, and no unauthorised person had access to the collected data.

3.10.6 Anonymity

Participants' identities remained confidential (Creswell, 2018). No personally identifiable information was collected, and anonymity was ensured by assigning unique codes to each participant.

3.10.7 Honesty

It entails honestly reporting data and not falsifying data. The researcher remained truthful and did not lie about the data.

3.11 Plan for dissemination and implementation of results

Upon the study's completion, the researchers will share the document with all the stakeholders involved in the data collection. Community meetings were held where data would be shared with community leaders, such as civic community members and healthcare workers. At least two papers would be shared with community leaders, such as civic community members and healthcare workers. At least two papers will be published from this study.

CHAPTER FOUR: PRESENTATION AND DISCUSSION OF RESULTS

4.1 Introduction

The previous chapter explained the data-gathering methodology and design. The researcher presents and discusses the findings in this chapter. The participants' views on barriers to accessing public PHC among older people in Mpheni village were categorised using interview themes. The interviews lasted 45 minutes per participant. The demographic information and themes are presented in Tables 4.1 and 4.2, respectively.

4.2 Participants' demographic information

The demographic data that the participants provided during the interview is provided in this section. The demographic details of the study participants are shown in Table 4.1 below. The demographic profile of participants in the study titled "Barriers to accessing public PHC among older people in Mpheni Village, Limpopo Province" offers significant insights into the population facing healthcare challenges. Participants' ages range between 60 and 74 years, highlighting a group that is uniquely vulnerable to healthcare access issues. The majority are in their early to mid-60s, a stage in life often associated with chronic health conditions and mobility constraints. This age range aligns well with the study's focus on understanding the barriers elderly individuals encounter when seeking public healthcare services.

The participants' educational backgrounds are varied, with the majority holding matric certificates (Participants B, D, F, and H). A smaller number have post-secondary qualifications, such as certificates in Human Resources or Tourism (Participants G, I, and J) or professional teaching qualifications (Participants C and E). While education level might provide some participants with better knowledge of navigating healthcare systems, the data suggests that systemic barriers, such as medication shortages, long waiting times, and transportation challenges, persist regardless of educational attainment. This underscores the widespread nature of healthcare access issues in the village.

Although gender is not explicitly detailed in this section, it is plausible that the sample includes a mix of men and women. Gender can significantly influence healthcare-seeking behaviour, with older women, for example, potentially facing added challenges such as caregiving responsibilities or safety concerns when travelling to clinics. Understanding the intersection of gender and age would provide a more nuanced picture of the barriers experienced.

The demographic data indicates that despite diverse educational backgrounds, all participants rely heavily on public health services, often due to financial constraints and limited access to alternative options. This uniform dependence highlights systemic issues in healthcare delivery rather than individual factors such as education or employment history. Elderly individuals, regardless of their qualifications, face consistent barriers, suggesting a critical need for targeted interventions.

Table 4.1: Demographic Information of Participants

Participant	Gender	Age	Qualification
A	Female	62	Computer certificate
B	Male	71	No official education
C	Male	68	Teaching
D	Female	74	Matric
E	Female	62	No official education
F	Male	61	Matric
G	Female	66	No official education
H	Female	73	No official education
I	Female	66	No official education
J	Male	60	National Diploma in HR

4.3 Presentation of findings in the form of themes and sub-themes

Along with the data's themes and sub-themes, the study's conclusions are presented with participant quotes and sub-themes, and the study's findings are presented with participant quotes from participants.

Table 4.2 Themes and Categories

Themes	Sub-themes
1.1 Challenges in Accessing PHC Services	• Long Waiting Times • Geographical barriers • Transportation issues • Availability of Healthcare Staff • Availability of Medication
1.2 Impact of Challenges on Health and Well-being	• Delayed or Poorly Managed Care • Emotional and Psychological Effects
1.3 Perceptions of the Quality of PHC Services	• Positive Aspects • Areas for Improvement

4.3.1 Theme 1: Challenges in Accessing Primary Health Care Services

On this theme, the responses from participants reveal several key challenges that elderly individuals face when accessing public PHC in Mpheni Village. These challenges start from long waiting in the clinic, Transportation issues, and the availability of Healthcare Staff and Medication. Each barrier significantly impacts the ability of elderly residents to receive consistent and adequate medical care. Geographical barriers also limit access to

PHC. Long distances to health facilities and poor transportation make it difficult for older persons in rural locations to obtain necessary care. Even in cities, mobility concerns and hazardous conditions can dissuade older people from accessing healthcare facilities (Dableh et al., 2024). Kelly et al. (2019) state that social and cultural factors complicate access. Age-related stigma and cultural attitudes may make older persons feel devalued in the healthcare system. Furthermore, health services may not be culturally sensitive or customised to the specific requirements of the elderly, leading to dissatisfaction and low usage of existing services.

Long waiting period

Long waiting was another sub-theme among participants, and the frustration was caused by long waiting times at PHC facilities. Elderly individuals often endure extended periods in queues, which is particularly difficult for those with chronic illnesses or mobility challenges.

“We go to a far clinic and wait for a long time before they assist us because of shortage of nurses (Participant A). Long waiting causes our health conditions worse and creates unnecessary discomfort to us as elderly patients, such as prolonged sitting” (Participant G).

These results follow the findings of Chikandiwa et al. (2021), who discovered that poor staffing levels in South African PHC institutions result in longer wait times, disproportionately affecting vulnerable populations such as older people. Similarly, Malatji and Mothiba (2022) found that excessive waiting times discourage health-seeking behaviour and worsen health inequities, leaving many older patients feeling neglected and underserved.

Transportation Issues

The findings in this section highlighted that transportation is a significant barrier for elders to access PHC in Mpheni village. Many respondents revealed the challenges posed by travelling or walking long distances to clinics and poor infrastructure. Respondents stated that:

*“I struggle because the long distances I travel to clinics worsen existing health conditions (**Participant A**). A lack of roads or accessible transport options causes reliance on expensive private transport since roads are sometimes inadequate for taxis during rainy seasons. (**Participant B**). I fail to go to the clinic during bad weather, limiting accessibility (**Participant G**)”.*

These barriers reflect the systemic issues in rural communities, where older people are affected. Several studies support these findings, showing that transport restrictions allow for access to healthcare. Nyathi and Jooste (2022) revealed that long travel distances and expensive transportation prevent elderly individuals from getting prompt medical care, worsening their health issues. Similarly, Baloyi and Ramathuba (2020) noted that poor road infrastructure in rural areas restricts mobility and contributes to delayed healthcare access, particularly during inclement weather.

Availability of Healthcare Staff

One of the challenges faced by elderly participants in this study was the insufficient availability of healthcare staff, which significantly hindered their access to PHC services. Participant Responses:

*“Insufficient staff results in long waiting times (**Participants C, I**). Overburdened staff leads to rushed consultations and a lack of attentiveness (**Participant B**). Late arrivals by staff disrupt clinic operations (**Participant J**)”.*

These challenges are similar to the findings from research by Adebayo et al. (2020), highlighting the detrimental effects of staff shortages in healthcare facilities, especially in rural areas. According to a study by Adebayo et al. (2020), inadequate staffing levels in healthcare facilities contribute to delayed care, suboptimal patient-provider interactions, and increased patient and provider stress. The Study by Cawood et al. (2021) found that healthcare staff shortages and high patient loads are associated with decreased quality of care, especially in PHC settings where patient needs are diverse and complex.

Availability of Medication

One of the issues faced by older people in Mpheni Village was the issue of medication availability, which is another significant challenge that is directly impacting their ability to manage their health conditions effectively. Participant Responses:

*“We frequently have medication shortages, so as patients, we have to return multiple times to buy medicines privately (**Participants D, F, I**)—shortages of essential diagnostic equipment impact treatment outcomes (**Participant F**)”.*

These findings correlate to previous studies showing medication shortages’ impact on healthcare quality. A study by Taylor et al. (2019) noted that medication shortages in primary care settings disrupt treatment regimens and negatively affect patient trust in healthcare systems. Additionally, research by Moyo et al. (2020) highlighted that equipment shortages in public health facilities could lead to inaccurate diagnoses, substandard care, and worsened health outcomes for patients, particularly the elderly, at higher risk for multiple health issues.

4.3.2 Theme 2: Impact of Challenges on Health and Well-being

Access to PHC services is a substantial barrier for older people, affecting their overall health and well-being. Delays in receiving care can worsen chronic diseases, increase hospitalisations, and raise the chance of fatality. Furthermore, the difficulty in obtaining prompt medical care can cause Emotional and Psychological Effects, including feelings of neglect and loneliness. Such consequences are well established in the literature, underscoring the necessity to resolve these obstacles.

Delayed or Poorly Managed Care

Delayed or poorly managed care is a challenge experienced by elders in the Mpheni village. Participant’s responses:

*“Missed doses and appointments, leading to the worsening of chronic conditions (**Participants A, D**). Delayed treatments result in avoidable complications (**Participant H**)”.*

The barrier to timely care contributes to a cycle of deteriorating health for elderly residents in Mpheni village. These delays can lead to chronic illnesses and increase the likelihood

of severe health issues. The study by Asher et al. (2019) discovered that older people with restricted access to healthcare services had poorer physical health outcomes and higher levels of anxiety and despair. Similarly, Rustad et al. (2020) found that a lack of accessible healthcare services for older people in rural locations resulted in delayed diagnoses and treatment, exacerbating health issues.

Emotional and Psychological Effects

*“Worries about healthcare access cause ongoing stress and anxiety (**Participants B, C, I**). Feelings of neglect and lack of prioritisation led to depression (**Participant G**)”.*

These results were like the results from the study by Clough et al. (2021), where they discussed how unmet healthcare needs among elders correlate with increased rates of depression and anxiety. Similarly, Ward et al. (2020) highlighted the role of perceived healthcare inequity in fostering feelings of marginalisation and psychological distress among ageing populations. These studies show the importance of addressing the emotional toll of healthcare challenges to improve mental and physical health outcomes for the elderly.

4.3.3 Theme 3: Perceptions of the Quality of Primary Health Care Services

The elderly participants in this study had mixed perceptions of the quality of PHC services, with both positive aspects and areas for improvement highlighted.

Positive Aspects: Accessibility and Environment

A recurring theme among participants was the appreciation of the accessibility and environment of PHC facilities.

*“Participant Responses: The cleanliness and safety of clinic environments are appreciated (**Participant F**). Free consultations provide financial relief (**Participant C**)”.*

The availability of free PHC consultations significantly alleviates financial strain, ensuring that elderly individuals can access necessary medical attention without the added burden of costly fees. This is important in improving healthcare equity and accessibility for marginalised groups.

Areas for Improvement

Despite these positive aspects, participants identified several areas for improved elderly PHC services.

Participant Response: *“Absence of specialised services or programs for the elderly (Participant H). Poor communication on medication availability (Participant J). Lack of mobile clinics to reach remote areas (Participant I)”*.

This finding corresponds with the findings of Smith et al. (2021), who discovered that a lack of specialised services for older adults in primary care clinics frequently results in poor health outcomes, as common health conditions in the elderly population, such as dementia, osteoporosis, and heart disease, necessitate specific expertise and care strategies. Ngcobo et al. (2019) underline that better communication regarding healthcare services and medications is crucial for increasing patient satisfaction and treatment adherence. Similarly, mobile health clinics have been proven to improve healthcare access in rural and underserved locations (Hughes et al., 2020).

4.4 Chapter Summary

This chapter presented and discussed the findings on barriers to accessing public PHC among older people in Mpheni Village, Limpopo Province. The demographic profile of participants revealed an age range of 60 to 68 years, highlighting a group vulnerable to chronic illnesses and mobility challenges. Despite varied educational levels, systemic barriers persisted across the group, emphasising reliance on public healthcare services. Key challenges identified included long waiting times due to staff shortages, transportation issues caused by poor infrastructure and high costs, and frequent medication shortages that disrupted treatment regimens and diminished trust in healthcare systems. These barriers had significant impacts on participants' health and well-being, with delayed care worsening chronic conditions and contributing to avoidable complications. Emotional and psychological effects such as stress, anxiety, neglect, and depression were also prevalent. Perceptions of PHC quality were mixed, with participants appreciating the cleanliness of clinic environments and financial relief from free consultations. However, they also noted areas for improvement, including the lack of

specialised services for elderly care, poor communication about medication availability, and the absence of mobile clinics for remote areas. The findings align with existing literature, emphasising the systemic nature of these challenges and the critical need for targeted interventions to improve healthcare access and outcomes for the elderly in rural settings.

CHAPTER FIVE: DISCUSSION OF THE FINDINGS

5.1 Introduction

This chapter presents and discusses the study's findings on barriers to accessing public PHC among elderly individuals in Mpheni Village, Limpopo Province. Building on the methodology and design outlined in the previous chapter, the findings are categorised into themes derived from participant interviews. These themes provide an in-depth exploration of the challenges faced by the elderly, the impact of these challenges on their health and well-being, and their perceptions of PHC services.

The data analysis process involved identifying key patterns and insights from the participants' responses, supported by relevant literature, to contextualise the findings. The participants' demographic profiles are first outlined to understand better the population affected by these barriers. The following thematic presentation is enriched with direct participant quotes, highlighting their lived experiences and perspectives.

This chapter addresses these findings to shed light on the systemic and structural issues within the healthcare system that hinder access to essential services for elderly residents in Mpheni Village. It concludes with a summary emphasising the implications of the results for policy and practice.

5.2 Finding discussion

This study investigated barriers to accessing public PHC among elderly people in Mpheni Village, Limpopo Province. The findings revealed critical systemic and structural challenges affecting this vulnerable population. Participants ranged in age from 60 to 74, an age group prone to chronic health conditions and mobility limitations. Despite varying educational backgrounds, from no formal education to post-secondary qualifications, all participants reported similar difficulties, underscoring the pervasive nature of these barriers.

The themes identified in the study included challenges in accessing PHC services, the impact of these challenges on health and well-being, and perceptions of PHC quality.

Among the barriers, long waiting times due to staff shortages were particularly prominent, with participants expressing frustration over delays in receiving care. These findings echo studies by Chikandiwa et al. (2021) and Malatji and Mothiba (2022), highlighting how insufficient staffing in South African PHC facilities disproportionately affects elderly patients, exacerbating inequities in care.

Transportation issues were another significant barrier. Many participants cited long distances to clinics, poor road conditions, and inadequate public transport as obstacles to timely healthcare access. These findings are consistent with research by Nyathi and Jooste (2022) and Baloyi and Ramathuba (2020), who observed that poor infrastructure and high transportation costs limit healthcare accessibility in rural areas. Medication shortages and insufficient healthcare staff compounded these challenges, leading to disruptions in treatment regimens and diminishing trust in the healthcare system. Similar challenges were documented by Taylor et al. (2019) and Moyo et al. (2020), who emphasised the negative impact of resource shortages on healthcare quality and patient outcomes.

The impact of these barriers on health and well-being was profound. Delayed care often worsened chronic conditions, with some participants reporting avoidable complications due to missed appointments or unavailable treatments. The emotional toll was also significant, as participants experienced stress, anxiety, and feelings of neglect. These findings align with studies by Clough et al. (2021) and Ward et al. (2020), which underscore the psychological distress caused by unmet healthcare needs among older people.

Despite these challenges, participants acknowledged positive aspects of PHC services, such as the cleanliness of clinic environments and the financial relief provided by free consultations. However, they identified key areas for improvement, including the need for specialised services for elderly patients, better communication about medication availability, and mobile clinics to serve remote areas. These findings are supported by Smith et al. (2021), Ngcobo et al. (2019), and Hughes et al. (2020), who advocate for

tailored interventions to enhance healthcare access and satisfaction for ageing populations.

5.3 Chapter Summary

This chapter presented and discussed the study's findings, highlighting the systemic barriers elderly individuals face in accessing PHC services in Mpheni Village. Key challenges included long waiting times, transportation difficulties, medication shortages, and inadequate healthcare staffing. These issues significantly impacted participants' physical and emotional well-being, exacerbating health inequities. While participants appreciated certain aspects of the healthcare system, such as cleanliness and free consultations, they also identified areas for improvement, particularly in providing specialised care and enhancing accessibility. The findings align with existing literature, underscoring the urgent need for targeted interventions to improve healthcare outcomes for the elderly in rural communities.

CHAPTER SIX: SUMMARY, LIMITATION, RECOMMENDATIONS AND CONCLUSION

6.1 Introduction

This chapter summarises the study, highlights its limitations, and makes recommendations based on the findings. It concludes with reflections on the study's significance and contribution to understanding barriers to accessing PHC services among older people in Mpheni Village.

6.2 Summary of the study

The study explored the barriers faced by elderly residents of Mpheni Village in accessing public PHC. Key challenges include long waiting times, transportation issues, insufficient healthcare staff, frequent medication shortages, and limited specialised services. These barriers had significant impacts on the health and well-being of participants, exacerbating chronic conditions and contributing to emotional distress. The study also highlighted mixed perceptions of the quality of healthcare services, with participants appreciating cleanliness and free consultations but calling for improvements in service delivery and communication.

6.3 Study limitation

The study was conducted in a single village, limiting the generalizability of its findings to other rural or urban areas. Additionally, it focused on elderly individuals, excluding other age groups that might face similar challenges. The reliance on self-reported data may have introduced bias, and the sample size, though adequate for qualitative analysis, might not represent the broader population.

6.4 Recommendation of the study

6.4.1 Recommendation on challenges older people face trying to access Primary Health Care services in Mpheni village

To address long waiting times, clinics should adopt queue management systems, prioritise elderly patients, and consider introducing appointment-based consultations. Improved public transport infrastructure, such as subsidised transportation for elderly residents and better-maintained roads, can ease clinic access. Additionally, community health outreach programs can provide essential healthcare services to those unable to travel.

6.4.2 Recommendation on the availability of healthcare staff or the availability of medication at Mpheni village

The Department of Health should prioritise recruiting and retaining healthcare staff in rural areas by offering incentives such as housing and professional development opportunities. Continuous professional development programs can also improve staff efficiency and patient care. To address medication shortages, clinics should implement better stock management systems and ensure timely delivery of essential medicines. Mobile clinics with diagnostic tools and medication can bridge the gap in underserved areas.

6.4.3 Recommendations for enhancing the quality of Primary Health Care services in Mpheni village

Improving communication between healthcare providers and patients is critical. Clinics should use clear and accessible communication channels to update patients about medication availability and other services. Introducing specialised programs for elderly care, such as geriatric clinics or regular health screenings, can significantly improve service quality. Furthermore, ensuring that facilities remain clean and well-maintained enhances the patient experience.

6.4.4 Recommendation to the department of health

The Department of Health should allocate more resources to rural healthcare facilities, ensuring they are well-staffed and equipped to meet the needs of elderly populations. Policies should prioritise training healthcare providers in elderly care and cultural competence. The department should also invest in infrastructure improvements, such as establishing mobile clinics and enhancing public transport to healthcare facilities.

6.4.5 Recommendation for future studies

Future research should include a larger sample size and compare barriers elderly individuals face in urban and rural settings. Studies focusing on specific interventions, such as mobile clinics, can provide valuable insights into their effectiveness. Moreover, research should explore the role of cultural and gender dynamics in healthcare access among the elderly population.

6.5 Conclusion

This study highlights critical barriers to accessing PHC services among elderly individuals in Mpheni Village, including long waiting times, transportation challenges, insufficient staff, medication shortages, and inadequate specialised services. These issues significantly impact the health and well-being of elderly residents, underscoring the need for targeted interventions. Addressing these barriers requires a multi-faceted approach involving improved infrastructure, better resource allocation, and enhanced service delivery. By implementing the recommendations, healthcare access and outcomes for older people in Mpheni Village can be significantly improved, fostering equity and dignity in healthcare services.

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APPENDIX A: Ethical clearance

ETHICS APPROVAL CERTIFICATE

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Mr N Netshakhuma

STUDENT NO:
18000050

PROJECT TITLE: **Barriers to accessing public primary health care among elderly people in Mpheni village, Limpopo Province.**

ETHICAL CLEARANCE NO: **FHS/24/PH/22/2609**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr AG Mudau	UNIVEN, Public Health	Supervisor
Prof L Makhado	UNIVEN, Public Health	Co-Supervisor
Mr N Netshakhuma	UNIVEN, Public Health	Investigator – Student

Type: **Masters Research**
Risk: **Minimal risk to humans, animals, or environment (Category 2)**
Approval Period: **September 2024 – September 2025**

The Human and Clinical Trials Research Ethics Committee (HCTREC) hereby approves your project as indicated above.

General Conditions
While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following.

- The project leader (principal investigator) must report in the prescribed format to the REC:
 - Annually (or as otherwise requested) on the progress of the project, and upon completion of the project.
 - Within 48hrs in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
 - Annually a number of projects may be randomly selected for an external audit.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the REC. Would there be deviation from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date; a new application must be made to the REC and new approval received before or on the expiry date.
- In the interest of ethical responsibility, the REC retains the right to:
 - Request access to any information or data at any time during the course or after completion of the project.
 - To ask further questions; Seek additional information; Require further modification or monitor the conduct of your research or the informed consent process.
 - withdraw or postpone approval if:
 - Any unethical principles or practices of the project are revealed or suspected.
 - It becomes apparent that any relevant information was withheld from the REC or that information has been false or misrepresented.
 - The required annual report and reporting of adverse events was not done timely and accurately.
 - New institutional rules, national legislation or international conventions deem it necessary.

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE
Date Considered: **September 2024**

Name of the HCTREC Chairperson of the Committee: **Prof NS Mashau**

Signature: 

UNIVERSITY OF VENDA
OFFICE OF THE DIRECTOR
RESEARCH AND INNOVATION

2024-09-26

Private Bag X5050
Thohoyandou 0950



PRIVATE BAG 10036, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE 015 951 9011 FAX 015 951 9010
"A quality driven financially sustainable, need-based Comprehensive University"

APPENDIX B: Letter for permission to the Chief

LETTER TO REQUEST PERMISSION FROM THE CHIEF

730 OSCHIAL STREET
ROODEPOORT
1124

THE ROYAL CHIEF
MPHENI VILLAGE
THOHOYANDOU
0950

To whom it may concern.

Receive humble greetings from the fourth-level students studying for a Master of Public Health at the University of Venda. We would like to research the challenges that the elderly go through in accessing PHC services. The purpose of this study is to explore and determine the challenges faced by the elderly in the delivery of PHC services. Moreover, if any measures can be taken to improve the services rendered for the elderly. We are hereby humbly requesting that you permit us to collect data in your village through asking citizens questions through one on one interviews.

May you please share with us the challenges that you face regarding access to PHC services. We duly ascertain you that, our research will not in any way or form cause harm to any participants, and the acquired information will be kept confidential. We will be happy if you allow us to collect data in your village.

Yours faithfully
Netshakhuma
Public health master's student

Permission to Conduct Research Study

To whom it may concern

I, DAVHANA M. N. FRANK the tribal leader of Mpheni Village, hereby grant permission to Mr. N. Netshakhuma, a student at the University of Venda (Student Number: 18000050), to conduct his research study titled *"Barriers to Accessing Public Primary Health Care Among Elderly People in Mpheni Village, Limpopo Province."*

This study will take place from 1 November 2024 to 15 November 2024 within Mpheni Village.

Date: 25/10/2024

Signature: 

Official Stamp (if applicable):



APPENDIX C: LETTER OF INFORMATION

LETTER OF INFORMATION

Title of the Research Study: Challenges faced by the elderly population of the Mpheni community in the delivery of PHC service.

Principal Investigator/s/ researcher: (Netshakhuma NC)

Co-Investigator/s/supervisor/s

Brief Introduction and Purpose of the Study:

Delivery of PHC at Mpheni Village is a situation wherein there is below the required standard delivery of PHC in Mpheni Village, PHC which is inadequate, unreliable, and unfavourable for a healthy life of the inhabitants of Mpheni Village, and this has a significant impact on people's health. These people experience challenges such as travelling long distances to hospitals seeking medical attention. Remember, some of them stay for a prolonged time with a specific communicable or non-communicable disease without any medical help due to a lack of services in the institution. There are diseases such as HIV and AIDS, diabetes mellitus, hypertension and STIs, and these diseases need to be controlled at an early stage at the clinic and managed. However, due to a lack of services in terms of staff members, medication and instruments, people tend to die. The study aims to explore and describe the impacts of substandard delivery of PHC at Mpheni Village, Limpopo province, to find ways to abetter the PHC delivery system.

Outline of the Procedures: The research will be conducted at Mpheni village in Limpopo province. Participants will be expected to provide accurate information on the questions asked. Research will be conducted using face-to-face interviews. The inclusion criteria will be participants between 18-65 years of age who consented to participate in the research.

Risks or Discomforts to the Participant: N/A Benefits: The research aims to explore the impacts of substandard healthcare delivery; the benefits thereof will be ideal or close to the ideal model of PHC services for the inhabitants of Mpheni.

Reasons why the participant may be withdrawn from the Study: for illness and non-compliance

Remuneration: NO

Costs of the Study: NO

Confidentiality: We will use codes to address the participants.

Research-related Injury: No injuries will be sustained.

Outcomes of this study: Upon completion of the study, the researchers will share the document with all the stakeholders involved in the data collection. Community meetings will be held where data will be shared with the community leaders, such as members of the civic community, together with the health care workers, and at least two papers will be published from this study.

General: Potential participants must be assured that participation is voluntary, and the approximate number of participants to be included should be disclosed. A copy of the information letter should be issued to participants. The information letter and consent form must be translated and provided in the primary spoken language of the research population.

APPENDIX D: UNIVEN STANDARD CONSENT FORM

Statement of Agreement to Participate in the Research Study:

1. I hereby confirm that I have been informed by the researcher (Netshakhuma N) about the nature, conduct, benefits, and risks of this study
- Research Ethics Clearance Number:
2. I have also received, read, and understood the above written information (Participant Letter of Information) regarding the study.
3. 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.
4. 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.
5. I may, at any stage, without prejudice, withdraw my consent and participation in the study.
6. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
7. I understand that significant new findings developed during the course this research which may relate to my participation will be made available to me.

Full Name of Participant Date Time Signature

.....

I (Netshakhuma N) here with confirm that the above participant has been fully. Informed about the nature, conduct and risks of the above study.

Full Name of Researcher

..... Date..... Signature.....

Full Name of Witness (If applicable)

..... Date Signature.....

Full Name of Legal Guardian (If applicable)

..... Date..... Signature.....

APPENDIX E: DATA COLLETION INTERVIEW GUIDE

SECTION A: PARTICIPANT INFORMATION

Age	
Gander	
WORK	
EDUCATION	
SECTION B CENTRAL QUESTION	
1 What are the main challenges you face when trying to access primary health care services in Mpheni village?	
2 Can you describe any specific difficulties you experience related to transportation, availability of healthcare staff, or the availability of medication at local clinics?	
3 How do these challenges affect your overall health and well-being? For example, do they lead to treatment delays or worsening health conditions?	
4 How do you feel about the quality of primary health care services provided in your village? Are there any aspects you find particularly helpful or problematic?	

APPENDIX F: TRANSCRIPT

TRANSCRIPT FOR PARTICIPANT B

Date: 01 November 2024

Venue: Mpheni Block C

Time: 11:00 – 11:45

Interviewer: Hello, my name is Netshakhuma Ndaedzo, and I am a student at the University of Venda currently doing master's in public health. I am conducting research on "Barriers to accessing public primary health care among elderly people in Mpheni village, Limpopo Province"

Interviewer: So, I would like to find out if you are comfortable to partake in this interview which will be used for research purposes for my research project?

Participant B: Yes

Interviewer: You will be required to sign the written consent agreeing to participate in the interview, is that okay with?

Participant B: Okay it is fine, but I cannot read and write

Interviewer: Not a problem I will help you sign the consent even if you just write and cross it will be fine, please note that this interview shall be recorded, and the audio will be transcribed and translated to a report. Your names, age, sex will not be mentioned in the research report. You have a right to withdraw from this interview at any given time. The transcripts of this interview will be kept in a safe lockable computer and the final report will be made available to you. Do you consent?

Participant B: I have no problem

Interviewer: So, I am just going to start asking you some personal questions to gain a better understanding of who you are. You are more than free not to answer some of the questions especially if you feel uncomfortable.

Interviewer: Please tell me what your names age and where were you born and what you do for a living?

Participant B: My name is Mudau Alfred, I stay in Mpheni village I am 71 years' old I worked in Elim primary school for 30+ years as a gardener now I'm a pensioner

Interviewer: Thank you, did you grow up here in Mpheni or you grew up somewhere else?

Participant B: I was born here at Elim Hospital, and I worked here 30+ years until I retired.

Interviewer: Do you have children and what is your relationship status?

Participant B: I have one son; he is married, and he stays with his wife in Gauteng he only come back during festive seasons I am married to my wife Rosina Nyawasedza Mudau

Interviewer: If I may ask do you have any chronic disease that you are taking treatment for every month?

Participant B: Yes, I take treatment for my high blood that I was diagnosed almost 15 years ago together with my pain block that I take for painful bones

Interviewer: Okay thank you. What are the main challenges you face when trying to access primary health care services in Mpheni village?

Participant B: "Transportation is a big issue, and this side where I stay its far from the clinic taxis don't enter since there are no roads; sometimes I can't afford the fare to hire a car to the clinic or hospital."

Interviewer: Follow up, I'm very sorry to hear that, can you describe any specific impact of these challenges on your health and wellbeing

Participant B: "The clinic is often short-staffed, so they rush through consultations and don't give enough attention sometimes we come and find that there is no medication which sometimes it worsens my condition."

Interviewer: How do you feel about the quality of primary health care services provided in your village? Are there any aspects you find particularly helpful or problematic?

Participant B: "The services are basic, and the clinic lacks specialised equipment's to fully are for us older people for example there was a time I fell and injured my knee I waited for walking crutches till up to date."

Interviewer: Thank you very much for your participation I appreciate your time and effort I think our interview has come to an End

Participant B: Okay good luck with your school

APPENDIX G: EDITOR'S LETTER

Office No 1: C-Block

School of Humanities, Social Sciences and
Education

University of Venda

February 17, 2025

Dear Sir/Madam

This is to certify that the mini-dissertation entitled **"Barriers to Accessing Public Primary Health Care among elderly people in Mpheni Village, Limpopo Province** by **Netshakhuma Ndaedzo**, student number **18000050**, has been edited and proofread for grammar, spelling, punctuation, overall style and logical flow. The edits were carried out using the "Track changes" feature in MS Word, giving the author final control over whether to accept or reject effected changes prior to submission, provided the changes I recommended are effected to the text, the language is of an acceptable standard.

Please don't hesitate to contact me for any enquiry.

Kind regards



Ms N.P. Rankakane (BAYID-UNIVEN, MA-UNIVEN, PGCE-STADIO, TEFL-TEACH
TEFL)

Cell number: 0725073783

Email address: Ngadi.rankakane@univen.ac.za

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