AN EVALUATION OF HEALTH-CARE SERVICE DELIVERY IN RURAL AREAS WITH SPECIFIC REFERENCE TO NDENGEZA TOWNSHIP

BY

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DECLARATION

I Masingi Nkateko Tracey hereby declares that the mini-dissertation titled "***an evaluation of health care service delivery in rural areas with specific reference to Ndengeza Township***", which is under Greater Giyani Local Municipality is my work in design and execution, and that all sources used or quoted have been referenced and acknowledged as prescribed by research ethics code.

Signature……Date …….

ABSTRACT

The dawn of democracy in 1994 saw huge strides in the adjustment of various statutory instruments that aimed at opening the systems to all South Africans particularly the previously excluded groups. Health care system was one of the ear marked areas by the South African government for post-apartheid transformation. Resultantly, access to health care was declared a right and incorporated into the Constitution of the Republic of South Africa 1996. Numerous legislative and practical steps towards achieving access to health care for all have been made with notable results. However, due the apartheid spatial planning which persuaded separate development left some sections of the community remote and with no infrastructure to support health care delivery. As a result, this has made the realization of the health care for all dreams elusive. Reportedly, the most affected communities were mainly homelands which were largely rural and townships. Despite notable improvements in the delivery of health care services across the Republic, there are still major challenges faced in this sector mainly in the rural areas and townships. Therefore, the study was set to investigate and evaluate the state of health care service delivery in rural Ndengeza Township. The study employed both qualitative and quantitative method following a descriptive design (cross-sectional) and data was collected using a self-administered questionnaire and interview questions. The results revealed that transport, staff-patient relationship, unavailability of medication and medical staff were the major challenges of health care service delivery in rural areas. The respondents alluded that to improve health service delivery in the area, there is need to make available basic medication and trained medical personnel. It is believed, by the participants, that adding the number of staff will go a long way in changing the negative perceptions such as long queues, unavailability of critical services and unprincipled professionals that the public have of the local health care centers.

Key Words: Health Care, Health Care Centre, Health Care Service, Rural Area, Service Delivery.

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TO GOD BE THE GLORY!

DEDICATION

I dedicate this study to the late, my grandmother N'wa Mlocha Chavalala who believed in me and nurtured me to be the best.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
COSATU	Congress of South African Trade Unions
DHS	District Health System
DOH	Department of Health
EDL	Essential Drug List
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
OPD	Out Patients Departments
PHC	Public Health Council
RDP	Rural Development Programme
SA	South Africa
SACP	South African Communist Party
RSA	Republic of South Africa
UNDP	United Nations Development Programme
WHO	World Health Organisation
FGD	Focus Group Discussion

CHAPTER 1: INTRODUCTION AND BACKGROUND TO THE STUDY

1. 1 Introduction

South Africa transcended to democracy in 1994 and this saw citizens from all backgrounds, race, gender and creed guaranteed their human rights including the right to access to health care as provided in the constitution of the Republic of South Africa 1996 (Enslin, 2003). Health care service is one of the fundamental human rights as stipulated in Chapter 2(27) of the Constitution of the Republic of South Africa Act, 1996 and all South Africans have the right to access to health care services including reproductive health care through government clinics and hospitals (Harris, Goudge, Ataguba, McIntyre, Nxumalo, & Jikwana, 2011). However, an individual has the option of opting for private health care provided he/she affords it (Harris, et al., 2011).

According to World Health Organization (WHO), Health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. This means that access to good health care service should not be a luxury to the people but compulsory and to address the notion of health care services in the rural areas in South Africa, the District Health System (DHS) was introduced (Huber, Knottnerus, Green & Van der Horst, 2011). The South African government welcomed the DHS as a cornerstone of their national health plan (Ginneken, Lewin & Berridge, 2010). Introducing the DHS was an opportunity for the SA government to improve access of health care in rural areas. The government's aim was to deliver an efficient service and link people with other components of the health system whenever needed. This chapter focuses on the background of the study, problem statement, aim of the study, and research questions. The chapter is concluded with the significance of the study, limitations, and delimitations, definitions of the concepts and lastly, the organization of the study.

1. 2 Background to the Study

The Reconstruction and Development Programme (RDP) is a South African socio-economic policy framework implemented by the African National Congress (ANC)

government of Nelson Mandela in 1994 (Abrahams, 2018). This programme was enacted after months of discussions, consultations and negotiations between the ANC government, ANC Alliance partners, the Congress of South African Trade Unions (COSATU) and the South African Communist Party (SACP), and 'mass organizations in the wider civil society (Gabula, 2012).

The focus in the development and implementation of RDP was to address the socio-economic problems left by the apartheid government (Abrahams, 2018).The government's aim was to alleviate poverty and provide better social services to previously disadvantaged South Africans by re-distribution of tax money for developmental projects. Also, the programme did not only focus on lightening the burden of poverty, but also focused on incorporating the RDP to build a stronger macroeconomic environment (Chatora & Tumusime, 2004).

During the apartheid, majority of the townships and rural communities were the main group affected by the effects of separate development (Van Rooyen, McGrath, Chirowodza, Joseph, Fiamma & Gray 2013; (Brundisini, Giacomini, DeJean, Vanstone, Winsor, & Smith, 2013). Therefore, health services in these areas have not been efficiently and effectively delivered to the people (Van Rooyen, et al., 2013). The availability and range of services has been found to be limited in rural areas and rural townships compared to those provided in larger towns and cities. The new dispensation led by the ANC government witnessed a change healthcare provision through infrastructure and policy provisions (Bond, 2012). These new developments have also led to the centralization of healthcare services. Despite these improvements rural communities have witnessed closures of health care centers mainly due to resource constraints and the need to provide safe and high-quality care. Resultantly, this has reduced access to numerous types of care such as maternity, paediatrics, surgical and accident and emergency services (Harris,et al., 2011) Likewise, there is also a limited availability of primary health care services such as pharmacies, general practitioners, dental practices, and other community-based health care-services (Department of Health, Social Services and Public Safety(DHSSPS) 2009:22). Patient choice therefore

is restricted and accessing services elsewhere can result in increased waiting times and poorer health outcomes.

According to Gupta, Gauria and Khemani (2003:119), there are also difficulties in supplying other specialist services such as health screening. One of the major reasons for the shortage of specialist in rural areas is due to lack of training or limited number of medical staves as compared to urban communities (Gupta, et al,. 2003:119). In addition, medical staff is neither able to develop or retain their skills at smaller clinics or health centers nor progress their careers on a par with staff in urban clinics. As a result, this has made it cumbersome and difficult to attract appropriately trained staff to permanent positions (Mayosi & Benatar, 2014). Regardless of the increase in spending in the 1960s and 1970s, the apartheid government did not make substantial progress in ensuring equity in the access of health care services. The health systems, as organized today, are not adequately addressing the increasing burden of disease (Tey & Lai, 2013). More recent cutbacks in health budgets have eroded previous advances in health care and weakened the capacity of South African government to cope with the growing health crisis (Mayosi & Benatar, 2014). It is reported that the poorest masses mainly in rural communities are being disproportionately hit by pro-rich national and international policy decisions (Gomez-Olive, Thorogood, Clark, Kahn, & Tollman, 2013). The health system is neither robust nor flexible enough to respond to emerging scenarios that lead to reversal of gains. Consequently, rural areas and rural townships have resorted to traditional, faith, and other informal sources of health care because of their easily availability, accessibility, affordability, and acceptability, however, these practices are ignored and therefore unregulated and unsupported by the central and local government (Wakefield, 2008).

1.3 Problem statement

In the recent years, new and re-emerging diseases have created a new scenario in service delivery as many diseases have defied conventional medical technology and this cannot be exaggerated any further in rural areas (Mayosi & Benatar, 2014). Furthermore, the development of drug resistance complicates the already unbearable

situation and the situation worsens as people seek health care too late, requiring sophisticated treatment, additional drugs, prolonged hospital visits, and unsatisfactory recoveries (WHO, 1999; Harris, et al., 2011). This is aggravated by weak systems of governance on the one hand and ecological stress on the other. Also, the inability to quantify and analyze the situation with credible data regarding the performance of the health system and the health status undermines the ability of effective decision making (Mayosi & Benatar, 2014). Moreover, poor health care service delivery in the public health care system has been attributed to bad infrastructure, inadequate staff and poor supply chain system (Hunter, Asmall, Ravhengani, Chandran, Tucker & Mokgalagadi, 2017). In the light of the above and as a result, the study was set to investigate and evaluate the state of health care service delivery in the rural township of Ndengeza.

1.4 Aim of the study

The aim of this study is to evaluate the state of health care service delivery in the rural Ndengeza Township in order to recommend strategies that can be used to improve access of health care services.

1.5 Specific objectives of the study

- To establish the challenges faced by residents of Ndengeza townships about access to health care services
- To determine the impact of the state of health care service delivery on the daily lives of the residents of Ndengeza Township
- To recommend strategies that can be used to improve access to health care services at Ndengeza Township

1.6 Critical research questions

- What are the health care challenges faced by Ndengeza Township residents?
- To what extent does the state of health care service delivery impact on the people of Ndengeza Township?

- What are the strategies that can be used to improve access to health care services at Ndengeza Township?

1.7 Significance of the study

This study is going to help the Department of Health to know whether they are rendering better health service to the people in the township areas. It is going to enable them to be aware of the health challenges and help them make necessary changes where possible. The study is also going to enable the community to voice out their challenges as well as to make necessary recommendations to assist the Department of Health. Once the community and service providers are working together, there will be excellent development in the country.

As a public management student, the study is going to help the researcher in knowing how health service delivery is important and how to care for the customers, which in this research are the Ndengeza Township people.

1.8 Limitations of the study

For the researcher to complete the study in time, there were things that hindered or delayed the study. The study was greatly hindered by financial constraints which inhibited the timely procurement of research material and related costs such as travelling, typing, binding and photocopying. Some people felt uncomfortable to participate in the research due to suspicions that the information they might give could be used against them.

1.9 Delimitations

The study focuses on evaluating the health service delivery at Ndengeza Township, Limpopo province. The study was conducted amongst the community members. The purpose of demarcating the study was to make it more manageable. Ndengeza Township is under ward 1 of Greater Giyani Municipality, Limpopo Province.

1.10 Definition of concepts

Rural area: Rural areas are defined as large and isolated areas of an open country with low population density (Pateman, 2011). According to Stats SA (2017) a rural area refers to “an area that is not classified urban and these areas are subdivided into tribal areas and commercial farms”. In this study, rural area refers to the tribal areas and rural informal settlements or settlements which started as informal settlements to small towns commonly called townships.

Health Care Service: Health care services refers to, “any medical or remedial care or service, including supplies delivered in connection with the care or service, that is recognized under state law” (Sørensen, Van den Broucke, Fullam, Doyle, Pelikan, & Slonska 2012). Health care service is also thought of as the physical, clinical, social, emotional and psychological care given to patients at hospital (Singer, Burgers, Friedberg, Rosenthal, Leape, & Schneider, 2011). Also, health care services is defined as, “the furnishing of medicine, medical or surgical treatment, nursing, hospital service, dental service, optometric service, complementary health services or any or all of the enumerated services or any other necessary services of like character, whether or not contingent upon sickness or personal injury, as well as the furnishing to any person of any and all other services and goods for the purpose of preventing, alleviating, curing or healing human illness, physical disability or injury” (Hui, De La Cruz, Mori, Parsons, Kwon, Torres-Vigil, 2013). In this study, due to the comprehensiveness and completeness of the above definition, it was adopted for the purposes to this study.

Service deliver: According to the universal Dictionary, (1961: 1394-1395) Service delivery can be defined as the performance of work or duty by an official or system providing the public with something useful or necessary (Mayosi & Benatar, 2014). Public service delivery is a crucial responsibility of government and government institutions (Du Toit & Van der Waldt). In this study, service delivery is focused on the services rendered by the Department of Health to the people of Ndengeza Township.

1.11 Organization of the study

The study is comprised of five chapters and the composition of each chapter is outlined below.

Chapter 1

In this chapter of the study, a high-level background of the scope of the research was provided. Specific focus was leveled at aspects such as the research process, background of the research problem, and the significance of the study.

Chapter 2

This chapter provides literature review on the concept of health service delivery in rural areas, theories on service delivery, and government's initiatives to enhance service delivery.

Chapter 3

Chapter 3 provides the overall research design which outlines the methodology used to conduct this research.

Chapter 4

This chapter focuses on data analysis and interpretation of findings.

Chapter 5

Chapter 5 provides conclusion, recommendations and study implications.

1.12 Conclusion

Most of the rural population is smallholders, artisans and labourers, with limited resources that they spend chiefly on food and necessities such as clothing and shelter. They have no money left to spend on health. The rural peasant worker, who strives hard under adverse weather conditions to produce food for others, is often the first victim of epidemics. The provision of health services in rural and remote areas is significantly affected by limited funding and other resource constraints. The next chapter deals with the literature on health care services in rural areas.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Health is defined by WHO (1948) as “a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity.” Within health, there are four main areas; promotion, prevention, treatment and rehabilitation (Petersen, Evans-Lacko, Semrau, Margaret, Chisholm, & Gronholm, 2016). In the delivery of health services, the aim should be to provide adequate promotion and prevention services to limit diseases and injury as treatment and rehabilitation are costlier. This chapter will broadly discuss the; characteristics of rural population, health care services in rural areas, Patients’ Charter, and as well as the health conditions in rural areas.

2.2 Characteristics of rural population

Despite the government efforts to alleviate poverty in rural and townships areas, rural and townships populations are generally still characterized by the following negative health determinants (Hunter et al., 2017):

2.2.1 Lower income levels

High cost of services and long distances to health facilities were the other main challenges established. Other studies conducted elsewhere have also indicated that cost is often a barrier to seeking health services especially among the poor. Due to abolition of user fees at public health facilities, rural communities use them frequently. However, due to the limited number of public facilities particularly in rural areas, inhabitants are necessitated to use private health care providers at a cost (Tey & Lai, 2013).

2.2.2 Lower employment levels

Unemployment and under-employment are taking younger people away from their families and work is low paid and intermittent. Young people are now moving to urban areas for work and this result in expansion responsibilities on a low pay (Alkire 2005).

2.2.3 Lower education levels

Education is fundamental to promote *agency* (Sen 1999). “Agency refers to a person’s ability to pursue and realize goals that he or she values and has reason to value” (Alkire 2005), but here it is just interpreted as the ability of rural poor to escape from poverty and hunger with their own means. Who is educated is more likely to find a job, but has also a capacity to use more rationally the resources he or she owns. Educated and informed people are more likely to select valuable objectives in life, such as having stable access to food for their household and practicing good health care.

2.2.4 Lower ‘health literacy’ (understanding of health issues)

Rural social networks are breaking down with a consequent increase in social isolation and loneliness, especially among older people. The fact that social isolation influences health outcomes in its own right suggests that this and the emotional and mental well-being of people in rural areas is important but neglected area in the promotion of public health (Sampaio, 1993; Ramos, 2001).

2.2.5 Poor supply chain (in health system)

Rural areas have worse access in terms of distance to health, public health and care services. Longer distances to GPs, dentists, hospitals and other health facilities mean that rural residents can experience ‘distance decay’ where service use decreases with increasing distance (Robeyns; 2006:3). Different models of service delivery may be needed for rural areas, including new models of workforce development. These also include the development of rural hubs providing a range of services, and more services provided on and through the internet.

According to Mukudi (2003), problem of regular stock out of drugs has been known in the South African health system for a long time. The reasons for its occurrence include the long procurement process (bureaucracy) for drugs from the main government suppliers (National Medical Stores - NMS), monopoly of NMS, inadequate funding for essential drugs, lack of skills in medicine forecasting, poor selection and quantification of medicines, poor records management and lack of prioritization (Glewwe; 2000:151).

The continued absence of essential drugs especially at public health facilities has a negative impact on health services utilization as people shun health facilities because of the usual trend of no drugs. This is likely to lead to unfavorable behaviors such as self-medication or use of traditional healers (Alkire 2005).

2.2.6 Higher levels of risky or high-risk alcohol consumption

According to Lanzi (2004:13), several studies have examined the effect of rural residency on adolescent alcohol use and found peers and community characteristics to be influential. Gardner & Shoemaker found that peer influence was associated with greater substance use in rural areas, but was moderated by the extent to which youth associated with peers who respect parents, teachers, and authority figures and avoid getting in trouble.

Alcohol causes changes in consciousness, mood and emotions. The intoxicating and psychoactive effects of alcohol can lead to accidents, injuries, diseases and disruptions to family life (Wiesmann 2002).

2.2.7 Lower levels of healthy exercise

Health knowledge is linked to the awareness, motivation, and competence of people in accessing, understanding, appraising, and applying health information. These factors help to maintain or improve individuals' behaviors and quality of life by making the appropriate judgments and forming decisions regarding healthcare disease prevention and health promotion in their daily lives. Increasing evidence has shown that the lack of

health knowledge and health behaviors are associated with problems connected with the use of preventive services, delayed diagnoses, understanding one's medical condition, one's adherence to medical instructions, self-management skills, and health outcomes (Hodge and Monk, 2004; Yarwood, 2005).

2.2.8 Inadequate staff

According to Ricketts and Hart (2008) rural health care system remains insufficient with shortage of staff compared to urban health care system. Financial stress and lack of medication makes it impossible to deliver quality health care system to South Africans. Rural and township areas where agriculture, fishing, forestry and industries take place can pose a threat to the health of community members (Ricketts & Hart, 2008).

The shortage of health professionals is a significant barrier to the rights of health service in rural and township areas in South Africa (Andersson, Schierenbeck, Strumpher, Krantz, Topper, & Backman, 2013). According to Ricketts (2000), rural and township areas have the lowest access to health professionals of different categories. Small teams of health professionals are particularly vulnerable, with the loss of one professional having a much larger impact on service delivery. The lack of health professional in rural and township areas can be attributed to lack of or limited resources (Hunter,*et al*., 2017). The urgency of replacement is not always well understood by decision makers located far from the rural and township services. This has become apparent with provinces imposing staffing moratoriums across the board, severely affecting recruitment in already understaffed areas (Ricketts, 2000).

2.3 Theories of Social Change Related to Intervention Strategies in a health care system

According to McCarthy (2012), implicit in the four types of direct intervention strategies in rural primary care that involve more than "capacity building" (i.e., simply putting or attracting more professionals in place to provide primary care) are four basic theories of how planned social change is initiated. These might be referred to as: individualistic, institutional, organization design, and community mobilization.

2.3.1 The individualistic theory

This theory of social change tends to focus on the characteristics of the individual provider or other persons involved in the delivery of health care or in the organization of the program (Buchanan, 2014). In general, these people are viewed as being change agents with individual characteristics varying from those thought to be innate (e.g., leadership, charisma) or fortuitous (e.g., having a rural-bred spouse), but in any case, not manipulated by planned intervention or qualities of leadership which can be learned (Knitzer & Gilliam, 2008). Individuals are thought to be critical ingredients able to develop a successful enterprise in a variety of organizational and community settings. Conversely, the wrong persons are likely to fail no matter how good the setting or environment which supports the program (Knitzer & Gilliam, 2008). The individualistic theory of social change pegs the ultimate responsibility for success or failure to the individual or individuals involved. Program sponsors who operate on this theory put their faith and their money people.

2.3.2 The institutional theory

This theory rests on the underlying thesis that social change comes about from the outside by the expansion from an established center, leading to the incorporation of the periphery into an integrated system (Peters, 2011). The assumption here is that the institution has the capacity (in terms of technology, managerial skills, and supporting services) to expand into a strategically located, medically underserved, adjacent area. The identification of the ultimate responsibility for the success or failure of this kind of arrangement rests with a pre-existing institution, and it is in this institution that the investment is made (Tolbert, David, & Sine, 2011).

2.3.3 Organization design

As an intervention strategy relies on a theory that assumes a kind of organization as the basic lever for social change, the design may be simple or complex (Thompson, 2017). The sponsors may even postulate that certain types of communities require a simple program, while others require a complex program.

According to Thompson (2017), the notion implicit in this strategy is that building an organization in conformity with a specified organizational design may be possible under several different external conditions which can be highly variable. The ultimate responsibility for success or failure of this kind of program is thus attributed to its conformity to the organizational design that the sponsor has in mind when it is funded. More than any of the other three strategies discussed here, this is an investment in a concept, suggesting the rational-technical theory of social change.

2.3.4 Community

The fourth major intervention strategy implies that the primary actors in the process of changing the healthcare scene are the community participants themselves and that consequently, the locus, investment, and responsibility need to be placed directly on its shoulders. It represents a systematic attempt to identify those communities which are ready for the introduction of such a program, to promote the idea in those which are not, and to understand why communities are of one type rather than another and how they go from one stage to another. According to Coburn et al. (2007) and as well as Cromartie and Bucholtz (2008), the critical ingredient in programs of this kind is thought to be that activated communities whose needs are articulated and supported by appropriate skills and knowledge, can design their own programs according to their own level and character of needs. The investment is in a community, either through the duly elected officials, a governing board specifically formed for this purpose, or some combination of these. The ultimate responsibility for the program's success or failure is thus placed in the community's hands.

2.3.5 Rationale approaches to the health care services

According to Chatora and Tumusime (2004), successful rural healthcare delivery systems require the resources of one or more institutions willing to serve the rural healthcare market, as well as dedicated practitioners willing to provide services in rural locations. The problems encountered in delivering healthcare to rural areas are much different from those in urban areas, and institutions undertaking this assignment must

recognize the uniqueness of the task. As Dr. Ludke suggests, new and innovative approaches to delivering high-quality healthcare in a rural setting must be found to replace the old ones. Communities throughout the country have undertaken numerous approaches, with varying degrees of success.

2.3.6 Reducing Knowledge Rationing

Residents might not always be aware that they should receive certain routine healthcare services or how to obtain those services; therefore, the community must establish strategies to reduce the knowledge gap. Most rural communities have potential access to a broad range of services available from larger institutions in surrounding urban areas (Peters, 2011). As healthcare provision is becoming more competitive in urban areas, many urban healthcare facilities seek to establish closer ties with rural communities. In this way, they may increase referrals to their urban facilities when patients from rural areas are hospitalized. As a result, many urban healthcare organizations, particularly medical schools, are willing to provide a wide array of services to rural residents. The community, including the physicians, hospital (when present), public, and employers, must be involved in planning whether only tertiary referrals are sent to the urban center or whether other acute care hospitalizations are involved.

Solutions sometimes available to resolve some of the access problems resulting from lack of knowledge are:

• Urban healthcare centers bringing health screening services to the community and promoting them, so that residents know they are available.

• Community leaders establishing a speakers' bureau that addresses public health, clinical, and administrative issues such as insurance coverage.

2.3.7 Reducing Location Rationing

Many organizations have reduced residents' healthcare access problems that resulted from location (Harris, et al., 2011). The motivation for hospitals and clinics to address

location rationing springs from competition among healthcare organizations and the desire to preserve and enhance their patient referrals. Location Rationing is central to long-term viability; therefore, it is also part of many organizations' mission. When a community believes it is unable to solve the problem itself, residents must seek an alliance between the community's health care facility, its practitioners, and an urban healthcare organization. In other situations, part of the strategy to address this issue can include unilateral community actions. In either case, the community needs a systematic healthcare plan.

Despite much progress, the gap between need and effective action is still large. More resources, further development of cost-effective interventions, and better health financing schemes are certainly needed. It is also striking that even the funds and technologies that are available are often not being used effectively (Tolbert, David, & Sine, 2011). In many countries, one encounters health facilities with shockingly few patients, communities with low levels of coverage in life-saving services even where capacity exists to provide that coverage, or trained workers missing from their assigned posts and empty shelves for drugs and supplies when workers have been paid and supplies purchased (Hana & Martin, 2005). Clearly, having money and technology are not enough conditions for impact. Even with more money and better technologies, a major challenge remains: improving the delivery of health services (Gomez-Olive, et al., 2013). Without improvement in the performance of the organizations that deliver health services, potential gains in health outcomes from increased funding and better technologies will not be achieved.

2.4 Types of health care services within health centers

Health centers offer a consistent source of primary health care to people living in underserved communities (Blumberg, Bramlett, Kogan, Schieve, Jones, & Lu, 2013). Some of the health services offered within health centers are as follows:

2.4.1 Education on health problems

Education for health is a process in which all public health and medical care personnel are involved. People learn both formally (planned learning experiences) and informally (unplanned learning experiences) (Hana & Martin, 2005). The patient, client, consumer and the community expect public health and medical care personnel to assist them with health and disease issues and problems. Education as a viable intervention for the maintenance of health and the prevention of disease has received increasing attention in the last decade (Hana & Martin, 2005).

2.4.2 Promotion of food supply and nutrition

A safe and nutritious food supply is essential for good health (Velleman 2014). Nutrition and illness influence each other. If children are ill often, they will eat less and become weaker and will have less resistance against disease and fall ill again, etc. With each infection the child takes a step further towards malnutrition. The WHO world Declaration on Nutrition from 1992 states that access to nutritionally adequate and safe food is a basic individual right. WHO has proposed actions that includes improving nutrition and food safety in the early childhood years, ensuring a safe, healthy and sustainable food supply, providing comprehensive information and education to consumers, integrating actions to address related determinants (such as physical activity, alcohol, water, environment), strengthening nutrition and food safety in the health sector, and monitoring and evaluating progress and outcomes (Peters, 2011).There is a growing need to understand how the health of both the individual and the population are shaped by external factors at the global level, and how these factors are influenced by human interventions and natural phenomena. Some of these factors include environment, nutrition, water supplies, and disease, as well as social and political conditions (Oza 2015). These factors may interact with each other and sometimes produce unexpected health consequences.

2.4.3 Safe water and basic sanitation

Adequate water, sanitation and hygiene (WASH) are essential components of providing basic health services (Lleras-Muney, 2005).The provision of WASH in the community and in health care facilities serves to prevent infections, spread of disease, and protect staff and patients. It also upholds the dignity of vulnerable populations including pregnant women and the disabled. Yet, many health care facilities in low resource settings lack basic WASH services, compromising the ability to provide safe care and presenting serious health risks to those seeking treatment.

The consequences of poor WASH services in health care facilities are numerous. Health care associated infections affect hundreds of millions of patients every year, with 15% of patients estimated to develop one or more infections during a hospital stay (Allegranzi 2011). The burden of infections is especially high in new-born children. Sepsis and other severe infections are major killers estimated to cause 430,000 deaths annually in South Africa. The risks associated with sepsis are 34 times greater in low resource settings (Oza 2015). Lack of access to water and sanitation in health care facilities may discourage women from giving birth in these facilities or cause delays in care-seeking (Velleman 2014). Conversely, improving WASH conditions can help establish trust in health services and encourage mothers to seek prenatal care and deliver in facilities rather than at home - important elements of the strategy to reduce maternal mortality (Russo 2012).

2.4.4 Immunization

According to Breierova and Duflo (2004), vaccinations are an essential tool in our fight against infectious disease. According to the World Health Organization (WHO), vaccination has greatly reduced the burden of infectious disease globally. Vaccines protect the vaccinated individual by direct immunization and can protect unvaccinated individuals through community protection or herd immunity. Not all diseases can be prevented by immunizations. However, there are several serious diseases that can be controlled and eventually even eradicated if the population at risk is given appropriate

medicines on a regular basis (Currie & Moretti, 2002). According to the World Health Organization (WHO), immunizations save an estimated 2.5 million lives each year from tuberculosis, diphtheria, tetanus, pertussis (whooping cough), polio, measles, hepatitis B, and Hib (*Haemophilus influenzae b*) infections.

2.4.5 Prevention and treatment of locally endemic diseases

All health professionals should receive training and take the necessary precautions to prevent infections. Written routines and continuing education are vital for professionals to internalize a sense of responsibility and adhere to the principle of foster patient and worker safety (Thomas & Morris, 2003). Health systems must meet ever-increasing performance expectations and, according to the World Health Organization (WHO), unsafe care is one of the five common limitations of healthcare services. Chevalier and Feinstein (2006) confirm that minimizing the occurrence of healthcare associated infections (HCAIs) is therefore a priority for assuring safe care.

2.4.6 Appropriate treatment of common diseases and injuries

High-quality health services involve the right care, at the right time, responding to the service users' needs and preferences, while minimizing harm and resource waste (Hill and Waldfogel, 2005). Quality health care increases the likelihood of desired health outcomes and is consistent with seven measurable characteristics: effectiveness, safety, people centeredness, timeliness, equity, integration of care and efficiency (Kan & Tsai, 2004).

2.4.7 Provision of medication

Patients need medicines that are safe, effective and of good quality. The drugs must be affordable, and they must be available. Because each government has financial limitations only the use of essential drugs will ensure that people can get the best possible treatment within the resources present (Bailey & McLaren, 2005). For other

diseases it is important to use medicines that have proven to be effective and to give them in the right dose and for the right period. Using drugs rationally will give the best treatment result and will reduce costs.

According to Bailey and McLaren (2005), over the past it has become clear that many medicines have been used too much or not in a sensible way. This has resulted in increasing resistance against certain drugs, for example antibiotics, but also anti-malarial and TB medication. Some medicines that were very useful in the past are now becoming ineffective (Bynner & Egerton, 2001). The Department of Health can partly prevent this if health workers use medicines rationally and in accordance to protocols.

2.5 Health care challenges faced by people in the rural areas

Many concerns have been raised regarding the quality of care that rural people are receiving at public sector facilities (McIntyre & Ataguba, 2016). Recent community consultations around healthcare in rural and township areas showed that rural health care users have identified shortages of staff, bad staff attitudes, large distances to health facilities and services, insufficient medication, lack of monitoring and evaluation, patient transport and shortage of ambulance services as major areas of concern (Harris, et al., 2011). The racial and geographical inequities of the apartheid past have not been adequately addressed in current healthcare spending processes, and provinces with greater existing capacity in terms of hospitals and number of doctors benefited from higher funding allocations (Rosedale, Smith, Davies, & Wood2011).

The continued inequities are explained by the “infrastructure inequality trap”, where better-resourced health infrastructure requires higher levels of funding to maintain current levels of care and has greater capacity to spend the funds allocated and leverage additional funds (Gomez-Olive, et al., 2013). As a result, the inequitable distribution of healthcare infrastructure continues to perpetuate inequalities between urban and rural areas, such as per capita spending on PHC. Performance of the healthcare system is frequently assessed by efficiency indicators such as cost per patient day equivalent (Whitener & Parker, 2007).

2.5.1 Limited health resources

People have a desire to stay near their homes and to access healthcare services in their local community (Harris, et al., 2011). This places an additional strain on the limited health service resources available. More innovative ways of linking patients to health providers (such as telemedicine, increased partnership working, the role of cross-border services) and of providing equality of access to healthcare will be required. Rural communities generally face a higher turnover of health care staff including nurses, physicians, dentists and others. The difficulty in attracting and retaining health care providers to northern and rural regions stems from the challenging working conditions. These challenges include long working hours, a lack of colleagues to share the workload, the lack of extra education, difficulties obtaining routine continuing education, and a perceived lack of opportunities for spouses and children (Mayosi & Benatar, 2014).

2.5.2 Geographic Barriers

Health care facilities in northern and rural areas are fewer and more dispersed than in urban areas (Ricketts, 2000). As a result, people in northern and rural regions typically travel great distances to obtain services that cannot be obtained in their local communities. It is not uncommon for persons requiring specialized health services or diagnostic testing to travel 200 kilometers or more to the nearest regional hospital (Van Rooyen, et al., 2013). In the Arctic, people from remote communities may travel up to three hours by plane to obtain routine hospital-based services. In northern regions, the problem is compounded by harsh weather conditions that make road or air travel dangerous or impossible for days at a time (Mueller, 2008).

Travel is not only stressful in terms of financial burdens; families and communities must find ways of coping without members who may be parents, wage-earners or community leaders (Andersson, et al., 2013). Pregnant women from communities that lack hospital facilities must relocate to a regional centre weeks before the delivery of their babies.

This separation from their families and home communities takes a toll in terms of relationships, child care issues and related stresses.

2.5.3 Transport

Closely related to financial coverage is the need for affordable and reliable transport, particularly when there are large distances and few facilities in rural areas (Luke & Heyns, 2013). Luke and Heyns (2013) further state that considerably greater access barriers are experienced by rural compared to urban communities, including distance, time and cost of accessing health services. Rural populations are particularly disadvantaged regarding emergency transport to access healthcare facilities.

2.5.4 Confidentiality

Participants were assured of confidentiality of their responses. In rural communities' people live a communal life and tend to know almost everyone in the neighborhood, this poses a challenge when collecting data from the youth. The rural youth fear openly discussing risky health behaviors or anything for which they may fear reprisal with an adult who they know is in contact with their parents, is extremely unappealing. Therefore, the participating youth were assured of the confidence of the data collected and this enabled them to give their views openly without fear. Beyond such concerns, which are a question of the professionalism of rural health workers, the small population of rural areas means that simply one's utilization of health services can be visible to others. Combined with the strong value that is typically placed on privacy in rural culture, for some rural residents simply being seen in a doctors' surgery can be a cause of embarrassment (Ricketts & Hart, 2008).

2.6 Key challenges hampering health care service delivery

Some of the key challenges within local government that are hampering service delivery include the following:

• Human resource challenges with regards to skills and capacity in the departments. Many departments in the government of South Africa just do not have the people with

the requisite technical skills and in cases where they do; there is sometimes a shortage of skilled personnel who can assist the municipality in rendering quality services to the people (Hongoro & Mapake, 2014).

• Corruption and maladministration. In many departments, corruption and maladministration have become endemic and the lack of accountability or transparency in rendering services to the people is a cause for concern (Managa, 2012).

• Financial challenges. Across South Africa, several departments are either bankrupt, or on the brink of bankruptcy which affects their ability to provide quality service delivery to the people (Managa, 2012).

• Lack of awareness and lack of knowledge by communities with regards to their rights. This hampers health service delivery as communities do not know how or who to approach when they face challenges regarding service delivery in their communities. This allows some health providers to act with impunity knowing that the community will not challenge this as they are not aware of their rights or the channels to follow when these rights have been abused (Mdlongwa, 2014).

2.7 Key questions to better service delivery

According to Kaseke (2011:30), these are the questions to better service delivery:

Quantity: Are the services and products supplied in enough volume and diversity to sustain basic needs?

Quality: Are the services and products of such quality that they will last for an appropriate period so that they do not have to be re-supplied at additional cost?

Time/Timeliness: Are the services and products rendered on time so that customers can derive the maximum benefit from them?

Value for money: Is the cost of the product or service balanced against the value derived by the recipient? Irrespective of whether customers pay directly for products and services, it is important that the cost of the product or service is balanced against the value derived by the recipient.

Access: Are the services and products being delivered at the ideal locality to relevant customers to enable them to make the best use of them, without incurring undue cost to gain access to the point of delivery?

Equity: Are the services and products provided without discrimination?

2.8 Legislation on Health Service delivery

Department of health is guided by the following legislation when rendering health care services to the citizens:

2.8.1 The constitution

Chapter 10 of the Constitution of the Republic of South Africa, 1996, stipulates that public administration should adhere to several values and principles such as;

2.8.1.1 A high standard of professional ethics should be promoted and maintained

Effective ethics codes are not merely a text. Rather, they exemplify the fundamental principles and values of a public service. These can include more legalistic precepts, such as restrictions on conflicts of interest (Defra, 2007). Codes can also contain values, but the critical elements in a code are the clear articulation of principles that are derived from values

2.8.1.2 Services should be provided impartially, fairly, equitably, and without bias

Provision of Information can be contextualized depending on its purpose; thus, it could mean many things to many people (Omogor, 2013). In that regard, provision of information can be regarded as a way of communication between organizations, constituencies and exchange information from person to person from one place to another (Sharman, 2012). Generally, it could mean that information can be a resource which local communities entitled to have access to; and that should be done by public servants through showing fairness in distribution of information for all. Therefore,

providing information to both rural and urban areas equally has benefits for both the government and its constituencies. According to Roling (2014), disseminating information equally does not bridge the gap between the urban and rural settings but it also paves the way for relative majority of rural people to hold public officials accountable about certain matters which were done indolently, misdirection and embezzlement of public resources.

2.8.1.3 Resources should be utilized efficiently, economically and effectively

All workplaces are an integration of numerous departments working together as one to ensure the business runs smoothly. Almost every sector is reliant on other departments and cannot function at its full potential without the rest putting in their best as well. One reason why companies end up compromising their profits is due to the inefficient use of the resources at hand (Lowe & Ward, 2007).

2.8.1.4 The public should be encouraged to participate in policy making

According to Surel (2000:565), public policymaking is a phenomenon in which citizens directly engage in governmental decision-making processes aimed at implementation of polices that affect citizens. Public policies are most often developed by politicians and larger government institutions, and then implemented for their citizens (Anderson, 2014). But while governments formulate these public policies, it is often citizens who decide whether or not a policy is actually implemented en masse. Public participation in the making and implementation of policy is not a new phenomenon in South Africa. Before the introduction of a democratic constitutional dispensation in April 1994, however, it was limited and not supported by legislation. For instance, in terms of Section 52 of the Constitution of the Republic of South Africa 1983, which was in effect from 1983 to April 1994, participation in general elections was limited to white, coloured and Indian citizens only. Furthermore, Constitution made no specific provision for other forms of public participation.

The introduction of a democratic constitutional dispensation in 1994 replaced the previous selective and undemocratic government. Consequently, it opened up new opportunities for public participation in policy-making and implementation. The Constitution of the Republic of South Africa 1993, commonly known as 'the interim Constitution', enlarged the scope of public participation in the affairs of the public sector. For instance, Sections 16 and 21 of this Constitution provided for the right of assembly, demonstration and petition, as well as political rights for all South African citizens.

The interim Constitution paved the way for the current Constitution of the Republic of South Africa 1996, which further enlarged the scope of public participation through the provisions of Sections 152(1)(e) and 195(1)(e), which encourage the involvement of communities and community organizations in matters of local government and public participation in policy-making.

2.8.1.5 Public services should be accountable, transparent and development oriented.

In public administration, integrity refers to “honesty” or “trustworthiness” in the discharge of official duties, serving as an antithesis to “corruption” or “the abuse of office.” Transparency refers to unfettered access by the public to timely and reliable information on decisions and performance in the public sector. Accountability refers to the obligation on the part of public officials to report on the usage of public resources and answerability for failing to meet stated performance objectives. The values of integrity, transparency and accountability in public administrations have enjoyed resurgence within the past three decades or so. Sound public administration involves public trust (Stockdale, 2004). According to Defra (2006), citizens expect public servants to serve the public interest with fairness and to manage public resources properly on a daily basis. Fair and reliable public services and predictable decision-making inspire public trust and create a level playing field for businesses, thus contributing to well-functioning markets and economic growth.

The integrity, transparency and accountability of public administrations are a prerequisite to and underpin public trust, as a keystone of good governance. Corruption and maladministration in this context could be seen as not only individual acts but also the results of systemic failure and indication of "weak governance." Publicized corruption and administrative failure cases have had a major negative impact on trust in public decision making (Stockdale, 2004).

2.8.2 Other Legislative frameworks on Health care services

The ANC's PHC blueprint was adopted by government in the White Paper on Health Services Transformation (1997), which envisages a decentralized, nurse-driven system, based on the district health system where people can get health services near to where they live (Kekki, 2011). Transformation in the health sector has been hindered by the lack of a legislative framework to guide the process. The National Health Act, giving effect to the White Paper, was only signed into law in 2004, providing guidance on how a national health system should be managed and run.

The Health Department's Quality Assurance Directorate developed a list of "core norms and standards for clinics" in 2000 and these are published on the DOH website (http://www.doh.gov.za/docs/policy-f.html).

These include that:

• The clinic renders comprehensive, integrated PHC services for at least 8 hours a day, five days a week;
• The clinic receives a supportive monitoring visit at least once a month to support personnel, monitor the quality of service and identify needs and priorities.
• Doctors and other specialized professionals are accessible for consultation, support and referral and provide periodic visits.
• There is an annual evaluation of the provision of the PHC services to reduce the gap between needs and service provision using a situation analysis of the community's health needs and the regular health information data collected at the clinic.

• The clinic has a mechanism for monitoring services and quality assurance and at least one annual service audit.
• Community perception of services is tested at least twice a year through patient interviews or anonymous patient questionnaires.

The “norms and standards” also stipulate that clinics need to have medicines and supplies as outlined by the essential drug list (EDL) and a mechanism for obtaining emergency supplies. All clinics are supposed to have electricity, cold and hot water and a reliable means of communication (telephone or two-way radio), and every clinic is supposed to be able to arrange transport for an emergency within one hour.

2.9 Health conditions in rural areas

Health center patients in rural areas are more likely to be poor, uninsured or publicly insured and members of a racial and ethnic minority. As compared with those seeking care in other settings, health center patients are more likely to have common chronic conditions such as depression, diabetes, asthma and hypertension and the percentage of chronically ill patients is growing rapidly (Rosedale, Smith, Davies, & Wood, 2011). Between 2000 and 2010, the percentage of health center patients with diabetes and hypertension increased by 154 percent and 147 percent respectively (National Centre for Health Statistics, 2011; Blumberg, et al., 2013). The common health conditions are discussed as follows:

2.9.1 HIV/AIDS

A survey of clinics conducted by Department of Health Facilities Survey (2003), found that almost a quarter did not provide immunization every weekday and only half offered antenatal care. The HIV/AIDS epidemic is also taking its toll on the health system at every level. Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) is a massive development challenge of global proportions facing human societies. The impact of the HIV/AIDS epidemic on both national development and household economies has compounded a whole range of challenges surrounding poverty and inequality.

Louwenson and Whiteside (2003: 33) have summarized the devastating implications of HIV/AIDS for poverty reduction in a paper prepared for the United Nations Development Programme (UNDP): “The devastation caused by HIV/AIDS is unique because it is depriving families, communities and entire nations of their young and most productive people. The epidemic is deepening poverty, reversing human development achievements, worsening gender inequalities, eroding the ability of governments to maintain essential services, reducing labour productivity and supply, and putting a brake on economic growth. The worsening conditions in turn make people and households even more at risk of, or vulnerable to, the epidemic, and sabotages global and national efforts to improve access to treatment and care.

Thus, the relationship between poverty and HIV transmission is not simplistic (Collins & Rau, 2000). The debate on the role of poverty in driving the sexual transmission of HIV in Sub-Saharan Africa is widely acknowledged and accepted in the literature around HIV/AIDS (HSRC, 2001a: 41). Although there are some powerful critiques of the poverty-AIDS argument which claim that many of the worst affected African countries such as Botswana, Zimbabwe and South Africa are among the most economically developed in the region, poverty does seem to be a crucial factor in the spread of HIV/AIDS. It should be emphasized that poor people infected with HIV are considerably more likely to become sick and die faster than the non-poor since they are likely to be malnourished, in poor health, and lacking in health attention and medications.

In effect, all factors, which predispose people to HIV infection, are aggravated by poverty, which “creates an environment of risk”. According to Johnson et al., (2014) poverty relates to the spread of HIV in two interrelated ways:

> Deep-rooted structural poverty, arising from such things as gender imbalance, land ownership inequality, ethnic and geographical isolation, and lack of access to services.
>
> Developmental poverty created by unregulated socio-economic and demographic changes such as rapid population growth, environmental degradation, rural-urban migration, community dislocation, slums and marginal agriculture.

2.9.2 Malnutrition

Health disorders due to too much or too little food energy or nutrients. Malnutrition includes over nutrition as well as under-nutrition. The main cause of malnutrition is low caloric intake due to seasonal shortage of food, which results from low agricultural production compounded by poor dietary practices (Rosedale, 2011).

2.9.3 Asthma

According to (Rosedale, 2011), Asthma has a relatively high mortality burden among the poor, particularly women. This could be related to the finding that the poor were using appropriate asthma medication less frequently than the wealthier South Africans.

2.9.4 Chronic illness

Chronic diseases and poverty are interconnected in a vicious circle. At the same time, poverty and worsening of already existing poverty are caused by chronic diseases. The poor are more vulnerable for several reasons, including greater exposure to risks and decreased access to health service (Rosedale, 2011).

2.9.4.1 Causes of chronic diseases

The causes (risk factors) of chronic diseases are well established and well known; a small set of common risk factors are responsible for most of the main chronic diseases. These risk factors are modifiable and the same in men and women:

- Unhealthy diet;
- Physical inactivity;
- Tobacco use.

These causes are expressed through the intermediate risk factors of raised blood pressure, raised glucose levels, abnormal blood lipids, overweight and obesity. The major modifiable risk factors, in conjunction with the non-modifiable risk factors of age and heredity, explain most new events of heart disease, stroke, chronic respiratory diseases and some important cancers (Rosedale, 2011).

2.9.4.2 Factors influencing chronic diseases in the poor in South Africa

In addition to the factors suggested by Yach (2001) as contributing to inadequate chronic disease prevention and control in the poor, some other factors play a role in South Africa. These are related to the historical situation in the country along with the developmental activities that have been introduced since 1994.

2.10 Patients' Charter

A Patients' Rights Charter of 1999 clearly outlines the rights of patients and the complaints mechanism should patients not be satisfied with the quality of care they received and it was further outlined by London (2004) as follows:

2.10.1 Every patient has the right to:

2.10.1.1 Access to hospital services

Patients have the right in a medical emergency to be admitted immediately to hospital. In cases other than in an emergency, the patient will be placed on a waiting list if you cannot be admitted immediately. If the person is on a waiting list and are concerned about his condition, he should consult his family doctor who can request that his condition be reviewed by his hospital consultant. When a recommended medical procedure is not available at the hospital, he will have the right to ask his consultant to transfer him to where the procedure is available.

Patients have the right should their admission be cancelled by the hospital to be given adequate and timely notice of such cancellation. However, in exceptional cases arising from emergency pressures or staff illnesses, patient's operation may have to be cancelled at very short notice. In these circumstances, the hospital must make every effort to contact the patient in advance. One has the right, in the event of a cancellation, to be given a new appointment for an early date and to be treated on a priority basis.

2.10.1.2 Out- patient services

A patient has the right when their family doctor refers them to hospital for an out-patient appointment to: receive confirmation within a reasonable time of the date of their first appointment; to be given an individual appointment time to be seen by a consultant or senior doctor on their first appointment; If the patient feels their condition has disapproved, they should consult their family doctor who can, if necessary, take up the matter with the hospital.

Patients have the right, should their appointment at an outpatient department be cancelled by the hospital, to receive adequate and timely notice of such cancellation and to be given a new appointment on a priority basis.

2.10.1.3 Courtesy

Patients have the right to be treated in a courteous manner at all times by every member of the hospital staff.

2.10.1.4 Visiting arrangements

Patients have the right to receive visits from their relatives and friends, including children. The hospital must ensure that visiting arrangements are flexible, consistent with the nature of the patient's illness and the needs of other patients.

2.10.1.5 Religious beliefs

Patients have the right to be treated with respect for their religious and philosophical beliefs.

2.10.1.6 Privacy

Patients have the right to have their privacy respected, especially when the nature of their clinical condition is being discussed with them or their relatives by hospital staff.

2.10.1.7 Information concerning your treatment

Patients have the right to be informed of the name of their consultant under whose care they are being placed, and, if they are to be referred to another consultant, they have the right to be informed of the reasons for such referral. The patient has the right to be informed of the nature of their illness or condition in language which he/she can fully understand and to be informed concerning: the results of tests and X-rays the purpose, method, likely duration and expected benefit of the proposed treatments; alternate form of treatment; possible pain or discomfort, risks and side effects of the proposed treatment.

2.10.1.8 Consent to treatment

Generally, treatment should only be given to a patient with his or her informed consent or, in the case of a child, the consent of a parent or guardian. The patient may request the presence of a person or persons of his/her choosing during the procedure for granting consent. The consent form he/she is asked to sign should clearly state the nature of the procedure to be undertaken.

Informed consent for clinical procedures is based on a patient being fully informed of the state of the illness, the diagnostic procedures, the treatment and its side effects, the possible costs and how lifestyle might be affected. If a patient is unable to give informed consent the family is consulted.

Only in cases where a patient lacks the capacity to give or withhold consent, and where a qualified medical doctor determines that treatment is urgently necessary in order to prevent immediate or imminent harm, may treatment be given without informed consent.

2.10.1.9 Confidentiality

Patients have the right to total confidentiality in respect of their medical records. Patients have the right to request the hospital to make details of their relevant records available to them. Hospitals should normally meet these wishes in this regard, except

where it would be considered that this would cause serious harm to the patient's physical or mental health. In such circumstances, the information may be communicated through a health professional, normally the patient's family doctor.

2.10.1.10 Teaching and research

The patients have the right to refuse to participate in the teaching of medical students by their consultant. The patient's permission must be sought before a consultation can involve them in the teaching of students. However, their co-operation would be important in view of the need to ensure that future doctors obtain the best possible training. Patients have the right to refuse to take part in clinical trials or research concerning the use of new drugs or medical devices. Clinical trials and experimental treatment should never be carried out without their informed consent being obtained by the hospital or medical personnel.

2.10.1.11 Discharge

Patients have the right on their discharge from hospital to have themselves and their family doctor informed of the nature of their condition, the treatment they received while in hospital, the medication required by them, and the arrangements for any further attendance at the hospital.

2.10.1.12 Complaints

Patients have the right to complain about any aspect of hospital service, to have the complaint investigated, and to be informed of the outcome as soon as possible. Hospital has detailed complaint procedures in place and should publicize them prominently throughout the hospital, together with the name and telephone number of the hospital's designated complaints officer. They have the right, where the patient's complaint is not resolved to his/her satisfaction, to have the matter referred to the hospital's complaints committee. The hospitals complaints procedures are without prejudice to the patient's

statuary rights to complain to the Ombudsman, the Medical Council, or An Bord Altranais (The Nursing Board).

In the application in this Charter, special consideration should always be given to the particular needs of children, expectant mothers, the elderly and persons with a mental or physical disability.

• When there is a problem the health care user is informed verbally of the health rights charter with emphasis on the right to complain and the complaints procedure is explained and handed over.

• The clinic has a formal, clear, structured complaint procedure and illiterate patients and those with disabilities are assisted in laying complaints.

• All complaints or suggestions are forwarded to the appropriate authority if they cannot be dealt with in the clinic.

• A register of complaints and how they were addressed is maintained.

2.11 Difference between a clinic and hospital

A Clinic is defined as a facility at and from which a range of PHC services are provided, but that is normally open only 8 hours a day. Certain staff may, however, be required to sleep at or near the clinic so that they are available on call in case of emergency (Cullinan, 2006).

Hospitals are primarily for those who need in-patient care, although all have outpatients' departments (OPD) and casualty/ emergency care. Eleven years ago, there were huge inequities in the quality of care between hospitals in formerly black areas and rural areas, and hospitals in urban areas to serve white patients. These still exist today.

2.12 Health care services in rural areas

In the period following independence, countries in sub-Saharan Africa rapidly expanded access to health services to wider segments of their populations, and there was rapid improvement in health indicators. Major communicable diseases were brought under control through public health measures. Investments were made in child and maternal health, health systems strengthening, and the inclusion of all actors, institutions, and resources involved in improving the health status of populations. However, these gains have now been reversed due to economic stagnation, rapid population growth, the spread of HIV/AIDS, and inadequate allocation of funds to the health care (Harris, et al., 2011; Van Rooyen, et al., 2013).

According to McIntyre and Ataguba (2016) health centers offer a consistent source of primary health care to people living in underserved communities. Community health centers provide preventive and primary care services to more than 21 million patients annually, and particularly those in “safety net” populations. Health centre patients are more likely to be poor, uninsured or publicly insured and members of a racial and ethnic minority. As compared with those seeking care in other settings, health center patients are more likely to have common chronic conditions such as depression, diabetes, asthma and hypertension and the percentage of chronically ill patients is growing rapidly. Between 2000 and 2010, the percentage of health center patients with diabetes and hypertension increased by 154 percent and 147 percent respectively.

2.13 Rural health status

Around the world, the health status of people in rural areas is generally worse than in urban areas. In South Africa, infant mortality rates in rural areas are 1.6 times that of urban areas. Rural children are 77% more likely to be underweight or under height for age; 56% of rural South Africans live 5 km from a health facility; and 75% of South Africa’s poor people live in rural areas. Critical factors in the relationship between poverty and health are population and environmental health issues (Department of Health Facilities Survey, 2003).

2.14 Effect of rural areas living conditions on health of the residents

The relationship between health and social determinants such as poverty, food security and nutrition are well documented. The high levels of deprivation in rural areas contribute significantly to poor health outcomes. Issues of education, sanitation, availability of potable water, household income, and food security all have an impact on the health status of individuals and households. Social determinants have a greater impact on the health status of a nation than the availability of curative healthcare services. One social determinant of disease that has strongly shaped rural health in South Africa is migrancy. There are high levels of mobility between rural and urban and within rural areas, particularly among the economically active (and healthier) part of the population. In some areas, seasonal labour in the agricultural sector contributes significantly to the mobility of the rural population (Mcloughlin & Batley, 2012).

2.15 The structure of the health system

Prior to 1994, the public health care system was hospital-based and provided excellent tertiary care linked to academic health centers. Primary health care services were not universally available, particularly not to the poor. Since 1994, the primary focus of the ANC government's health plan has been the development of primary health care with universal access. This has resulted in a substantial shift of patients away from large hospitals to primary health care centers in the community. Despite the large numbers of primary health care centers that have been built since 1994, particularly in rural areas of South Africa, there are staff shortages and inadequate facilities for outpatient care in the face of the enormous additional patient load.

The Department of Health initiatives to improve primary health care provision includes the expansion of partnerships of the primary health care team with patients and communities. Attempts to improve professional behavior through the implementation of social teaching models are also part of current initiatives. However, there have been financial restrictions and limited resources available. This has resulted in poorly organised primary health care clinics (PHCC), with limited numbers of trained staff and inadequate facilities, equipment and medication. Chronic disease prevention and care

have proved to be inadequate under such conditions (Collins, Shpilberg, Drobyski, Porter, Giralt& Champlin1997; Levitt, 1999; Steyn, 2001).

2.16 Ways to a better health care system

Quality does not come automatically; it requires planning and should be a clearly identified priority of universal health coverage, along with access, coverage and financial protection.

2.16.1 Leadership and management

To address the issues of access to health care in rural areas as described above, the healthcare system must function adequately. This is influenced strongly by leadership and governance as well as equity in resources. Local leadership and management are crucial to improving patient care. Chopra et al, (2005) argues that stronger leadership and greater local accountability are conditions for improvement in coverage and quality of maternal and child health services.

A recent study found that the provinces with the greatest health burdens, least economic resources and largest populations received the smallest share of national public healthcare funds. The racial and geographical inequities of the apartheid past have not been adequately addressed in current healthcare spending processes, and provinces with greater existing capacity in terms of hospitals and number of doctors benefited from higher funding allocations (Goodman, 1997; Levitt, 1999; Steyn, 2001).

The continued inequities are explained by the “infrastructure inequality trap”, where better-resourced health infrastructure requires higher levels of funding to maintain current levels of care and has greater capacity to spend the funds allocated and leverage additional funds. As a result, the inequitable distribution of healthcare infrastructure continues to perpetuate inequalities between urban and rural areas, such as per capita spending on PHC (Goodman, 1997; Levitt, 1999; Steyn, 2001).

2.16.2 Governance

Many of the current health reforms draw on the experience of other countries such as Brazil which managed to move rapidly toward achieving the Millennium Development Goals by implementing PHC strategies (Kekki, 2011). A critical feature of their healthcare reform was that it took place in a social and political context in which there was increased demand for local governance and improved services. In SA however, governance, both in terms of provincial accountability to implement national strategies as well as local accountability to communities, remains poor. The accountability of local leadership has been identified as a concern for rural health. The role of the community and meaningful and empowered mechanisms of holding services accountable locally are crucial yet largely lacking (Baron, 2011).

2.16.3 Prevention

Disease prevention is the most effective form of healthcare because it protects people from illness, and as a result, saves money, minimizes suffering and improves the quality of life. To prevent disease effectively, we must first understand fully the cause of an illness and change the conditions that permit it to occur. The department of health collects Data on an ongoing basis to monitor for public health problems, and, when problems are identified, take action to control them. Thereafter conduct ongoing monitoring for outbreaks and other public health problems.

However, people are exposed to myriad environmental factors, physical as well as social, daily that could adversely affect their health. In addition, everyone has different genetic predispositions to disease and different probabilities for exposure (Booth, 2011; Chambers & Golooba-Mutebi, 2012: 379-403). At the National Institute of Environmental Health Sciences (NIEHS), researchers strive to understand disease end points that result from environmental exposures by approaching health as an integrated response of all organ systems over time to the environment.

2.16.4 Involving people and communities

In their own care and in the design of their health services is now recognized as a key determinant of better outcomes. People and the communities in which they are born, raised, live, work and play are at the heart of delivering quality health services. People who are actively engaged in their own health and care suffer fewer complications and enjoy better health and well-being. At the clinical level, this means enabling patients to partner in their care and in clinical decisions, and to actively manage their health. People-centeredness is the “doorway to all qualities”. This means caring with compassion and respect. But people-centeredness goes beyond individual care. People and patients should be involved in priority setting and in policy development. Nowhere is this more important than in primary and community care. These services need to be designed with input from the communities that they serve, based on their unique needs and preferences.

The department of health should take action to create the conditions that promote health in the population. Inform and educate people about how to improve their health Support legislation and regulations to promote health.

2.16.5 Policy makers

According to Booth (2011), the challenge for policymakers is to demonstrate rapid improvements in the quality of care and service delivery indicators such as waiting time and patient satisfaction; while at the same time addressing the intractable health management issues that bedevil efficiency and drive up costs. The establishment of a district-based system was one of the biggest post-1994 innovations, making health management more responsive to local conditions and distributing resources more equitably. In retrospect, its success has been hamstrung by the failure to devolve authority fully, and by the erosion of efficiencies through lack of leadership and low staff morale. Retooling district health management to improve local service delivery would seem to be an example of a ‘breakthrough strategy’ that could be easily accomplished Booth (2011).

As urgent health systems problems are addressed, policymakers must also focus on larger macro policy issues and programmes. In terms of reducing the burden of disease, the most critical objective is to reduce the rate of new HIV infection in South Africa - by implementing a comprehensive national HIV prevention programme at enough scale to have real impact. If existing programmes were scaled up and fully implemented, the incidence of HIV could be halved within five years. Although this is an ambitious target, it is vital to the long-term sustainability of the treatment and care components of a comprehensive response to HIV/AIDS (Johnson, Dorrington, Rehle, Jooste, Bekker & Wallace, 2014).

High-level actions are called for from each of the key constituencies that need to work together with a sense of urgency to enable the promise of the Sustainable Development Goals for better and safer health care to be realized.

From the perspective of three global institutions concerned with health; Organisation, for Economic Co-operation and Development (OECD), the World Bank and the World Health Organization (2018), proposes the following as a way forward for health policy-makers seeking to achieve the goal of access to high quality, people-center health services for all:

All governments should:

• have a national quality policy and strategy

• demonstrate accountability for delivering a safe high-quality service;

• ensure that reforms driven by the goal of universal health coverage build quality into the foundation of their care systems;

• ensure that health systems have an infrastructure of information and information technology capable of measuring and reporting the quality of care;

• close the gap between actual and achievable performance in quality;

• strengthen the partnerships between health providers and health users that drive quality in care;

• establish and sustain a health professional workforce with the capacity and capability to meet the demands and needs of the population for high-quality care;

• Purchase, fund and commission based on the principle of value;

• Finance quality improvement research.

All health systems should:

- Implement evidence-based interventions that demonstrate improvement;
- Benchmark against similar systems that are delivering best performance;
- Ensure that all people with chronic disease are enabled to minimize its impact on the quality of their lives;
- Promote the culture systems and practices that will reduce harm to patients;
- Build resilience to enable prevention, detection and response to health security threats through focused attention on quality
- Put in place the infrastructure for learning
- Provide technical assistance and knowledge management for improvement.

All citizens and patients should:

- Be empowered to actively engage in care to optimize their health status;
- Play a leading role in the design of new models of care to meet the needs of the local community;
- Be informed that it is their right to have access to care that meets achievable modern standards of quality;
- Receive support, information and skills to manage their own long-term conditions.

All health care workers should:

- Participate in quality measurement and improvement with their patients;
- Embrace a practice philosophy of teamwork;
- See patients as partners in the delivery of care;
- Commit themselves to providing and using data to demonstrate the effectiveness and safety of the care.

2.16.6 Development of therapeutic guidelines

The National Department of Health's Directorate for Chronic Diseases, Disabilities and Geriatrics has undertaken an extensive programme to develop therapeutic guidelines based on expert opinions, for the common chronic diseases (SEMDSA, 1997; SA Hypertension Soc Executive Committee, 2001). These have been widely distributed to the primary health care clinics. However, there are certain limitations in this approach as observed by Daniels *et al*.(2000)

Some of the guideline recommendations were unrealistic with respect to the resources available in PHCC. Furthermore, some medications that were recommended were not on the Essential Drug Lists or were not in the dispensaries due to budget limitations. These problems will have a greater effect on poor patients with chronic diseases who attend these PHCC rather than the private sector.

2.16.7 Tobacco control in South Africa

One aspect of the chronic disease prevention that has been particularly successful in South Africa has been the introduction of strong tobacco control legislation (Amos, Greaves, Nitcher, & Bloch 2012). Tobacco control initiatives have increased dramatically in South Africa, especially since 1994 when the new post-apartheid government came into power. In 1993, the first Tobacco Products Control Act was passed, and in 1999, President Mandela signed the Tobacco Products Control Amendment Act. This provides the country with one of the most comprehensive tobacco control legislation packages in the world. The act protects children and adolescents

from multimillion-Rand marketing campaigns by banning advertising and promotions. It also ensures the rights of non-smokers to a clean environment unpolluted by tobacco smoke. These actions seem to have had a marked impact on tobacco consumption in South Africa as tobacco consumption declined continuously between 1991 and 1997. The Tobacco Board reported that annual tobacco consumption dropped by 21.6% from 43.6 to 34.2 million kg of tobacco leaf during this period (RSA Tobacco Board, 1992; RSA Tobacco Board, 1998).

2.16.8 The AIDS epidemic and chronic disease care in South Africa

The most striking feature of the AIDS pandemic in South Africa is the tremendous increase in the mortality of young adults (Johnson, et al., 2014). Therefore, the older and poorer people do not only have to care for their adult children who suffer from AIDS, but also for their grandchildren who are orphaned when their parents die. Although not yet formally evaluated, the impact this has on the quality of chronic diseases care for the elderly must be extensive. They are emotionally drained because of the changing family structure and through the premature loss of their children, who traditionally would have cared for them in their old age (Steyn & Fourie, 2006). The impact that the AIDS epidemic has on chronic diseases and chronic diseases care in older persons must surely aggravate the position of the poor.

2.16.9 Measurement and generation of information.

Health care is changing all the time, so quality needs to be continually monitored and assessed to drive improvement (Barro, 2001). This relies on accurate and timely information. The banking industry devotes 13% of its income to information systems. Health care invests less than 5% – a paltry amount for an information-intense sector. When they exist, the data generated by health systems are too often concentrated on inputs and volume of activities (Contoyannis, Jones & Rice 2004). This needs to change if quality is to become a routine part of health care. Reliable quality metrics must be embedded in local and national health information infrastructures, this is even more important than measuring inputs. In the spirit of transparency, information must be

available to all relevant factors, including patients, providers, regulators, purchasers and policy-makers. All dimensions of quality should be measured (Lindahl, 2002).

According to Case (2001),It is important to know about adherence to essential protocols and the quality of processes and pathways, for example hand hygiene; surgical safety checklists; adherence to clinical practice guidelines; and clinical outcomes, for example readmissions, mortality rates, adverse drug reactions, survival after a diagnosis of cancer and adequate control of glycaemia during pregnancy Heckman (2005). But knowledge must also be generated on the outcomes and experiences of care that are valued by patients through the measurement of patient- and community-reported quality indicators. All this needs to be done with a clear eye on strong linkages between measurement and improvement measuring alone will not improve quality.

2.17 Conclusion

Despite much progress, the gap between need and effective action is still large. More resources, further development of cost-effective interventions, and better health financing schemes are certainly needed. But it is also striking that even the funds and technologies that are available are often not being used effectively. In many countries, one encounters health facilities with shockingly few patients, communities with low levels of coverage in life-saving services even where capacity exists to provide that coverage, or trained workers missing from their assigned posts and empty shelves for drugs and supplies when workers have been paid and supplies purchased. Clearly, having money and technology are not enough conditions for impact. Even with more money and better technologies, a major challenge remains: improving the delivery of health services. Without improvement in the performance of the organizations that deliver health services, potential gains in health outcomes from increased funding and better technologies will not be achieved.

The rural populations, who are the prime victims of the policies, work in the most hazardous atmosphere and live in abysmal living conditions. Unsafe and unhygienic

birth practices, unclean water, poor nutrition, subhuman habitats, and degraded and unsanitary environments are challenges to the public health system. The next chapter will focus on research methodologies used for the study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the approaches and methods used to investigate and describe various interacting groups of factors that could influence the mentioned variables. This chapter illustrates the research path, study area, study design, research methodologies, study population and sampling. Furthermore, how data will be collected and analysed is also outlined in this chapter. Research methodology enables the researcher to scientifically investigate the problem in question.

3.2 Research Methodologies

Research methodology refers to the rationale and the philosophical assumptions that underline a study (Babbie & Morton, 2010:898). This study was conducted using mixed methods. Thus, both the qualitative and the quantitative research methods were employed for the purposes of this study. This was done to achieve broad, candid and readable information about the state of and access to health care services at Ndengeza Township.

3.2.1 Qualitative Research Methods

According to Creswell (2017) "a qualitative study is defined as an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting. Qualitative research is primarily exploratory research. It is used to gain an understanding of underlying reasons, opinions, and motivations. Hence, the design chosen for this study was explorative design and it is explained and operationalised in section 3.3 below. Qualitative research is also used to uncover trends in thought and opinions, and dive deeper into the problem.

3.2.2 Quantitative research methods

Quantitative research is used to quantify the problem by way of generating numerical data or data that can be transformed into useable statistics (Lambert & Lambert, 2012). It is used to quantify attitudes, opinions, behaviours, and other defined variables – and generalizes results from a larger sample population (Neuman, 2013). Quantitative research uses measurable data to formulate facts and uncover patterns in research (Bernad, 2017). Quantitative data collection methods are much more structured than qualitative data collection methods. Quantitative data collection methods include various forms of surveys online surveys, paper surveys, mobile surveys and kiosk surveys, face-to-face interviews, telephone interviews, longitudinal studies, website interceptors, online polls, and systematic observations (Bernad, 2017). In each of the adopted methods, a research design must be selected. The following section outlines the chosen research design and how it was applied and operationalised for this study.

3.3 Research design

Research design refers to the overall strategy that the researcher chooses to integrate the different components of the study in a coherent and logical way. This ensures that the research problem or study phenomenon is effectively addressed. Maxwell (2012) added that research design is used to investigate the research problem systematically and scientifically. In mixed methods approaches there designs such as explorative sequential design, convergent parallel design and embedded designs. Ongosi (2010) stipulated that the nature of the study determines the design to be chosen. In this study, explorative and descriptive designs were used.

3.3.1 Descriptive design

Descriptive research refers to research studies that have as their main objective the accurate portrayal of the characteristics of persons, situations or groups (Lampard & Pole, 2015). Flick (2015) define descriptive design as a non- experimental research design used to observe (and measure) a variable when little conceptual background has been developed on specific aspects of the variables under study. This design is used to

describe variables rather than to test a predicted relationship between variables. In this study, the descriptive design will facilitate the description of the perception of residents towards the access to and state of health care service delivery in Ndengeza Township. Thus, this design will enable a deeper, clear and detailed description and understanding of the state of health care in the study area.

3.3.2 Explorative design

Explorative design involves an examination and exploration of research problem with an intent of understanding the phenomenon broadly (Creswell, 2017).The method is used in circumstances where the research problem has not been clearly defined or outlined and a deeper understanding of the problem is required (Flick, 2015). In this study, the researcher intends to understand deeply the challenges faced by residents in accessing health care services in Ndengeza Township hence the selection of this design. Also, this design will enable the determination of the impact of the state of health care service delivery on the daily lives of the residents of Ndengeza Township.

3.4 Study area

The study was conducted at Ndengeza Township under Greater Giyani Municipality, Limpopo, South Africa. Ndengeza Township is divided into 5 Sections which are Ndengeza A, B, C, D and E (Ndengeza Township). The area is under Ndengeza Tribal Authority which is ruled by Chief Thapelo Ndengeza (Siweya).

3.5 Population

According to Denzin and Lincoln (2005: 116), target population is described as the group of subjects to whom the findings of a given study will be generalized. Flick (2015) states that population is the total number of subjects or objects being observed. In this study, the population comprised of community members and keys informants (Tribal Authority officials, Clinic council, health ward committee members) of Ndengeza Township. Thus, all the community members, health ward committee members, tribal authority officials and council members in the township of Ndengeza for part of the population being investigated in this enquiry. The total population is very complex and

sometimes impossible to collect data in all the members of the population. This is mainly due to the limiting factors such as time, resources, financial constraints and the nature of the problem being investigated. In this study, a certain portion of the total population was used for the purposes of this study, and how the sample was selected is explained in the sampling section below.

3.6 Sampling

Sampling is the process of selecting a portion from the population of interest. The study is then administered to the chosen sample to make conclusions and generalisations about the target population (Ongosi, 2010). In the following sections sampling methods and sample size used in this are study are explained and outlined.

3.6.1 Sampling Method

According to Kumar, Mohri, and Talwalkar (2012), sampling methods provide a wide range of methods that enable the researcher to reduce the amount of data needed to collect. To achieve this, one must consider only the data from sub-group rather than all possible cases. In this study, a multistage sampling technique was used. The use of both qualitative and quantitative methods resulted in the use of multistage sampling. Multistage sampling is common very popular in the mixed methods approaches. Complications brought by the data collection in mixed methods, necessitates the use of this method. This means the study combined various probability and non-probability sampling methods and techniques.

3.6.2 Sample size

According to Denzin and Lincoln (2005:68), a primary consideration in determining the sample size is the methodology to be used. Firstly, the members of the target population including the key informants were invited into the community meeting which is referred to as voluntary sampling in human sciences (Creswell, 2015). This implies that the meeting attendees became the study participants. The participants were grouped according to the community leaders, youth, adults, aged and community health

organizations. This grouping of the population into sections is called cluster sampling and this would be the second level of sampling. Clustering of respondents according to common characteristics enables the collection of study data that is more objective, unpolarised and with limited bias. In all the clusters, census sampling was applied meaning all the members in each cluster participated in the study data collection. A total of one hundred and forty-six respondents (n =146) participated in this study (Table 3.1).

Table 3.1: Sample Size

Clusters	**Sample Number**
Community leaders	4
Adults (Female and Male)	47
Aged (Female and Male)	53
Youth (Female and Male)	39
Community health organisations (Clinic Council & Ward health committee)	3
TOTAL: 146	

3.6.3 Inclusion Criteria

To be included in this study one should be;

- A resident at Ndengeza Township
- A member of any community organization that deals with heath issues in Ndengeza Township
- A community leader in Ndengeza township

3.7 Data collection

Data collection methods refer to gathering and measuring information on targeted variables in an established systematic fashion, which then enable one to answer

relevant questions and evaluate outcomes. As stated above, the population was divided and grouped into five categories (Table 3.1), and data was collected from each of the clusters. While methods vary by discipline, the emphasis on ensuring accurate and honest collection remains the same (Denzin & Lincoln, 2005). Qualitative data was collected using one on one interview and focus group discussions. On the other hand, quantitative data was collected using a questionnaire developed from the literature and collected qualitative data. These data collection methods and techniques are explained before.

3.7.1 Key Informant Interview

Interview is one of the major sources of data collection, and it is also one of the most difficult ones to get right. In qualitative research, the interview is a form of discourse. According to Christensen, Johnson, Turner and Christensen (2011), its features reflect the distinctive structure and aims of interviewing, namely, that it is discourse shaped and organized by asking and answering questions. An interview is a joint product of what interviewees and interviewers talk about together and how they talk with each other. The record of an interview that researchers make and then use in their work of analysis and interpretation is a representation of that talk. In this study, the interviews were used to collect data from the key informant interviews. The interviewed participants are the community health organizations or structures representatives (clinic health council and ward health committee).

3.7.2 Questionnaires

A questionnaire is a research instrument consisting of a series of closed or structured questions for gathering information from respondents (Christensen, Johnson, Turner, & Christensen2011). Questionnaires have advantages over some other types of surveys in that they are cheap, do not require as much effort from the questioner as verbal or telephone surveys and often have standardized answers that make them simple to compile data. The questionnaires used in this study were developed from the data in literature and from the qualitative data collected.

3.7.3 Focus Group Discussion

Focus group discussions (FGD) are sometimes referred to as group interviews and they are comprised of a small group, usually between 10 to 12 people. In FGDs, the moderator or an interviewer guides and directs the discussion in more loose and open way to allow interviewees to express their perceptions, experiences and views (Creswell, 2015). Thus, a moderator was used in this study to allow the respondents to share their experiences and challenges about the state of the health care service delivery in Ndengeza Township. In this study, the FGD were used to collect data from each of the sub groups or cluster (youth, community leaders, adults and the aged). To perform this, the researcher used an interview guide which was used to direct and guide the discussion during data collection.

3.7.4 Data Collection techniques

The study used a combination of techniques to collect data. Data was collected through the field notes, observations and audio recorders. Prior to administering the audio recorders, the respondents were informed the consent sort, and this was done to comply with the ethical considerations needed. Further, the respondents could respond in the language of their choice with the assistance of the interpreter.

3.8 Data analysis

Once the data has been collected it has to be transcribed and transformed into a meaningful and understandable form. The two data sets (quantitative and qualitative data) will be analysed separately and data merged during interpretation (Collis & Hussey, 2013). Qualitative data will be analyzed thematical using the Atlas-ti soft water version 8.1 while quantitative data will be analyzed descriptively using mean scores, ranking and descriptive statistics. To perform quantitative data analysis, Statistical Package for Social Sciences version 25.0 (2018) will be utilized.

3.9 Ethical consideration

Ethical principles are designed to articulate a common set of values to guide and support the professional conduct of academic research and research-related activities. The primary responsibility for the conduct of ethical research lies with the researcher. It is a fundamental principle that staff, and students engaged in research adopt a continuing personal commitment to act ethically, to encourage ethical behaviour in those with whom they collaborate, and to consult where appropriate concerning ethical issues.

3.9.1 Types of ethical considerations

The common types of the ethical considerations are fully discussed below:

3.9.1.1 Respect for anonymity and confidentiality

The issue of confidentiality and anonymity is closely connected with the rights of beneficence, respect for the dignity and fidelity. Anonymity is protected when the subject's identity cannot be linked with personal responses. If the researcher is not able to promise anonymity, he must address confidentiality, which is the management of private information by the researcher to protect the subject's identity (Miller, Birch, Mauthner, & Jessop, 2012). Confidentiality on the other hand means that individuals are free to give and withhold as much information as they wish to the person they choose. The researcher is responsible to "maintain confidentiality that goes beyond ordinary loyalty".

3.9.1.2 Informed consent

Informed consent is the major ethical issue in conducting research. According to Miller et al., (2012), informed consent means that a person knowingly, voluntarily and intelligently, in a clear and manifest way, gives his consent. Informed consent is one of how a participant's right to autonomy is protected.

3.9.1.3 Approval Requirements

The primary responsibility for the ethical conduct of research lies with the researcher. Researchers must seek approval from the members of Research Units and Institutes, the relevant Head of Research Unit or Institute will act as the gatekeeper. Staffs who are not members of Research Units are responsible for seeking guidance from their Associate Dean Research or equivalent. A pro forma for recording decisions and advice from relevant gatekeepers should be obtained from the Postgraduate Research Centre (Sharon Brookshaw, 2008).

3.10 Conclusion

This chapter has covered all issues concerning the overall research methodology adopted, population identification, sampling procedures and units of analysis, the means of access to study sites and methods for data collection and analysis. The issue of how data were collected and analysed was dealt with in this chapter. The next chapter deals with the interpretation and analysis of the collected data.

CHAPTER 4: DATA PRESENTATION, INTERPRETATION AND ANALYSIS

4.1 Introduction

This chapter focuses on presentation of data and results. The results are then interpreted and discussed to explain and expatiate what they mean to residents of Ndengeza and the community at large. As indicated in the methodology chapter, the collected data was both quantitative and qualitative in nature. Quantitative data was analysed descriptively while qualitative data was analysed thematical using Atlas-Ti scientific software version 8.1. This chapter gives answers to the research questions and presents the results as per the objectives of the study. The study was set to achieve the following specific objectives, and these are presented individually. This is done to ensure that the aim and objectives of the study are adequately addressed, however, firstly, the demographic information of the respondents are presented.

- To establish the challenges faced by residents of Ndengeza townships about access to health care services
- To determine the impact of the state of health care service delivery on the daily lives of the residents of Ndengeza Township
- To recommend strategies that can be used to improve access to health care services at Ndengeza Township

4.2 Demographic Information

Table 4.1 presents the demographics of the respondents who participated in the study. The demographic variables of the participants included age, gender, marital status, level of education and household income. These give a brief description of the respondents' demographic profile. As shown in Table 4.1, forty-three percent (63) of the respondents had at least matric as the highest qualification followed by 35.6% (52) of those with no formal education. There were 21.2% (31) of the respondents who had reached or at least acquired tertiary qualification. Furthermore, the respondents were asked to indicate their employment status. The largest number of the participants 41.9% (60) were unemployed, with 32.2% (47) employed and the remaining respondents of 26.7%

(39) were self-employed. Employment status of the respondents could greatly affect the ability of the residents to access health care services. Most of the respondents were unemployed; thus, this affect the way in which individuals within the community could afford and access health services as well as medication.

Table 4.1*:* Characteristics of the Participants (n = 146)

Item	Category	Frequencies	Percentage (%)
Gender	Female	89	61.0
	Male	57	39.0
Age	29 years and below	27	18.5
	30 to 39 years	12	8.2
	40 to 49 years	23	15.8
	50 to 59 years	24	16.4
	60 years and above	53	36.3
Marital Status	Single	20	13.7
	Married	83	56.8
	Divorced	27	18.5
	Windowed	16	11.0

Level of Education	No formal education	52	35.6
	Matric	63	43.2
	Tertiary	31	21.2
Employment status	Unemployed	60	41.9
	Employed	47	32.2
	Self-employed	39	26.7
Household Income	Less than R3500.00	73	50.0
	R3 600.00 to 7000.00	38	26.0
	R7 100.00 to R10 500.00	27	18.5
	R 10 600 and above	8	5.5

Figure 4.1: *Gender of the participants in Ndengeza Township*

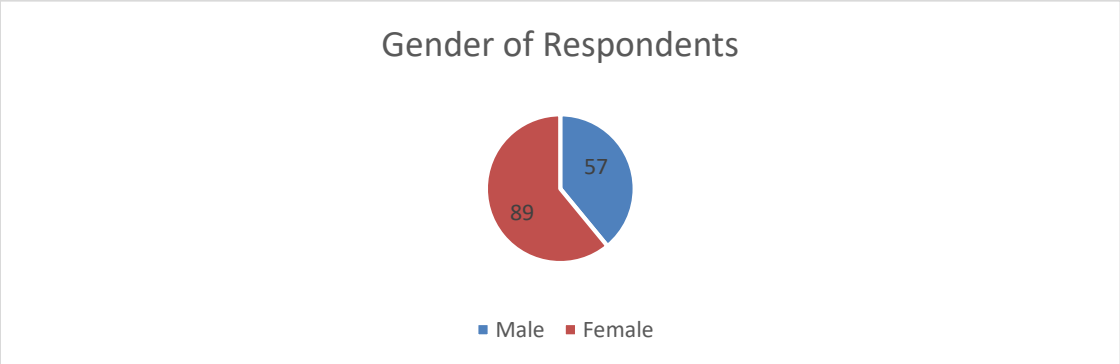

Figure and Table 4.1 shows the gender compositions of the respondents. As shown, 61% (89) were female and males comprised of the remaining percentage. The higher participation of women could be attributed to national demographic profile which shows that women are more than men. StatsSA (2011) reported that there were more than 56% of females compared to males. Tsani (2012) highlighted that in most rural communities, males leave in search of greener pastures elsewhere and this leaves rural communities dominated by the female gender. Therefore, the fewer number of male counterparts could be attributed to this trend. Tsani, (2012) revealed that in South Africa, more frequently than not, economically active groups tend to leave their rural communities to bigger cities such as Johannesburg, Cape Town and Pretoria in search of jobs and economic opportunities. Males form the highest proportion of those moving to these major urban centers.

4.2.2 Age of Respondents

Those between the age groups of 60 years of age and above 36% (53) consisted most of the respondents (Table 4.1; Figure 4.2). Participants of age groups; 40 to 49 years and 50 to 59 years had insignificantly different representation at 15.8% (23) and 16.4% (24), respectively. The youthful group of 29 years and below was also fairly represented in the residents of the Ndengeza Township (Figure 4.2). The early adults' group of 30 to 39 years 8.2% (12) was the least represented however significant. The compositions of these various ages show that indeed full or a clear picture of the state of health care and its accessibility broadly explain the views of all the diverse groups in the population. The youth, young adults, middle aged adults and as well as old aged were fairly represented across. This strengthens the validity and reliable of these findings as the views or perceptions expressed are reflective of diverse but common and perhaps shared

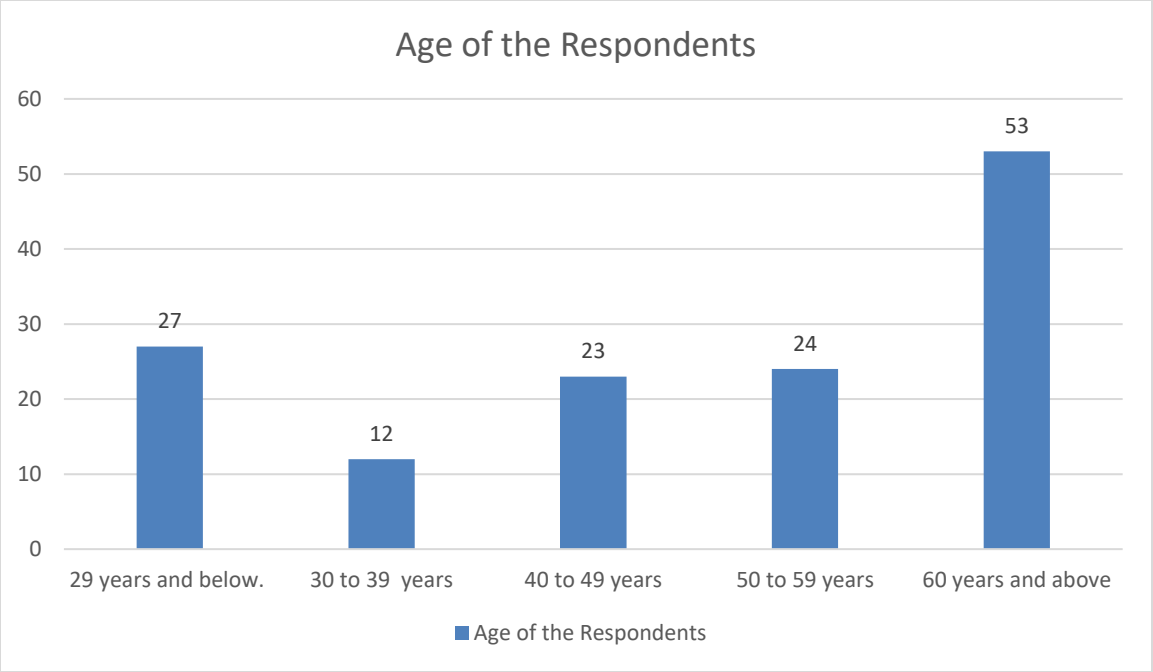

***Figure 4.2**: Age Groups for Ndengeza Residents*

In Health care access services, it could also be noted that old aged (60 years and above) were largest group. Old aged residents are among the most vulnerable groups in the community as they are exposed to more diseases due to weakened immune system. Individuals above the age of 60 years have comparatively weaker immune system and as a result, they are in constant need to visit the hospital or clinic for regular checks. Also, in consideration that the aged group constituted the larger portion of the total of the respondents, thus, their views and experiences in terms of health care access were adequately represented.

4.2.3 Employment Status and Household Income

Employment status and household income has significant implications on one's ability to access health care services. Employed individuals have wider choices in terms of accessing health care services including other medicines which might not be readily available in public hospitals. In this study, unemployed residents made the most of the study participants at 41.9% (60), employed residents were found to be 32.2% (47) and lastly, self-employed residents were the least represented at 26.7%. According to Alkire

(2005), high income earners were found to have a better access to health care services. This is so because they can afford and opt for better and more advanced health care services. The household income brackets for residents who can access better health services are also considered. Thus, more than eighteen percent of Ndengeza residents with household income of between R7 100.00 to R10 500.00 and above have better access to health care services compared to low income earners.

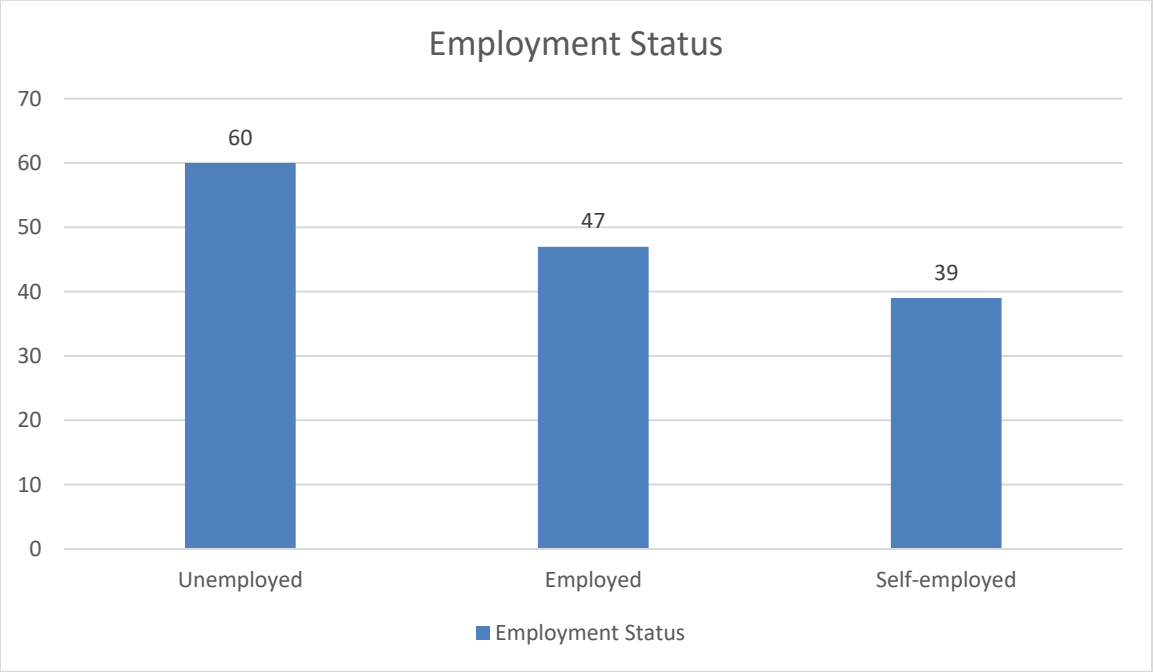

Figure 4.3: Employment status of Ndengeza township residents

4.3 Results Presentation

This section presents the main findings of the study. The results and findings are presented a per a specific objective of this study which are the health care access challenges and impact of these challenges to residents' ability to access health care services.

4.3.1 Health Care Access Challenges

Figure 4.4 shows the health care challenges experienced by the Ndengeza township residents. The health care challenges as experienced by the residents could be

categorised into poor infrastructure, unavailability of critical services, expensive medication, opening and closing times, distance and transports costs, inadequate medication and fewer and unprincipled professionals. Table 4.2 and 4.3 shows the percentage and mean scores ranking of health care access challenges as seen by Ndengeza residents, respectively. Each of these identified challenges are explained and presented separately as themes below.

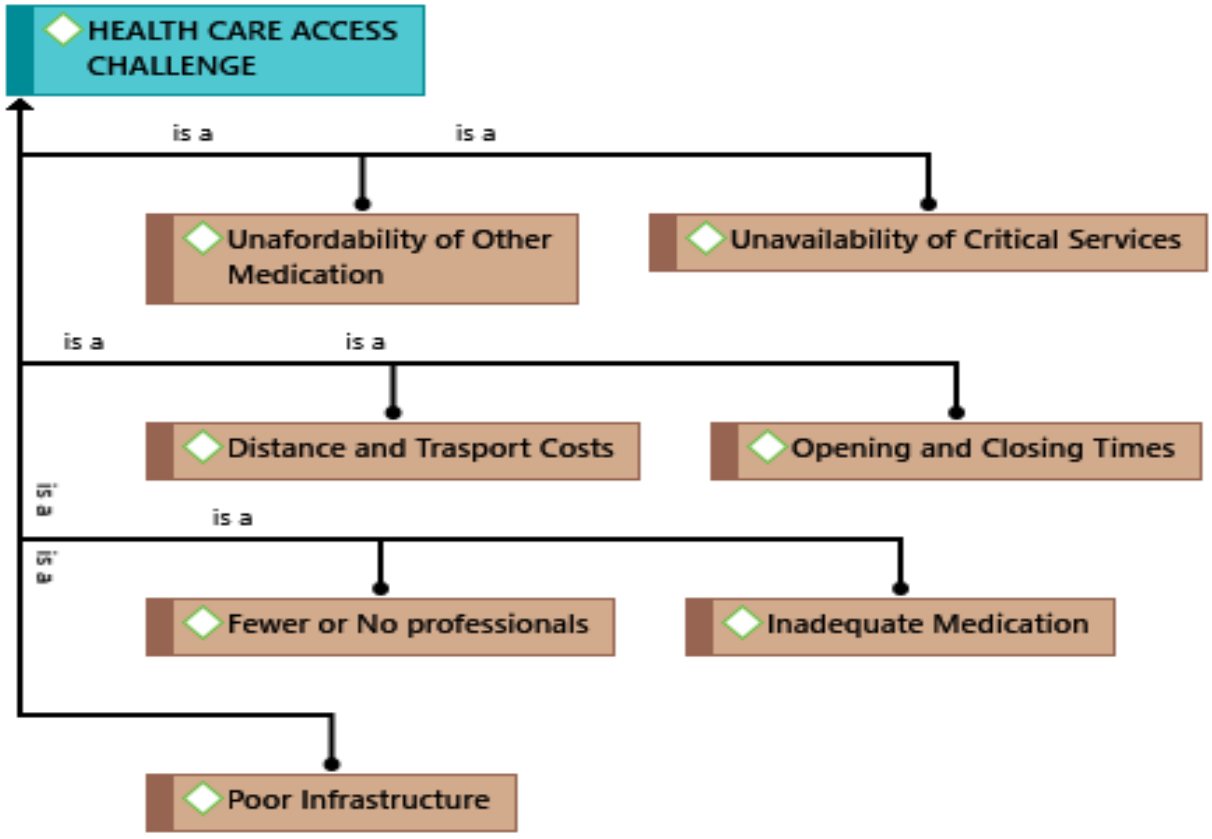

Figure 4.4: Challenges faced by residents in accessing health care services in Ndengeza Township

4.3.1.1 Distance and Transport Costs.

Out of 7 identified health care access challenges faced by residents, distance and transport costs was ranked the first by the mean scores as major challenge (Table 4.3). Eighty-two percent of the respondents indicated distance and transports cost were major challenges to their ability to access health care services (Table 4.2). Below are some of the verbatim quotes from the different FGDs.

"As old as I am, I am expected to travel that long journey to e to the clinic. I cannot even walk now, and the only way to get to the clinic is to use a taxi" (A respondent from an old age FGD)

"Visiting the hospital is a nightmare to many people die to the distance and these taxis are very expensive. This situation is worse especially for some of us who do not work, we cannot afford to be paying bus taxi-fare all the time. If possible, a mobile or another clinic should be built to supplement the existing ones" (A respondent from youth FGD).

The concerns expressed above, are a clear indication of that distance and transportation costs to the hospital are a major hindrance to residents in accessing health care services in Ndengeza Township. Residents are of the view that there is a need for additional health care facilities in order to reduce the distance travelled and related costs.

4.3.1.2 Unavailability of Critical Services

More than 69 percent of the participants agreed to the fact that there's a lack of or inadequate provision of critical services in the public rural hospitals (Table 4.2). Unavailability of critical services was ranked third on the means score rankings (Table 4.3). Rural communities rely heavily on government or public health care services to meet their health care needs. Public hospitals and health care services and its systems leave a lot to be desired. Some of the major or rather critical services are limited and sometimes unavailable in most rural health care centers. Ndengeza residents indicated that, some of the critical or major services such as dialysis are not readily available in these public health care centers. They must wait in the queues for days and sometimes weeks and other cases they must be transferred to other hospitals in major cities such Polokwane and Johannesburg among others. One of the residents was quoted as saying;

"A person with a kidney failure cannot be helped in this area. The person must be taken to the nearest hospital at Nkhensani Hospital, in Giyani Town so he can be transported

by an ambulance to Mankweng Hospital in Polokwane to get the dialysis services" (A respondent from Adult FGD)

A ward health committee member agreed and added to the above sentiments by stating that,

"As the ward committee members we have noted some of these concerns before, we even tried to raise them with the department of health through the due channels. Unfortunately, we are always told, there is no money currently and in the future we will be assisted. There are many other people who have many various chronic and deadly diseases that need urgent attention. Collectively we are trying to also take the concerns of the residents and bring at least two or three of these most needed health care services" (Ward committee member, One on One Interview).

These findings show that there is inadequacy in the provision of certain key and critical health care services. The Ndengeza residents viewed this as the one of the major obstacles in their right to access to health.

4.3.1.3 Poor Infrastructure

As shown in Table 4.3, poor infrastructure as health care access challenge was ranked last by Ndengeza residents and only 46.6% (Table 4.2) of the residents noted it as a challenge. The residents pointed out that some of the reasons why they could not access certain health services if because of poor, bad and outdated infrastructure in the public health care facilities particularly in townships and rural communities. One of the youths indicated that,

"If the infrastructure in these clinics and hospitals here were up to date, it will be easier to upgrade and introduce latest technologies to deals with some of the critical and basic health care services here. There is a need to revamp the whole apartheid system in rural public health care centers and introduce flexible health care infrastructure" (A respondent from the youth FGD).

According to the FGD for community leaders, infrastructure development is one of the key things always with the government health care officials. Health infrastructure has always come out first in these contestations for infrastructure development. A considerable number of residents have noted this as problem and is probably the key to many of the problem stated. Given, the fact that infrastructure is the first step in either virtual or direct service provision, one could argue that this is the number one problem in accessing health care services by Ndengeza residents.

Table 4.2: Descriptive statistics of the health care services

CHALLENGE	YES		NO	
	Frequency	Percentage	Frequency	Percentage
Unavailability of Critical Services	101	69.2%	45	30.8%
Poor Infrastructure	68	46.6%	78	53.4%
Opening and Closing	111	76.0%	35	24.0%
Inadequate Medication	82	56.2%	64	43.8%
Fewer and Unprincipled Professionals	103	70.1%	43	29.9%
Unaffordable Medication	84	57.5%	62	42.5%
Distance and Transport	121	82.9%	25	17.1%

4.3.1.4 Opening and Closing Times

Opening and closing hours were ranked the second highest (Table 4.3). More than 70% of the participants expressed their dissatisfaction with opening and closing hours by the health care services. The resident highlighted that the public health care service centre closes early. The clinic was said it opens at 07h30 and close at 17h00. Residents said they have been calling for the opening of the clinic for 24 hours a day everyday like hospitals.

“The clinic and the hospital are further apart; the hospital is open 24 hours and those who stays close are lucky, how about those who are far?”, said one of the residents from the adults FGD. The resident continued by stating the following,

“Let those who are close to the hospital benefit the same as those who are close to the clinic”, concluded the resident.

Ndengeza residents further stated that although the hospital is open for 24 hours a day, it is a good as if it closed. Most critical services are not available at night and you must wait for the following day if not more to see a specialist. The opening and closing should not only be viewed as related to opening of the hospital gates and doors. The opening should be accompanied by availability of that health care service at a given time.

“You can’t tell us that the hospital is open for 24 hours when you know very well that most of these major services are not available at night. Drinking pain killers and sleeping tablets and as well as using the hospital bed does not mean you have been attended to. Let’s be realistic here” (One of the residents during the quantitative data collection phase).

4.3.1.5 Inadequate and Unaffordable Medication

Inadequate medication was ranked number six out of the 7 health care access challenges identified by the Ndengeza residents. More than half of the respondents (56.2%) indicated that there is no enough medication in the public health care centers. More frequently than not, patients in public hospitals and clinics are turned away or referred to private pharmacies to purchase certain medication. Hospitals do have medication according to the residents however, there is certain medication that almost never available in public health care centers. Furthermore, residents expressed dissatisfaction by the governments’ failure to make enough medication available to residents which is a right enshrined in the constitution of the Republic of South Africa.

“We have a right to health and our constitution says so. It is a crime by the government not to provide enough medication for residents. It cannot be correct that, we still don’t

have proper systems in place to provide and improve health care access after 24 years of democracy" (A resident and an activist from the adult FGD stated).

Inadequate medication coupled with expensive medication is a curse to the poor rural resident of Ndengeza. Almost three fifth of the respondents indicated that the cost of medication in private sector is one of the key hindrances to access to health care services in Ndengeza hospital. According to the mean score rankings, unaffordable medication was ranked 5th (Table 4.3) as a health care access challenge for Ndengeza residents. Due to lack of adequate medication in public health care services, Ndengeza residents are expected to procure medication from private and mostly expensive health care service providers. Medication in private health service providers was viewed as unattractive and unsustainable by and for the rural residents of Ndengeza Township. When residents cannot obtain medication from public health care service centers, they are referred to private service providers. These service providers are for profit and therefore, they sell medication at unaffordable prices for the poor majority of Ndengeza township residents.

4.3.1.6 Fewer and Unprincipled Professionals

A considerable and significant portion of the residents (70.1%) pointed that fewer and unprincipled professionals in the health care facilities was one of the major challenges affecting Ndengeza residents in accessing health care services (Table 4.2; Table 4.3). More than two third (70.1%) of the residents lamented shortage of and unprofessional conduct by public health care staff. Residents hinted that there are no enough professionals at the public health care centers. As consequentiality, for certain services one must book as the specialist whose services are also in urgent need elsewhere.

"You see, when you are waiting to consult at the hospital you will be occupying the space that could be used by someone else in urgent need of attention. People spend two or more days waiting to see a doctor or specialist. If there were enough specialists, hospitals will have more space to take care of other illnesses" (A resident from the FGD)

The available staff is sometimes perceived as unfriendly to patients and most of the time patients have stated that "*some nurses lack nursing skills*". Some public health care professionals are said to be impatient, "*disrespectful"* to the adults and lack tolerance.

Table 4.3: Mean scores ranking for health care access challenges.

Positive consequences	Ranked mean	Standard error	Rank
Distance and Transport Costs	4.65	0.131	1
Opening and Closing Times	4.43	0.115	2
Unavailability of Critical Services	4.36	0.112	3
Fewer and Unprincipled Professionals	4.19	0.037	4
Unaffordable medication	4.12	0.123	5
Inadequate Medication	3.78	0.094	6
Poor infrastructure	3.71	0.114	7

4.4 The Impact of Current State of Health Care Services to Residents

Figure 4.5 shows the impact of the current state of health care access to lives to quality of life of Ndengeza residents. As a result of limited access to health care services, residents stated several concerns and the extent to which this has affected their general quality of life. The perceived impact of the current state of access to health care services by Ndengeza residents could be summarized as prolonged sickness and

agony, loss of life, increased costs and spread of diseases. The state of health care access at Ndengeza Township has put residents through great deal of pain. A lot of suffering and agony is experienced by patients while waiting for the clinic to open or for the assigned professionals to attend to you. Some of the diseases if not attended to quickly, spread to other residents as well defeating the attempt to contain it. Moreover, residents highlighted that due to distance, expensive medication, late openings and shortage of health care staff in public health care hospitals has resulted in increased households' expenditure and in the worst-case scenario; some residents have lost their lives and loved ones in the process.

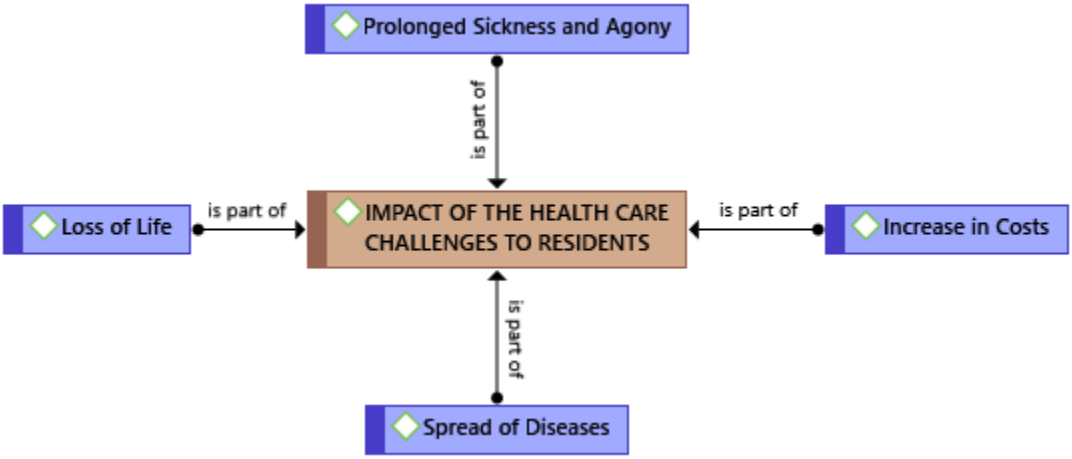

Figure 4.5: The extent of the impact of the current state of health care services to residents

4.5 Conclusion

The chapter outlined the findings and results of this study. The objectives of the study were to identify the challenges faced by residents in accessing health care services. Furthermore, the study aimed to establish the impact of these challenges to the quality of life of Ndengeza residents. The results showed that residents had a wide range of challenges related to accessing health care services. Chief amongst them was the distance and transports costs. Residents indicated that the health care centre in the township is allocated far away limiting their access to the services this critical facility provides. The combined effect of these challenges has resulted according to the residents, spread of diseases, increased family household expenses and in some

instances, loss of life. The next chapter deals with discussions, conclusions and Recommendations of the study.

CHAPTER 5: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the discussions and conclusions of the study. The previous chapter outlined the results and here, their practical implications and what has been found in literature is discussed. This chapter' sections are discussions, conclusions and lastly, recommendations.

5.2 Discussion of the Findings

The findings will be discussed based on the objectives of the study.

5.2.1 Challenges faced by Ndengeza Township residents.

The following are the challenges that the residents of Ndengeza Township face when they need to access health care services.

5.2.1.1 Distance

Distance and transport costs to the health care center were listed as one of health care access challenge. The challenge was said to be more pronounced among the participants from disadvantaged background who are make up the majority. The participants mentioned that for them to get health services they must first have money for transportation. This sometimes leads the residents not to visit the health centers even when they are in serious need of health services. The distance is said to be a critical challenge when it comes to the residents who are bed ridden or those in need of urgent medical attention because they have to pay a huge amount of money to be taken to the health centers by the other resident's private cars.

In support of this, Luke and Heyns (2013) asserted that public transport services are inadequate and generally expensive for average rural dwellers that are predominantly poor. The difficulty in physical access to health care services is a common problem in South African rural areas. According to White Paper (1995), patients usually travel long

distances from their various homes to get access to health care services. Though the South African medical care is free at public health centers and clinics, patients usually must spend a lot of money on transport.

5.2.1.2 Shortage of health professionals

Another challenge mentioned was the shortage of health care professionals as a major issue the residents of Ndengeza Township are facing in accessing health care services. This shortage affects health care service delivery more each day, more especially in the light that less or not much is being done to address it. The participants mentioned that the centers usually have two Nurses who are dealing with a number of patients. Resultantly, the number of patients per health care staff member has increased thus, decreasing the quality of the care given. Furthermore, respondents highlighted that the shortage of health care staff causes long queues and long waiting period to access health care services.

Meyer and Bishop (2007) found similar results that revealed that health care staff shortages are felt in many health care centers such as nursing homes, clinics and health care agencies. Patient Protection and Affordable Care Act of 2010, the limited supply of health professionals in rural areas and difficulty recruiting professionals creates challenges for rural health centers to secure and sustain adequate staffing.

5.2.1.3 Shortage of medication

The results from the respondents revealed that there was a challenge of inadequate medication. The respondents mentioned that sometimes they use their last money to visit the health care center only to come back with a Panado because there are no other medications at the center. The shortage of medication is said to have been a problem for some years now. Participants added that they are usually told to buy medication from pharmacies. These shortcomings endanger the health and lives of all patients, add costs to the health care system, and reduce productivity.

According to Seitio-Kgokgweet al. (2014), shortage and erratic supply of medicines was reported by health centers across the country. One of the problems leading to unavailability of adequate medication in public health care centers is mainly caused by inefficient supply chain management systems. The poor supply of medicines limited access to services with patients having to travel long distances from one facility to another looking for drugs.

5.2.2 The impact of the state of health care service delivery on the daily lives of the residents of Ndengeza Township

5.2.2.1 Unprofessionalism of the health care staff

The findings revealed that patients and health care givers often have a negative relationship. This has prevented patients from seeking health services. Some patients feel maltreated and not being given the necessary respect by health care providers. This kind of negative treatment often makes patients to be unable to express their feelings for fear of being shouted at and this in turn, affects the treatment received which becomes ineffective. One participant mentioned that she was once scared to ask about the prescription given to her and ended up using it the way she thought best because she was intimidated by the health care staff.

Hana and Martin (2005), in a study done in Saudi Arabia on quality of primary health care, agree with the assertion that health care providers are often seen as being rude and lacking in compassion by patients.

5.2.2.2 Delaying to get medical help

The state of health care service delivery in Ndengeza Township has a huge impact on the residents. The participants mentioned that there are in a point where visiting the health care centre is the last option due to the transportation money and waiting long queues only to be told there are no medications. The participants further mentioned that before they could visit the health care centre, they first wait a few days just to see if their

illness does not go away. As a result, without the knowledge of the illness, they unknowingly infect others and also their condition gets worse due to not getting treatment fast.

5.2.3 To recommend strategies that can be used to improve access to health care services at Ndengeza Township

5.2.3.1 Professionalism

Professional treatment of patients by health care providers can influence patients to make healthier lifestyle choices, such as stopping smoking, increasing physical activity, making healthy dietary modifications, and complying with other health living recommendations. Capitalizing on this influential relationship depends, in part, on whether these two groups can effectively communicate with one another. Effective communication between patients and providers helps to optimize counseling interactions and has a significant influence on patient behaviors and health outcomes.

According to Awino (2007), in patient perception of quality of health care service delivery, emphasized the importance of a good relationship between a patient and health care providers. Patients who are treated with dignity and are well informed and able to participate in treatment decisions are more likely to comply with their treatment plans. The patients' feelings are what matters even if the staffs' perception is different, since patient satisfaction evaluation relates to their behaviour and can be used to improve nursing services (Merkouris et al., 2013).

5.2.3.2 Waiting time

Patients are often expected to wait for too long in the queue before they are attended to by a doctor. Patients who have had to wait for too long in the queue will have a negative view of the treatment they receive by the time they are attended to. The health centers should make it a point that patients do not wait more than 30 minutes on the queue. In situations where there are some delays at the health centre, patients should be told in

time. This helps the patients to bear with the health care staff and will not bear any negativity from the patients.

Offei et al. (2004) also indicates that patients want services that: are delivered on time by friendly and respectful staff; are safe, produce positive result and that they can afford; provide them with adequate information about their condition and treatment; provide them with all the drugs they need; give privacy and are within their reach (distance) and given in a language they can understand.

5.2.3.3 Availability of medications

Health care professionals should put patients first by ensuring that health care services are always accessible to patients when the need arises. The South African government has legislated that no patient should be sent home without receiving medical care. Patients should not be kept waiting for a long time, being exposed to agony and still be told that there are no medications (White Paper, 1995). The department of health should always ensure that there are medications in health centers, that way; the residents will not be negative when they think of getting medical help and there will not be continuous infections of diseases.

5.3 Conclusions

According to the Constitutions of the Republic of South Africa, everyone must have adequate and timely access to quality health care. However, given the study findings and revelations from literature, it could be concluded that indeed there are a varied and multileveled number of health care access challenges in Ndengeza Township and these have adverse effects to the day to day quality of lives of residents.

5.4 Recommendations

Based on the findings of this study the following recommendations are made.

5.4.1 Recommendations to the Provincial Department of Health

- Ambulance services should be made available 24 hours at the health care center. The patients should never wait for hours to access the Ambulance nor hire private transport to get to the health care center.

- The Department of Health (DOH) should hire more doctors and nurses among other health care givers to improve residents' access to health center services. Furthermore, this will avoid overworking the health care workers and in turn, deliver effective and efficient treatment.
- The DOH should organize workshops regularly for the health center staff focusing on provider-patient relationship. The DOH should further make sure that there is an employee assistance practitioner at every health center where the staff can go and discuss their issues whether personal or work-related which to improve their relationship with patients.

- The DOH should organize campaigns and road shows to educate patients about their rights so that the communities can be well informed even before they go to access services in health centers.

- The DOH should conduct surveys on a regular basis in health centers where they can gather information on whether patients are satisfied with their services or not.

5.4.2 Recommendations to the Health Centre's Management

- The health centers management should make sure that the ambulances in their health centers are always easily accessible to patients and that they are being utilized for their purpose.
- Interaction between patients and health care providers should constantly be monitored and all complaints by patients should be taken seriously.
- The health care management should make sure that patients' rights are written in all official languages and displayed where they will be visible to every patient.

Furthermore, they should make sure that these rights are always explained to patients.

- The health care center management should regularly engage with patients to hear how they view the treatment they are receiving at the hospital.

5.4.3 Recommendations to the Nurses

- Nurses should make patients in health centers feel as comfortable as possible by making sure that patients are able to access all health center resources with ease. They should assist in acting as guides for patients by properly explaining to them where they should go to access a service and where possible, accompany the patient.
- Nurses should always practice the *Batho Pele* principles to improve the relationship with patients. They should always exercise patience since not all patients are literate or understand easily.
- Nurses should always make it a priority to explain patients' rights to every patient who enters the hospital and, in a language that the patient will understand.
- Nurses should always enquire how the patient is feeling, this will assist the nurse to determine whether the patients view the treatment they are receiving as effective or not and know where the patients' concerns lie.

5.4.4 Recommendations to the Hospital Administrative Staff

- The administrative staff should always treat patients who are struggling with caution and respect as well as being empathetic towards them.

5.4.5 Recommendations to the Community

- Community leaders should hold meetings with community members to hear what challenges they are facing regarding accessing hospital facilities so that they can report it to hospital management.

- Community members should try and build a good relationship with health centers staff and listen to advice.
- Community members should always encourage the each other to exercise their rights as clients in the health centers.

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Appendices

Appendix 1: Time Plan

	J	F	M	A	M	J	J	A	S	O	N	D
2017												
Proposal Development	■	■	■	■								
Submission of Research Proposal to the School of Management Higher Degrees Committee					■	■	■	■	■			
Submission of Research Proposal to University Higher Degrees Committee										■	■	
Incorporation of Comments from University Higher Degrees Committee												■
2018												
Data Collection	■	■										
Data Analysis and Interpretation			■	■	■							
Write Up							■	■	■	■		
Submission of Final Draft Thesis											■	■
2019												
Incorporation of external examiners' comments	■	■	■									
Submission of Book Bound Thesis				■								
Graduation					■							

Appendix 2: Consent Form

TOPIC: EVALUATION OF HEALTH CARE SERVICE DELIVERY IN RURAL AREAS WITH SPECIFIC REFERENCE TO NDENGEZA TOWNSHIPS

INVITATION TO PARTICIPATE

You are being asked to participate in this research study because the researcher would like to evaluate the health services provided by the Department of Health.

PROCEDURES

As a participant, you will be enrolled in the study and complete the questionnaires that will be provided to you by the researcher.

RISKS

Some of the questions on the questionnaires you will be completing may touch on sensitive areas. However, every effort will be made by the researcher to minimize your discomfort. You are encouraged to discuss with the researcher any negative or difficult feelings or experiences you have because of participating in this research. If at any time you feel you would like to stop your participation in the research study, you will be free to do so.

COSTS AND FINANCIAL RISKS

There are no financial costs directly associated with participation in this project. Services from the researcher are provided at no cost to you.

BENEFITS

There is no guarantee that you will benefit directly from the study.

COMPESATION

You will not receive any compensation for participating in this study

ALTERNATIVES

Participation in this research study is entirely voluntary and you may choose not to participate.

CONFENDETIALITY

Every attempt will be made by the investigation to keep all information collected in this study strictly confidential, except as may be required by court order or by law. If any publication results from this research, you will not be identified by name.

ADDITIONAL INFORMATION

Your participation in this study is entirely voluntary, and you are free to refuse participation. You may discontinue your participation at any time without prejudice or without jeopardizing the future care either of yourself or your family members. If you discontinue participation in the project, you may request that we not use the information already given to us. You are encouraged to ask questions concerning the study at any time as they occur to you during the programme. Any significant new findings developed during the study that may relate to your willingness to continue participation will be provided to you.

DISCLAIMER/WITHDRAWAL

You agree that your participation in this study is completely voluntary and that you may withdraw at any time without prejudicing your standing within the community.

SUBJECT RIGHTS

If you have any questions pertaining to your participation in this research study, you may contact the supervisor of the researcher, by telephone (081 800 1756)

CONCLUSION

By signing below, you are indicating that you have read and understood the consent form and that you are agreeing to participate in this research study.

Participant's Signature: Date:

Researcher's Signature: Date:

Witness's Signature: Date:

Appendix 3: Data Collection Tools

INTERVIEW QUESTIONS

How would you explain the health system in your community?

What health challenges of do you think are affecting the people of Ndegeza RDP?

What do you think of the health service provided to the people in your community?

Do they have difficulties with accessing the health services?

What channel of communication are the people expected to use when the service is not rendered well?

Who advocates for the people of Ndengeza Township when the health service is not rendered well?

Do you think the health challenges of the people of RDP are being addressed?

Do you think the people of Ndengeza Township are satisfied with the health services provided to them?

What would you recommend to better the health services rendered to the people of Ndengeza Township?

QUESTIONNAIRE

Personnel

Are the services rendered by qualified Staff?	YES	NO
Are there enough staff?	YES	NO
Does the institution have various specialists, e.g.; dietician, Optometrist?	YES	NO

Infrastructure

Are the services rendered in a permanent basis?	YES	NO

Is there a waiting area in the centre?	YES	NO
Are the consultation rooms in a closed area?	YES	NO

Location

Is the institution located within the vicinity of the community?	YES	NO

If no, how far do you travel in terms of Kilometres?

Is there a need for transport to get to the health centre?	YES	NO
What kind of transport do you use to get to the health centre?		

If yes, is the transport accessible?

How much does the transport cost to get to the centre?	

Security Measures

Is there a security services available in the centre?	YES	NO
Do you feel secured when you are in the centre?	YES	NO
Do you think the staff members feel safe in the centre?	YES	NO

Service standards

Do you pay for the services?	YES	NO

If yes, how much is it?

What are the operational hours of the centre?		
Is there an availability of medication?	YES	NO
Do you find the staff welcoming and helpful?	YES	NO
Does the staff respond to your concerns with ease?	YES	NO
Does the staff give direction on how the medication should be taken?	YES	NO
Are you satisfied with the services provided in the centre?	YES	NO

If no, what would you recommend for services improvement?

Emergency Medical Services

Are there any Ambulances in the centre?	YES	NO

If yes, is it easily accessible?

YES	NO

In the case of emergency, how long does it take for the ambulance to arrive?	
If your answer to the first question is no, what do you use to get to the centre in case of an emergency?	