



**UNIVERSITY OFTM
KWAZULU-NATAL**

**INYUVESI
YAKWAZULU-NATALI**

**ATTITUDES AND EXPERIENCES TOWARDS STATE PROVIDED HEALTH SERVICES IN THE
CASE OF INANDA, KWAZULU NATAL.**

BY

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SHORT DISSERTATION

A Dissertation submitted to the School of Built Environment and Development Studies in fulfilment of the Masters in Development Studies degree at University of KwaZulu-Natal, Howard College Campus, Durban, South Africa.

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2020

DECLARATION

I Thabisile Peaceworth Goba hereby declare that:

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“ I praise you for I am fearfully and wonderfully made; your works are wonderful, I know that full well...”
Psalm 139vs14

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ABSTRACT

This study investigated the attitudes and lived experiences of the community of Inanda towards state provided health services. The study included an investigation of how the attitudes and lived experiences impact on the individuals' inclination towards the utilization of public health services. A mixed method approach was adopted for this research to enable an in-depth exploration of the attitudes and lived experiences of the community of Inanda towards state provided health services. A survey, conducted through an electronically administered questionnaire, which focused on individuals' attitudes towards their experiences when accessing health services, was sent to 50 participants from Inanda. Furthermore, 10 in-depth interviews which were conducted telephonically provided elaborate details of individuals' experiences at the health facilities, and how those experiences shape their attitudes towards health services.

Data collected in the survey were analyzed using the google forms built in analyzing tool, as well as the Microsoft Excel spreadsheet. The results were presented in the form of graphs and narratives. Thematic analysis was used to analyze the qualitative data. The interview recordings were transcribed and then coded for the identification of themes and codes.

The study found out that participants had easy access to public health facilities, most of them being able to walk to the facility. It was established that the public health system is faced with a multitude of challenges which impact on the individuals' attitudes towards them. These include a lack of resources, a lack of poor work ethics among the staff at the facility which includes verbal abuse and humiliation of patients and others.

It can be concluded that health services available at public health facilities are substandard and result in negative attitudes among patients. It is recommended that government strives to improve communication at its facilities which will improve patient knowledge. It is also recommended that the government put in place consequence management to address issues of unethical conduct from staff member.

The study serves to provide evidence of the challenges encountered by individuals whilst utilizing the public health services. It contributes towards the formulation of policies which aim to improve the efficiency of services in this sector and, ensuring the provision of streamlined services.

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CHAPTER 1

1.1 Introduction

The White Paper on the Transformation of Health System in South Africa, published by the South African Ministry of Health to Parliament in April 1997, presents to South Africans the objectives and principles which are the basis for the Unified National Health System. This Unified system is capable of delivering quality Health Care to the people of South Africa. The White Paper also presents implementation strategies which are designed to meet the basic health needs of all South Africans, given the available resources (Department of Health, 1997).

The National Health Act 61 of 2003 is an act that aims to provide a framework for a structured and uniform health system with the Republic of South Africa. The Act effects the obligations imposed by the Constitution of South Africa, in Chapter 27 of the Constitution of the Republic of South Africa, stipulating that all South African have the right to quality health care, food, water and Social Security (Republic of South Africa, 1996). The state is therefore mandated to take reasonable legislative and other measures, within its available resources to achieve the progressive realization of these rights (Republic of South Africa, 1996).

One of the general functions of the Department of Health is the provision of health services including social, physical and mental health care to all citizens (Republic of South Africa, 2002). South Africa offers free health care at its public health facilities; however the facilities often face the challenges of poor management, under staffing and inadequate infrastructure. This greatly affects the quality of health care available at these facilities (Karen, 2019).

Despite the many attempts made by the government to improve the quality of health services at the public institutions, reports by media communities in 2009 reveal that services in the public health facilities were still failing to meet the basic needs and standards of care as well as patient expectations (National Department of Health, 2012.) This has caused the public to lose interest in the health care system (Zubane, 2011). It also led to an evident decline in the willingness for the public to utilize state provided health services at the public health facilities. This study therefore investigates the

attitudes and experiences of patients which contribute to the decline in the utilization of state provided health care.

1.2 Background to the Study

Health care is a basic service which is essential in any effort to reduce poverty. One of the general functions of the Department of Health in South Africa is the provision of health services including social, physical and mental health care to all citizens (Republic of South Africa, 2002). These services are subsidized with public funds and they rest on two fundamental objectives, namely efficiency and equity (Castro-Leal et.al, 2000). It is thus envisioned that South African citizens take full advantage of such services, however it has been discovered that Government funds which are directed towards curative health care, are poorly targeted to poor households, and instead favor those who are better off. Improving targeting to the poor households involves not only rearranging the public subsidies, but also addressing the constraints that prevent the poor from accessing the services (Castro-Leal et.al, 2000).

Recent studies have shown that vulnerable groups of the population, such as the poor and immigrants underuse health services. Studies also show that they tend to receive a lower quality of health care than the general population utilizing the same facilities (Dias et. al., 2012). The failure of the government to improve the quality of health services at public institutions has led to a decline in the willingness for the public to utilize state provided health services at the public health facilities. A study conducted by Castro-Leal (2000) indicates that in South Africa only 12% of the poorest quintile is likely to report illness or injury over a four week period. Of this 12%, 25 % received no care, while 46% received care at a public institution and 23% received care at a private institution. This was compared to the richest quintile, and found that 26% of this population is likely to report injury or illness over the same period. Of this 26%, only 14% received no care, 9% received care at a public health facility and 74% received care at a private health facility. These figures reflect on the availability, the cost, the quality of the health services as well as circumstances in the individual household. The findings also suggest that poorer households are less likely to report illness than their better off counterparts. It could be because the poor accept illness as a normal feature of life. Lower reporting could also occur because of poorly educated respondents who are less likely to identify

untreated illness as a problem (Castro-Leal, 2000).

Inanda is located approximately 20 kilometers from the Durban Central Business District (CBD). Inanda has grown as an informal settlement outside of the city boundaries. The area is relatively poor and is characterized by high unemployment levels, low income levels, high crime rates and poor access to both government and business services (Meyer et.al, 2003). Inanda has two local authority clinics, four provincial authority clinics and one faith based clinic. Combined, these facilities offer women reproductive and maternal health services such as pap smears, family planning, termination of pregnancy, maternity, and so on. The facilities also offer adult curative services such as the treatment of TB, management of HIV, acute services such as treatment of flue and other general ailments. Some of the facilities offer chronic disease management, rehabilitation for disability and emergency care (Meyer et.al, 2003).



Image 1: Map showing proximity of Inanda in relation to Durban (Muswema, 2012).

1.3 Problem statement

The national Department of Health, through its nine provincial departments projected to spend ZAR200 Billion in the 2018/19 financial year. KwaZulu Natal was allocated ZAR42.3 Billion. These national figures represent 13.4% of total government resources and approximately 4% of the country's gross domestic product (Unicef, 2018). Despite such high investments, missed clinic appointments by patients are a common phenomenon in healthcare. The problem with missed appointments is that continuity and effectiveness of health care is compromised. Appropriate monitoring of health care lapses and the cost of follow up health care services escalates (Magadzire et.al, 2017).

South Africa spends approximately 8.6% of its Gross Domestic Product on health, however it has been noted that when it comes to health, South Africa is not doing as well as it is expected, when considering the financial investments made by the government. This poor performance has been attributed to, among other factors, the escalation of HIV and AIDS, Tuberculosis and an ailing health system (Naledi et. al. 2011).

According to Sekhri and Savedoff (2005) many developing countries have public health expenditures of less than US\$ 10 per person per year; however the commission on macroeconomics and health advises that it costs US\$ 34 per person annually to provide a package of essential health interventions. As stated above, inconsistent health behaviour adds strain to the already stretched health care budget. In developing countries such as South Africa, there exists three financing mechanisms which aim to protect citizens from the financially catastrophic effects of illness; these are taxation, social security and private health insurance. Developing countries have large informal sectors, which make tax collection difficult. This limits the ability of developing countries to generate sufficient tax revenues or fund social security systems to provide broad financial protection for health care. This then leads to poor health care for the poor and elite health care for the rich, who can afford medical insurance. (Sekhri & Savedoff, 2005).

It is proposed that universal coverage of quality health care is affordable and sustainable in South Africa; however it requires substantial increases in the funding of health care. The government of South Africa has indicated that it intends to pursue universal coverage through what is termed the

National Health Insurance (NHI). The NHI will be funded largely through general tax revenue, but there will also be additional taxes which will be collected through additional charges on all taxable income, a payroll levy on all employees as well as an increase in Value Added Tax (TAX). (McIntyre & Ataguba, 2012).

As highlighted above, the poor performing South African health system, adds pressure to the national finances as the country is required to invest more in order to restore the health of citizens who have experienced inconsistent access to health care. Furthermore, it has been proven that provinces with the greatest health burdens, the least economic resources and the largest populations receive the smallest share of the national public healthcare funds. (Gaede & Versteeg, 2011). This poses a big problem to continuity of health care, as substantial barriers remain to receiving health care even in the public health arena. Many families are unable to access healthcare services due to the costs involved, and are thus affected to a greater degree due to higher levels of deprivation. An episode of illness within a family with few resources can have a catastrophic impact on the entire family which can be hard to recover from. (Gaede & Versteeg, 2011).

Thus, the National Health Insurance, though it may be arduous to fund and implement fully, may in its entirety be the only hope for sustainable health care for some households and individuals.

1.4 Motivation for the study

It is a belief widely held by theorists that attitudes consist of three interrelated components. The first is an affective component which involves the feelings about and evaluation of an object or phenomenon, a cognitive component involving beliefs about an object or phenomenon and a behavioral intentions component which involves the behavior of a person about an object or phenomenon. (Fazio, 1986). Fazio (1986) asserts that attitudes do relate to subsequent behavior.

This study intends to establish the attitudes and delve into the lived experiences of individuals relating to their access to health services. In particular, the study seeks to determine the pull or push factors which relate to patients experiences and attitudes, and that may result in an individual's behavior concerning their health, especially when there is a need to restore or maintain ones health.

A study of prevention of mother-to-child transmission of HIV, conducted in Dar es Salaam, revealed a high and increasing detectable viral load during follow up for two years postnatally in women given

continuous antiretroviral treatment for their own health. This suggested barriers to adherence to treatment. It was discovered that most women who participated in the study did not acknowledge poor adherence until they were confronted with the high viral load. They reported that their motivation to adhere to treatment decreased once they had successfully protected their babies from becoming infected with HIV. Some reported that the overwhelming demands of everyday life, poverty and a lack of empowerment also posed a significant barrier to long-term adherence. A majority reported that their need to keep their HIV status a secret and not let anyone see them taking the drugs was a very steep barrier to their adherence (Ngarina et. al., 2013). This study clearly illustrates how lived experiences can influence the attitudes of individuals and thus shape health seeking behaviour. The study indicates that factors such as the demands of everyday life, poverty, a lack of empowerment, fear of stigmatization and simple ignorance, have all contributed to the patients not accessing health services as their personal situations demanded that they do and the consequences of this is a higher and detectable viral load, which will need even more time and resources to address.

There are countless factors which serve as barriers for the public to access various health services. This study seeks to explore the community of Inanda's own barriers to the access of health care. It seeks to enquire whether these barriers are connected to attitudes and lived experiences. Furthermore, this study seeks to reveal to the communities themselves, the impact these barriers bear on their health and motivate towards the effective diversion from such barriers towards fully utilizing services available.

From this study, the individual community member needs to get a two-pronged benefit, namely access and effectiveness. The individual community members need to at all times establish if they are getting the care they need from the public health sector. The study aims to provide mechanisms to ensure patients are capacitated and empowered enough so they know how to get relevant access to health care. Secondly the individual needs to be able to ascertain if the care received is effective. When considering the effectiveness of health care service one needs to look at the structure of the health care, the process as well as the outcomes resulting for the services. (Campbell, Roland & Buetow, 2000).

The community of Inanda should from this study obtain salient information about the state of their health services they may have not previously critically engaged on. Information such as the reasons for palpable relations between health care professionals and patients, and the attitudes acquired from

experiences of possible bad engagements between the two parties. This study aims to provide to the community a rationale to why certain phenomenon happens, and will thus find stimulus to change previous patterns of behavior in an effort to gain superior access health care. The study will highlight the reasons patients experience dissatisfaction with the services received from the public facilities and propose possible solutions.

The public health facilities in Inanda will through this study be enlightened on the experiences of their patients and how those experiences have shaped their attitudes and behavior. The study aims to, at a micro level, inform policy and practice which will seek to provide improved health care to the public. The findings of this study should enable facilities, through their governing structures such as Clinic Committees to have a basis on which recommendations for additional resources can be motivated for, thus enabling improvement in the quality of health care provided. The study also needs to provide the facilities with insight and the reason for some of their most perplexing issues pertaining to patient behavior in the area, most importantly, through this study the facilities need to be able to make efforts to improve the services they provide given the resources at their disposal.

The health practitioners should through the findings of this study, gain finer understanding of the patients they serve on a daily basis. They should use the contents of this study as the foundations which will enable them to understand reasons behind certain behaviors and attitudes which may be displayed by the patients. This will help to curtail the sometimes unpleasant relations between patients and health care professionals.

At a broader level, the study seeks to also make valuable contributions towards publicizing the previously concealed overall attitudes of communities, and how they negatively impact on the service delivery. It should serve as an exposition of patient experience and a guide of how patients are to be received at the health institutions and relevant policy formulated which governs the various operating procedures. This will not only ensure continuity and the effectiveness of health care, but it will also result in less strain in terms of financial investment as the cost of restoring health is much higher than the cost of maintain health. It will also provide an opportunity for comparison, where the case of Inanda, can be compared to other areas within the Ethekewini District and similarities and differences may be explored.

1.5 Objectives for the study

1.5.1 Aim of the Study

The aim of this study is to investigate the attitudes and experiences of the community of Inanda towards state provided health services. This will include investigating how the attitudes and lived experiences shared by the community impact on their willingness to access state provided health care. In the process, it will unpack the factors leading to possible negative thoughts and actions towards state provided primary health care at public health facilities.

1.5.2 Specific Objectives

- To examine the attitudes widely held by the community of Inanda (KwaZulu Natal) towards state provided health services
- To explore the lived experiences of the community when utilizing public health facilities.
- To establish the impact of these lived experiences on the lives of the patients.
- To draw conclusions and make recommendations on how patient experiences may inform both practice and policy.

1.5.3 Research questions

- How do the lived experiences of the community of Inanda influence their attitudes and behavior towards state provided health services?
- What are the attitudes of the community of Inanda towards state provided health care?
- What are their shared experiences relating to health services?
- What impacts or implications do these experiences have on the lives of patients utilizing public health facilities in Inanda?
- Based on the findings what recommendations can be made to ensure improved experiences in the future?

1.6 Definition of Key Terms

The term **attitude** bears multiple meanings in the English language. It connotes a subjective or mental state of preparation for action. It also refers to the outward or visible posture of a figure or individual. Arriving at a certain judgement or decision depends on the attitude of mind while engaging with the matter at hand (Allport, 1933). Individuals have many attitudes on many different topics, thus the term attitudes should not be used with the current slang meaning of being pugnacious or sullenly deviant (Oskamp and Schultz, 2005). For the purposes of this study, Allport's perspective will be adopted as the key definition of attitudes.

A **lived experience** is a representation and understanding of a person's human experiences, choices and options, and how those factors influence one's perception of knowledge (Given, 2008). Experiences are unique to the individual encountering them. No one else is able to undergo the same feeling, though the phenomenon may appear similar. This simply means, language is inadequate in describing experiences as society uses the same words to describe their own individual occurrence (Van Manen, 2016).

The constitution of the World Health Organization defines **Health** as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity (World Health Organization, 2003). Authors such as Grad (2002) have adopted this definition.

According to Rathmell (1966), a service can be looked at as an act, a deed, a performance, processes or an effort. However, recent studies by Voorhees et.al. (2017) define the term **service** as a discrete interaction between the customer and the service provider relevant to a core service offering, including the interaction involving provision of the core service offering itself. They proceed to assert that services have many forms and can be face-to-face in an actual setting or online; they can also be over the phone, through the mail or even by catalogue.

Health services which are sometimes referred to as health actions are defined as any effort, whether in personal healthcare, public healthcare or through inter-sectoral initiatives, whose primary purpose is to improve health (Given, 2008). Health services can also be defined in relation to the relationship between health service delivery and the health needs of a population (Bowling, 2014).

The term **health facilities**, refers to the location of health services in relation to the communities they are intended to serve. It is the cornerstone of health systems planning, which ensures that the right services are accessible to the population and that no one is geographically marginalized from essential health services (Maina et.al., 2019).

A public is a group of people who behave similarly. It can also be defined as a grouping which arises out of a community around a controversial issue. A public arises when a group of people face a similar indeterminant situation, recognize what is problematic about that situation and organizes to do something about the problem (Alla, 2017).

Government is defined as a territorial body that makes authoritative decisions, for which it has a constitution and or legislative authority. The decisions made by the government are binding on residents and businesses within its boundaries (Schweigman, 2001).

1.7 Chapter outline

Chapter 1 introduces the study and focuses on a synopsis of the study topic. A short background to the study is postulated, and the problem statement is clearly outlined. The study is rationalized and motivated for.

Chapter 2 consists of the Literature review and conceptual and theoretical frameworks. It focuses on the review of related literature, health related legislation and policies. It will elaborate on the health belief model, highlighting its strengths, weaknesses and its relevance and applicability to the study

Chapter 3 will comprise the research methodology covering research design, the paradigm used in this study, research approaches, sampling, data collection and data analysis, ethical considerations and limitations.

Chapter 4 presents the analysis of the results of the study. It clearly states the findings and offers an interpretation of the data.

Chapter 5, presents the conclusions relating to the attitudes and lived experiences of the public relating to state provided health care in Inanda. It also provides recommendations for addressing issues which will be uncovered by the study.

1.8 Conclusion

South African legislation and policy documents provide frameworks for the effective and efficient rendering of public health services. Role players such as all levels of government, health care professionals, the public as well as the private health sector all play a role in health service. Challenges encountered by the health sector contribute greatly to the state of health care. Vulnerable groups are the ones likely to receive the least amount of care and the little care they do receive is usually of a poor quality. Health care costs South Africa a big portion of the Gross Domestic Product, hence the government is seeking innovative ways to improve health services, and ensure equity and equality of care for all citizens.

In the next chapter, previous writings will be explored on the attitudes and experiences of individuals at public health facilities. Theory will also be investigated, in order to get an understanding of how lived experiences and attitudes affect behavior.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter explores the existing body of knowledge pertaining to the attitudes and lived experiences towards state provided health care services. The researcher will start by investigating the broader, global context, and then narrow the focus to the South African context including Inanda in KwaZulu Natal - the essence of our study. Relevant theories are identified to get an understanding of the topic. Theory will provide a basis on which a critical perspective on this topic is developed. Pertinent and current publications are critically analyzed with an aim of deriving a clear representation of existing knowledge on the attitudes and lived experiences of individuals towards state provided health care services in KwaZulu Natal and specifically in Inanda.

2.2 The global perspective

The Sustainable Development Goals (SDGs) represent a set of universal goals and targets that articulate the need and opportunity for the global community to build a sustainable and desirable future (Costanza, Fioramonti & Kubiszewski, 2016). Adopted in 2014, the goals which succeeded the Millennium Development Goals can be seen as a network in which links exist through targets that refer to multiple goals, which shows the interconnectedness of the various thematic areas (Le Blanc, 2015). Health is centrally positioned in the Sustainable development Goals, but the third goal: Ensure healthy lives and promote well-being for all at all ages, and its thirteen targets provide for the fulfillment of the global major health priorities, and it also links with many other goals (World Health Organization, 2016). Just as tracking progress was important for the Millennium Development Goals; it is just as important for the sustainable development goals. According the World Health Organization, (2016) health related monitoring needs to occur in the context of overall assessment of progress towards the sustainable development goals, and it also needs to be comprehensive, including the monitoring of: overall progress towards the third goal, the attainment of the Universal Health Access target, other health targets and health-related targets in other goals. All of this will be done with a strong emphasis on equality. The sustainable development goals

present the ideal situation regarding global health, however, Kruk et. al. (2018) bring forth a somewhat different reality for most low and middle income countries around the world. The authors assert that the medical care individuals receive, is often inadequate and of a poor quality, with the most vulnerable suffering the most. They qualify this claim by their research findings which indicate that in low and middle income countries, mothers and children receive less than half of recommended clinical action in a typical preventative and curative visit. Furthermore, less than half of suspected cases of tuberculosis are correctly managed and fewer than one in ten people diagnosed with major depressive disorder receive minimally adequate treatment.

People with a low income have more difficulty in accessing medical care and are more likely to experience unmet medical needs compared to people with a higher socioeconomic status. Income has been found to be a major determinant of access to health services as it is associated with the possibilities of delayed or missed medical care (von dem Knesebeck, Vonneilich and Kim, 2016). A study conducted on 28 countries indicated that 50 percent of the population of those countries judged health access as “somewhat unfair” and “very unfair”. More advantaged groups reported lower unfairness while more disadvantaged groups perceived inequalities in healthcare to be more unfair. Unfairness perceptions were also higher for women than for men and for older compared to younger age groups (Immergut and Schneider, 2020). This inequality is a global phenomenon, which is an important political and public health issue. According to von dem Knesebeck, Vonneilich and Kim (2016) if people perceive health care inequalities as unacceptable or unfair, it can bear negative impacts on their assessment of and trust in the health care system. These authors assert that there is evidence that the level of trust in health care systems is a crucial factor for the help-seeking behavior, utilization of services, the relationship between patients and provider and patient compliance. In other words, perceptions and attitudes towards health care inequalities lead to decreased levels of trust in the health care system, which in turn can be expected to negatively affect utilization and quality of health care.

2.3 The South African context

An article published by the Vaal University of Technology (2019) records the findings of the Indigo Wellness Index. This is a study which tracks and determines the health status of countries using a metric of ten key measures. The study, which covers over 150 countries across the world, rates South Africa as the unhealthiest country in the world. Currently the life expectancy in South Africa is

63.6 years. Obesity rates are high, with twenty-eight percent of adults and twenty percent of children being obese. The article estimates that babies born in 2019 are unlikely to live until 2100.

With official reports such as stated above, it is evidently clear that much needs to be done to improve the health of South Africa in order to see development. It will be impossible to achieve the national and international health goals without the greater and more effective investment in health systems and services. While it is the role of the government to provide resources to actualize these investments, health ministries need to find ways of maximizing output from the available resources (World Health Organisation, 2007). Moreover, the onus still rests on individual choices and behaviors. After the state has taken all the required steps towards ensuring an improved health service, it is the individual who must make the relevant lifestyle adjustments and choices in-order to attain an improved state of health. Individual attitudes play a vital role in the decision making processes.

According to Ajzen and Fishbein (2005) the determinants of behavior is guided largely by a reasoned action approach, that assumes that people's behavior follows reasonably from their beliefs, attitudes and intentions. These pose great barriers to health care as they influence individual's behavior. Stigma remains a great barrier for patients to access some services. The fear of having to accept ones diagnosis leads many to avoid the services altogether (Hansoti et.al., 2017).

Attesting to how lived experiences shape and influence individual attitudes is a study conducted in Sub-Saharan countries including South Africa which investigates how patient experiences in the clinic influence their attitudes and thereafter their health behavior. This study investigates how health workers relate to and communicate with as well as their attitudes towards clients of voluntary counselling and testing and antiretroviral treatment. The study, conducted in Ghana and which discussed how health workers relate to and communicate with clients of VCT and ART treatment, indicated that when patients were received warmly and treated with courtesy and support, they were more likely to interact comfortably, and also to have a positive attitude towards the services rendered, which enables them to honor follow up appointments and adhere to treatment better. The study also revealed that when patients are disrespected and treated poorly, with a lack of communication, verbal and emotional abuse and are discriminated against, it discourages them from utilizing the services offered by the facilities (Dapaah, 2016).

The current two-tiered South African health care system comprises an under-resourced public health

sector serving over eighty percent of the population and an over-resourced private health sector serving less than twenty percent of the population. This has contributed to the inequalities in our current system, in addition to being unsustainable, costly and hospital-centric. South Africans are dissatisfied with both the private and public health sectors and are ready for health reform.(Mathew & Mash, 2019).

2.4 The South African health System

According to the ANC (1994), the state has two separate but important functions to perform when it comes to health. The first one is to create, monitor and amend the framework which will govern the promotion and delivery of healthcare. This framework is pivotal when planning mechanisms to adopt in protecting the public, who are seen as consumers of health from possible exploitation and abuse. The framework also prescribes the powers, functions, rules and regulations of health authorities and it is constructed through legislation and regulations (ANC; 1994). The second function of the state, concerning health is to serve as the major provider for the services. The state is to ensure that all citizens have access to good quality health care (ANC, 1994).

The origins of primary health care in South Africa dates back to April 1940, when the Pholela Health Centre was launched in KwaZulu Natal. The model was profoundly innovative for its time as it integrated curative care with preventative health services in a comprehensive community-based package (Kautzky & Tollman; 2008). According to the authors, Pholela utilized population-based investigations to inform the provision of services and incorporated health education. Health promotion was an essential part of the health delivery system. Under the Pholela program the focus was on the health of families and communities, rather than the health of individuals alone. Special programs were employed as interventions to address the health needs of the vulnerable and high risk groups. Realizing the role that the Pholela Centre played in the South African health system, the new Pholela Health Center was built and launched in 2001 at Sisonke District to serve the catchment population of 17 819 people (KwaZulu Natal Department of health, nd).

The Pholela health care program was well received by the communities it services. The positive attitudes are evident in the manner the communities utilized its services, accepted its teaching and

even promulgated some of the programs fundamental teachings. The program, with the strong support and acceptance of the public worked towards the reduction of some of the major illnesses which affected the community, such as typhoid, typhus fever, small pox and diphtheria. Through the program hygiene was attained in the households which contributed to the reduced burden of disease. Furthermore, the community accepted teachings such as developing compost pits, establishing home vegetable gardens and taking measures to protect their water supplies from contamination (Kark and Cassel, 1999). The manner in which the Pholela Health Care Centre, and its entire program was adopted by the community, is indicative of favourable attitudes towards a health service that is fair and whose impacts are evidently beneficial to all.

Similarly to Kautzky & Tollman, Phillips (2014) records the emergence of other programs soon after the Pholela initiative. Programs such as the Institute for family and community health were developed and they were funded by the National Department of Health. A problem encountered by the Health Service, is that it required drastic reforms and a higher tax burden on the dominant white population, which neither the white population nor the political power of the time, were willing to have. The Pholela experiment was indeed the model to be replicated throughout the country until a new health system in its image was in place; however the accession to power of the National Party saw an end to the health system as well as the expulsion of the founders from office.

According to Baker (2010) when the ANC ascended to power in 1994, it inherited a health service that was indelibly marked with the inequities of the apartheid era. It was two developments which took effect during the apartheid era which were recorded to have damaged the South African health system even more. These were; the racial fragmentation of the health sector, and the deregulation of the health sector. The health services provided at black residential areas often failed to provide adequate medical and public health care. These services were poorly organized, inefficient and they lacked efficient management. It was during this time that the church made a significant contribution to health care in South Africa. Missionary health services in an attempt to bridge the rural and peri-urban gap, established networks of hospitals and clinic systems to meet the needs of the unserved communities(Kautzky & Tollman; 2008). In an environment occupied with influence the African tradition, the beliefs, customs were to be overpowered by the Christian faith and medicine. The therapeutic practices of the missionaries disturbed the traditional communal ties by introducing the concept of the individual. The missionaries, carrying medicine chests, displaying instruments to be used, examining with the stethoscope, all these practices and more were instruments of visibility

aiming at manipulating and converting the African body and soul to the kingdom of God and to civilization (Van den Bosch, 2010). The missionaries were portrayed as liberators, who had arrived to emancipate African bodies and souls from disease believed to be brought by witchcraft. Their facilities were seen as healing sites.

Parnell (1993) asserts that segregation in South Africa was effected in order to separate the black society from the white society and thus provide services that were unequal. He further claims that under the apartheid regime the racial segregation protected the poor white communities. Huge effort have been made to improve the quality of health care delivery in South Africa since 1994 (Shisana et.al., 2006), but several issues have been raised by the public regarding public institutions which include; prolonged waiting time, adverse events, poor hygiene and poor infection control measures, increased litigation because of avoidable errors shortage of resources in medicine and equipment and poor record keeping (Maphumulo and Bhengu, 2019).

During the last 20 years, health care in South Africa has still been faced with a multitude of problems, constraints and deficiencies, which relate to the health care system as the provider and distributor of health services, and also on the population as clientele of the system (Van Rensburg and Fourie, 1994). Despite political commitment, strong policies and sound regulations since 1994, the public health sector in South Africa has not yielded desired health system performance due to fragmentation and weak and lacklustre leadership (Malakoane et. al., 2020). Maphumulo and Bhengu (2019) describe the South African health system as ruined and in serious need of repair. Then they further state that improvement in quality care must include fewer errors, reduced delays in care delivery, improvement in efficiency, increased market share and lower cost. An improvement in quality care will initiate the end of the distress experienced by the South African health services, including both the community and the employees (Pelompe, 2018).

The National Health Insurance will address the challenges faced by the health system. Despite the post-apartheid legislation which aims to improve the health industry, there has been a significant decline in private health coverage, where fewer people are able to afford private insurance and medical care provision has become increasingly unaffordable. This has resulted in many patients who previously relied on private health care but are now using the public sector, thereby increasing the burden on an overstretched public health system (Shisana et al., 2006). The maldistribution of resources between public and private health sectors reflects inefficiencies and inequalities. Harris et.al. (2011) advances the inverse care law, because the availability of good medical care varies

inversely with population health needs. The inverse health care law states that the availability of good medical care tends to vary inversely with the need for it in the populations served (McLean et al., 2015). This means that the poor and vulnerable communities, who are often most stricken by ill-health have less access to healthcare than the wealthier communities who often times are not as badly affected by disease and ill-health.

The National Health Insurance as a health financing system, designed to pool funds to provide access to quality affordable personal health services for all South Africans, is based on the health needs of citizens, irrespective of their socio-economic status (Republic of South Africa, 2017). The main objectives of the National Health Insurance are; to improve access to quality health services for all South African, irrespective of their employment status. It is to pool risks and funds to ensure the achievement of equity and solidarity through a single fund. It is also to ensure the procurement of services for the entire population and ensure its efficient mobilization and control of key financial resources, and it is also to strengthen the under resources and strained public sector to improve health systems performance (Matsoso and Fryatt, 2013).

Though much positive effects are expected to emerge after the successful implementation of the National Health Insurance, it too does have its anticipated drawbacks such as the issue of funding. Theron et. al. (2016) asserts that while the National Health Insurance is expected to yield universal coverage to all South Africans and improve health outcomes, there are deep concerns about the affordability of such an ambitious program. These concerns cannot be overlooked as an underestimation could bear negative impacts of service delivery, leading to negative patient experiences and attitudes. The National Health Insurance will serve as an enabling mechanism to facilitate the realization of universal health coverage, which will ensure that all citizens have access to health services they need without risk of financial ruin or impoverishment (Dye, Reeders and Terry, 2013). Universal health coverage aims to provide increased access to health care services for the previously uninsured population who currently have limited access. It is defined as the assurance that all people receive the health services they need, including initiatives designed to promote better health, prevent illnesses, and to provide treatment, rehabilitation and palliative care of sufficient quality (World Health Organization, 2017). International evidence indicates that such a policy is expected to cause an increase in the demand and utilization of health care services. It can be expected that South Africa's multifold burden of disease will increase the quantity and intensity of care required by newly insured individuals (Theron et, al., 2016).

Generally, South Africa has shown much improvement in most of its health programs. It is known as being a country with an HIV program that has national and international acclaim. Despite the many obstacles faced by the health program in general some of its response to health crises is recognized globally. An example of this is the response to HIV and AIDS, South Africa has the largest antiretroviral program in the world, with well over 2Million HIV-infected people receiving treatment (Pillay and Barron, 2014). However, the hard challenge of strengthening the health care system still lies ahead of South Africa. As a developing country, South Africa still faces the challenges of persistence poverty, a lack of investment infrastructure, corruption and maladministration, which has and still is a hindrance to the improvement of country's health system (Ogujiuba and Jumare, 2012).

2.5 Role players in the SA health system

Contribution to the health of a population also derives from social determinants of health such as living conditions, nutrition, safe drinking water, sanitation, education, early child development and social security measures (Lakshminarayanan, 2011). In this publication Lakshminarayanan argues that public health is concerned with disease prevention and control at the population level, through organized efforts and informed choices of social role players. He states that the role of government is crucial for addressing the challenges and achieving health equity. Parliament (2003) in its publication of the National Health Act 61 of 2003, states that the department of health has the responsibility to endeavor to protect, promote, improve and maintain the health of the population. To effect this, all levels of government, ie. National, provincial and municipal departments are to establish such health services that are required for the realization of quality health care for all. Contribution to health of a population derives from systems outside the formal health care system, and this inter-sectoral contribution to the health of communities is increasingly recognized worldwide. Therefore, the role of government in influencing population health is not limited within the health sector but also by various sectors outside the health systems (Lakshminarayanan, 2011).

Health care workers are the primary role players in the South African health care system. They play an indispensable role in the implementation of health policy and the provision of health care services. They are the ones who bear the responsibility of facilitating health services both within the facilities as well as in the communities. According to the Health Systems Trust (Day, et. al., 2018), South Africa is faced with the challenge of insufficient health care workers. An estimated nineteen percent of health care professionals are no longer active in the health field (Day, et. al., 2018). This figure is determined by examining the number of health care professionals currently employed and comparing it to the number of health care professionals appearing on the regulatory bodies such as the South African Nursing Council. It is found that there are less professionals employed than the number of professionals on the register (Hall, 2004). The author also claims that more health care professionals are lost from the system due to certain morbidities which affect them such as HIV/AIDS. South Africa has also lost more health care professionals to other countries in the pursuit of greener pastures including better working conditions and better remuneration packages (Hall, 2004).

High levels of absenteeism due to staff attending workshops or trainings and staff taking leave, as well as low productivity adds more pressure to the already overworked available human resource. This presents a big shortage for the South African public health system. The shortage in human resources results in the few that are servicing the communities to experience dissatisfaction due to poor conditions of service, long hours as well as low remuneration. These challenges result in the failure of the public health system to meet the basic needs and standards as well as patient expectations (National Department of Health, 2012). According to studies done in Tanzania (Manzi et. al., 2012) health care workers find, it is difficult to implement new programs which have the potential of advancing health care and saving more lives when considering staff shortages, as the new programs are believed to add more pressure and increase the workload of the already stretched staff members. Shortages of staff have a significant and negative impact on health systems and decrease the ability of health systems to maintain a state of readiness (Bradley et. al., 2015)

It is reported that 43.6% of the South African population live in rural areas. This portion of the population is serviced by only 12% of the Country's Doctors and only 19% of the country's nurses (Day, et. al., 2018). The shortage of health care professionals in rural

communities is a global problem affecting both developed and developing countries. Studies indicate that rural communities are on average sicker, poorer and less educated; they also are said to have less access to health care than urban communities (Jenkins et.al.,2015). The discrepancy between health needs and service provision can be better explained through Hart's "inverse care law" (Wilson et.al., 2009). According to Wilson et.al. (2009) there are a number of factors which affect the probability for professionals to practice in rural areas. The authors report of a strong evidence that an individual who completed his primary and/or secondary school education in the rural setting is more likely to voluntarily practice in the rural setting. This phenomenon is referred to as rural origin. Also professionals whose spouses are from the rural setting are also more likely to practice there. In a study conducted by Jenkins et.al.(2015), five common themes found to be motivation for health care professionals to work in rural settings. The first one was that the health care professionals have a shared purpose of making a difference to the said community. They often referred to their profession as a "calling", which they were not prepared to abandon. The second theme was the relationships they had formed working as a team in the facilities, as well as the support they received from visiting specialists. This "teamness" involves much more than a general team spirit, but relates to transformation in people's minds, using the "we" language and celebrating and rewarding people and events for mutual benefits. The third theme was the culture of support they got from the environments. This meant prioritizing social relationships and seeing ones work community as an extension of one's personal community. Fourth were the perceived opportunities for growth. They wanted challenging and stimulating work environments which will advance their professional development, and the rural setting provided opportunity for that growth. The final theme centered on issues of establishing a work-life balance. This is the ability to balance structure and flexibility. It is recognizing that work does not happen outside of life, people live as they work, so making that daily transition between the two worlds of work and family, determining those boundaries is shaping the environment while being shaped by the environment. Such motivations shape the manner in which the health care professionals behave towards patients, and also shape the attitudes of both patients and professionals.

Community health workers (CHWs) are increasingly advocated as the solution to overcoming current shortfalls in human resources for health (van Ginneken et. al., 2010). The World Health Organization proposed the training of community health workers as an

effort to strengthen the HIV AIDS program, and identified this action as instrumental in achieving improved health service delivery (Schneider, Hlophe and van Rensburg, 2008). The community health workers program expanded due to the rapid change which was generated by the HIV and AIDS pandemic in the 1990s (Day, et. al., 2018). Community Health workers are defined as heterogeneous group of lay health workers. They are a group of people chosen by the community to perform functions related to health care delivery, who have no formal professional training or degree (van Ginneken et. al., 2010). According to Day, et.al., (2018) the Community Health Workers program sought to fulfill a range of care and support functions, ranging from palliative home based care to HIV counselling and testing, following up and tracing of TB patients and support of orphaned and vulnerable children. However with time this sector's functions have expanded to include newer programs such as prevention of mother to child transmission of HIV and universal access to antiretroviral therapy, which requires adherence counselling and support. There is also a reported shifting of tasks from professionals to community health workers. An example of this is the HIV testing and counselling, as well as the training for tracking defaulters and drug readiness training in the ART program; these functions were initially conducted exclusively by nurses, but as patient numbers increased, these functions and others gradually became delegated to CHWs (Schneider, Hlophe and van Rensburg, 2008). Community health workers have become important players in public health in South Africa, as they carry out functions that are person centered, support-team based care, address social determinants of health and promote health care access, patient engagement and outcomes (Hartzler et.al., 2018). Community health workers occupy a critical space in community health care because of their proximity to vulnerable individuals and communities and the health care system (Ramukumba, 2020). Community health workers generally maintain good relations with patients in the communities and they are able to effectively act as a bridge between the facilities and the patients, thereby improving the patients' experiences with the health system (Huang et.al., 2016).

Traditional medicine practices encompasses a holistic worldview which reflects that of the World Health Organization's definition of health, which is one of physical, mental and social wellbeing, and not merely the absence of disease. This worldview recognizes good health as a complex system involving interconnectedness with the land, recognition of spirit and ancestry and social, mental, physical and emotional wellbeing of both the individual and the community (Oliver, 2013). According to Puckree et.al. (2002) traditional healing has always been a component of health care,

with a significantly large number of patients consulting traditional healers for potentially life-threatening conditions. Up to eighty percent of African patients consult a traditional healer before going to a primary health care practitioner (Setswe, 1999). A recent study conducted in Tanzania found that nineteen percent of people with dementia had visited traditional healers (Hindley et. al., 2017). Of those with mental health problem who were given traditional treatment, nearly sixty percent reported that the outcome was good, resulting in great improvement in their condition (Ningsangrenla and Rao, 2019). With a ratio of one traditional healer per three-hundred and fifty people, compared to one medical doctor per thirty-three thousand people, it is not surprising that traditional healers may be able to play a role in improving care for people in sub-Saharan Africa (Ningsangrenla and Rao, 2019).

A study conducted by Kelak, Cheah and Safii(2018) reflects that patients experience positive attitudes towards traditional healers and medicines, and they expressed negative attitudes towards barriers to traditional medicine practices. The study also indicated that patients perceived that disclosing the benefits of traditional medicines usage is a good thing, especially when one is also using the medical health facilities and services. The study indicates that the patients sometimes view the attitude of medical health care professionals towards traditional medicines and practices as negative and as a barrier in their journey to health. This therefore affects their attitudes toward medical health services as they sometimes withhold information regarding their traditional health practices (Kelak, Cheah and Safii, 2018).

A study conducted by Alfaro-Velcamp (2017) revealed that in South Africa, vulnerable groups such as undocumented immigrants, asylum seekers and refugees are sometimes refused health services by health care professionals. This negative patient experience is deemed inconsistent and unconstitutional as health administrators narrowly interpret legislations which to instruct health care providers on how to treat patients and whom they can treat.

According to Pretorius (1999), the embrasure of traditional and modern health care system comes about within the Primary Health Care approach, as well as the District Health System. At this juncture, people's basic health needs are met at the district level, where the community can participate in the planning and provision of services. With the help of the formal health system,

indigenous practitioners can become important allies in organizing efforts to improve the health of a community, as they share their history, culture and environment with those who consult them (Okello and Musisi, 2015).

2.6 Poverty and Health

When extreme poverty affects a large proportion of the population, as in South Africa, health is predominantly affected by a lack of access to the basic requirements of life, such as clean water, adequate nutrition, effective sanitation, reasonable housing conditions, access to public health facilities, good schooling and employment opportunities (Mayosi and Benatar, 2014). Wagstaff (2002) asserts that poverty and ill-health are intertwined. He states that the association between health and poverty reflects a cause and effect relationship running both ways; poverty causes sickness and disease, and sickness and disease plays a big role in keeping poor people poor. Extreme poverty interacts with health in many ways and undermines a range of human capabilities, possibilities and opportunities. People living in poverty are also usually less educated. They often have less knowledge about activities to promote health and when to access health care. This is seen in the instance of poor women who access antenatal services less often and this leads to them experiencing poorer birth outcomes than women with financial resources (Murray, 2006).

Not much literature exists on the attitudes of individuals towards health services, however a study conducted by Lau et.al.(2020) in the Philippines indicates that when asked what their response would be if they exhibited symptoms of a serious illness, individuals responded that they would contact a community health worker, or visit a local health facility. Most notable is the fact that individuals reported cognizance of the fact that disease and ill-health disturbed their lives, some experience much anxiety as they worry about how disease may affect their lives. This indicates an attitude of concern and an eagerness to prevent disease at all cost, given the available resources.

Inanda is an area that was entirely rural, until the 1950s. That is when it developed into a reception area for people who moved to Durban in pursuit of job opportunities. They came to Inanda since it was easy and cheap to get accommodation or a site, and they were encouraged by the affordable lifestyle of the inhabitants. This caused the area to become densely populated as it had a large influx

of people who were escaping poverty in their homelands (Ngceshu, n.d). It is said that the major bonding factor for the people of Inanda is poverty. They lack the means for survival. Their lives are characterized by vulnerability, low productivity, disease, dependency, ignorance and other similar problems (Ngceshu, n.d.). A survey conducted in Inanda bore the following health related findings:

- 87% of children in Inanda had immunization cards, but only 52% were fully immunized, 30% partially immunized and 18% not immunized at all.
- 10% of children are underweight, while 85% are normal weight and 5% overweight.
- 99% have access to clean water, however 91% are primarily using pit toilets with no ventilation.
- 59% were reported to have diarrhea, with only 25% using home-made rehydration solution.
- 70% had chest infections with 65% being treated at the clinic while 53% did not know when to seek help.
- 74.2% of respondents who were malnourished reported symptoms of depression while only 37.5% of respondents with normal nutritional status experienced depressive symptoms.(Narainsamy, Chipps and Cassim, 2015)

2.7 Empirical literature

The purpose of this study is to investigate the attitudes and lived experiences of the public towards state provided health care. It can be suggested that it is the lived experiences of individuals that shape their attitude and hence their behavior towards any given phenomenon. The same approach can be employed within the context of this study, that it is the lived experiences of individuals which are a major contributing factor in the shaping of the attitudes and thereafter their practices of regarding their health.

Attitudes express passions and hates, attractions and repulsions, likes and dislikes. Individuals possess attitudes when they adore or detest things or people, and when they approve or disapprove

of them. Because people express their likes and dislikes in many ways, all aspects of responding, including emotions, cognitions and overt behaviors are infused with the evaluative meanings that attitudes impart (Eagly & Chaiken, 1998).

This section explores how the attitudes which are shaped by the lived experiences affect individuals and inform practice. Existing literature is reviewed to establish the findings from previous studies on the practices of individuals.

A study was conducted by Ngarina et. al. (2013) in Tanzania, on the prevention of mother to child transfer of HIV. This was a qualitative study utilizing inductive content analysis, which involved twenty-three women to whom interviews were administered twenty-four months after they had given birth to children. A semi structured interview guide was used during the in-depth face to face interviews as it was identified as the best method which enabled the women who undoubtedly felt stigmatized because of their HIV infection, to express themselves freely, explaining the challenges they faced. The study explored the women's own perceived barriers to adherence to antiretroviral therapy (ART) which is a critical service offered at both the public and private health institutions. The main findings of this study attribute the reasons why women do not adhere to treatment to six categories. These categories include the lack of motivation experienced by the women after having succeeded in preventing their child from becoming infected with HIV. This indicates inadequate information, which could be attributed to many factors such as insufficient health education and promotion done at the facility level. Counselling, or health education and promotion are of major importance. Counselling given inadequately is found not to be effective as the patient may not hear or remember all that has been said (Krabbendam et. al., 1998). Support groups play an important role in providing continuous counselling, providing ample opportunities for the patients to learn about the facts and thus have more motivation to adhere to treatment. Another key point that was discovered was that the women defaulted treatment as they were trying to hide their medication due to the stigma of being HIV infected making it difficult to follow the drug regimen. For patients with HIV, stigma emerges as an insidious deterrent to integrating HIV primary health care (eg. Medications, clinic appointments) into daily life (Relf, et.al., 2005).

A similar study conducted by Portwig and Couper (2006) looked at the reasons why Patients who had tested positive with TB were stopping their treatment prematurely. This was a descriptive qualitative study conducted in the Western Cape, South Africa, in which free attitude interviews

were conducted with six non-adherent patients from Van Wyksvlei (Western Cape). The findings of this study again was grouped into three themes, first of these being related to the patients inability to correctly prioritize their health over other aspects of their lives such as finding and keeping employment, even if it was temporary. The second theme which was also observed in the first study is that of a lack of motivation coupled with the fear of disclosure to avoid being stigmatized. This study highlighted the importance of health workers to try and find solutions to nonadherence with their patients and communities. It is important for the patients to be well informed and for them to adhere to treatment, thus strong support is critical. The third theme identified in this study centered around issues of family support. A lack of support from family caused many instances of non-adherence and subsequent relapse of the disease. In this study participants reported that the absence of a supportive infrastructure was a major factor. The study proposes that patient should not carry the primary responsibility for their adherence, but should rather be a part of a long chain of responsible people, including health care professionals, family and community structures, support groups etc. (Portwig and Couper, 2006).

A study investigating the reasons why women choose to give birth at home with the assistance of traditional birth attendants and not trained health care professionals conducted by Sialubanje et.al. (2015) gives insights on how attitudes affect decision making. This was a qualitative study conducted in Kalomo district, Zambia; which included 100 women of child bearing age, who participated in 10 groups of focus discussions. The study also involved in-depth interviews with 30 participants who were inclusive of traditional birth attendants, headmen, husbands, wives, health committee members, community health workers and nurses. The study records that most women who gave birth at home had a negative attitude towards nurses and the health care system because of the way they were treated during ante natal care, or during previous deliveries at the clinic. The nurses were reported to be harsh to the women and used abusive language towards them. A vast majority of women who had delivered at the clinic before reported that nurses shouted at them, and left them to struggle alone in labour or did not assist them and their babies after labour. Some of the other barriers resulting in more home deliveries include a lack of funds to go to the clinic, and also to buy baby clothes and requirements for the mother for during and after labour. There was also a challenge of travelling long distances to the clinic and high transportation costs. There was also a great concern over the state of the maternity wards which were said to be in a deplorable condition (Sialubanje et.al., 2015).

A qualitative study was conducted by Shortall et. al. (2015) investigating the experiences of pregnant migrant women. The data was collected through telephonic interviews with patients who previously visited the Doctors of the world drop in clinic in London. The findings in this study were said to be similar to those that can be expected to be found in developing countries like South Africa. The study identified some barriers to health care that confronted the pregnant women. The biggest barrier was that the women feared the debt that they might attain from attending the clinic. The other thing they feared is getting arrested for not being in possession of relevant migration documentation. This has resulted in the women accessing the first antenatal clinic appointment late (after 12 weeks), and also them having fewer appointments than is necessary. It has also resulted in complications that could not be reversed, for instance two of the women who participated in the study lost their babies.

A study conducted by Lombardi (2001) through the university of California in Los Angeles, United States of America, which aimed to enhance transgender health care by looking at their experience with health institutions. The study found that the transgender community was faced with challenges of discrimination frequently. It was discovered that 60% had experienced some form of harassment or violence and 37% had faced some form of economic discriminations. It was also noted that they reported less visits to the clinics because the health care professionals were insensitive and disrespectful towards them. This untoward behavior suggested a lack in the provision of culturally sensitive interventions and services. This adversely influences whether the transgender individual accesses or adheres to treatment or not, which in most cases results in resistance to seeking help because of previous experiences of reports from other who have experienced the ill-treatment.

These studies reflect only an example of some of the experiences that lead individuals to behave in a certain way towards health services. Of the studies cited above, a number of overriding factors were identified as key contributors to the practices entailed. The majority of the respondents in the studies cited above have a background of poverty and vulnerability. As it was previously stated, poverty has a strong influence on one's access to health care. Some of these studies are conducted in developed countries such as London(England) and Los Angeles(United States), yet we find that the challenges to health care are almost always attributes to a type of vulnerability and powerlessness. Other factors found to be common in the studies above is the issue of stigma. Respondents experience a diminished desire to access the health facilities because of the fear of stigmatization. Thirdly, patients will make fewer health appointments when they are not well informed about the reasons and full benefits of visiting the health facility.

2.8 Theoretical framework

The Health Belief Model was first used in the 1950s by social psychologists in an effort to explain the widespread failure of people to participate in programs to prevent and detect diseases (Champion and Skinner, 2008). It was later extended to apply to people's responses to symptoms, and to their behavior in response to diagnosed illness (Stretcher and Rosenstock, 1997). The health belief model is an approach that grew from learning theories derived from two major sources: the Stimulus Response theory and the Social Cognitive Theory (Champion and Skinner, 2008).

The Stimulus Response theorists believed that events or reinforcements affect physiological drives that affect behavior. The hypothesis developed was that the frequency of a behavior is determined by its consequences or reinforcements. For Skinner, Tiro and Champion (2015) the mere temporal association between a behavior and an immediately following reward is thought to be sufficient to increase the probability of that behavior to be repeated. According to these authors, behavior is automatic and does not require mental processes such as reasoning or thinking.

The cognitive theory emphasizes the role of subjective hypotheses and expectations held by individuals. Theorists believe that behavior is a function of the subjective value of an outcome and of the subjective probability or expectation that a particular action will achieve that outcome (Champion and Skinner, 2008). This theory asserts that reinforcements operate by influencing expectations rather than by influencing behavior directly. It suggests that people learn by noticing the benefits of actions that they observe others performing (Raingruber, 2014). These theorists also assert that mental processes such as thinking, reasoning, hypothesizing and expecting, are critical components of cognitive theories. This is because cognitive theories are often termed as value expectancy models, because they propose that behavior is a function of the degree to which individuals value an outcome and their assessment of the probability or expectation for that particular action to achieve the outcome, and that behavior change is determined by the environment and social, personal and behavioral elements (Raingruber, 2014).

Human motivation and action are extensively regulated by forethought. It is believed that when individuals value avoiding illness or recovering from any possible ailment, and they also expect that a specific health action may prevent illness or maintain wellness, they are more likely to perform that action in-order to secure the health benefit (Tougas et.al., 2015). The expectancy is further

described in terms of the individual's estimates of personal susceptibility to and perceived severity of an illness, as well as the likelihood of being able to reduce that threat through personal action (Champion and Skinner, 2008).

The health belief model focuses on two aspects of individuals representations of health and health behavior: threat perception and behavioral evaluation (Abraham and Sheeran, 2005). Threat perception is interpreted as two key beliefs, the first one is the individuals self-predicted likelihood to acquire an illness or health problems(Perceived susceptibility); the second is the intensity of the consequences of an illness(perceived severity). Behavioral evaluation also consists two sets of beliefs, the first one concerns the benefits or effectiveness of a recommended health behavior (Perceived benefits), the second belief concerns the cost of, or barriers to enacting the health behavior (Perceived barriers) (Abraham and Sheeran, 2005).

Perceived susceptibility suggests held beliefs about the possibility of an individual to get a disease or health condition, and this held belief is likely to prompt an action. For example; a women must believe there is a possibility for her to get cervical cancer, before she will be interested in doing a Pap Smear (cervical cancer screening) (Champion and Skinner, 2008).

Perceived severity explains how the individual views the seriousness of getting an illness, or leaving it untreated and the consequences they have to face as a result of that negligence. Possible consequences commonly thought of are pain, disability and even death. Some are less of a physical nature but are more social, such as the effects of the conditions of work, family life as well as social relations. This perceived severity, combines with perceived susceptibility is labeled as a perceived threat (Skinner, Tiro & Champion, 2015).

When an individual identifies a perceived threat, this could be through identifying a personal perceived susceptibility to a serious health condition, the individual's beliefs which pertain to their perceived benefit of available health behaviors or actions to reduce the disease or threat will be greatly influence the possibility of the individual's actual behavior change. Perceived benefits can be those of a non-health related nature. For example a person may decide to quit drinking alcohol to save money. So the action of quitting is motivated by a non physical/ non health perceived benefit (Deshpande, Basil & Basil, 2009).

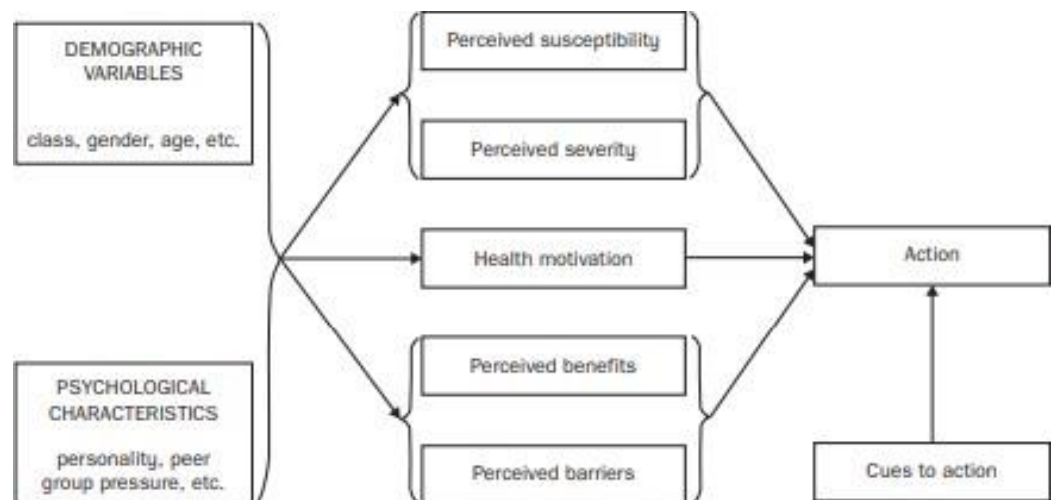
Perceived barriers are potential negative aspects of a particular health action. These may serve as impediments to undertaking recommended behaviors. When an individual considers the expected

benefits of an action versus the perceived barriers, they subconsciously conduct a cost-benefit analysis, by comparing the benefit to the cost of the action (Champion and Skinner, 2008).

Cue to action refers to the activation of an individual’s perceived susceptibility and perceived benefit by an internal or external factor. These factors are referred to as cues which instigate action (Conner and Norman, 2005). An internal factor, could be experienced when an individual feels a symptom that increases a perceived threat, eg. A persistent cough and headache which is a symptom indicative of possible Covid 19 infection could be perceived as a cue for an individual to screen and maybe even test for Covid 19. An external cue is often times in the form of stimulation or information made available to an individual which triggers the feelings of perceived threats and benefits. Eg. A Billboard showing the dangers of smoking can serve as a cue to prompt a smoker to attempt quitting smoking due to health reasons.

Self-efficacy is the belief that one can successfully complete the behavior of interest despite the considered barriers (Jones et.al., 2015). It refers to an individual’s confidence in their ability to successfully perform a behavior which is required to produce a desired outcome (Nieuwenhuijsen et.al., 2006).

Figure 1 The health belief model



According to the health belief model, there are two main types of beliefs that influence individuals to take preventative action, beliefs related to readiness to take action and those related to modifying factors that facilitate or inhibit action (Nejad et.al., 2005). The health belief model is said to be different from other models because it does not have strict guidelines on how the different variables predict human behavior. It simply proposes that the independent variables are likely to contribute to the prediction of health behaviors, but lacks structure. According to Nejad et.al. (2005), though this lack of structure is often a source of criticism among researchers, health belief variables have been moderately successful in predicting variety of behaviors.

The variables of the health belief model may be summarized and tabled and possible intervention strategies proposed as per the illustration below.

Variables	Definition	Possible Intervention Strategy
Perceived Susceptibility	An individual's assessment of his or her chances of getting the disease	Use self-monitoring, simulation, and personalization/tailoring strategies to help individuals develop accurate perceptions of own risk.
Perceived Severity	An individual's judgment as to the seriousness of the effects of contracting the health condition	Use Systemic Desensitization, Vicarious reinforcement, and biofeedback technique to help individuals develop a realistic perception of the consequences of a condition and recommended action.
Perceived Benefits	An individual's evaluation of the positive things that will happen as a result of enacting the health behavior	Use gain-framed appeal and positive reinforcement/reward mechanism to portray the potential benefits of adopting healthy behavior.
Perceived Barriers	An individual's opinion regarding the difficulty or cost of adopting the new behavior	Teach problem solving and decision making strategies to overcome the perceived barrier of enacting healthy behavior
Cue to Action	This consist of both internal and external prompts that will trigger an individual to performing the target behavior	Employ reminder and suggestion strategies as an external prompt to performing the target behavior. Biofeedback strategy could be used as an internal trigger.
Self-efficacy	Personal belief on one's own ability to enact the desired behavior	Use role-playing, modeling, incremental goal setting strategies to build an individual's believe about his/her ability to adopt healthy behavior.

Table 1: Health belief model variable summary and related intervention strategies

Critics of the Health Belief Model claim that not all health behavior is based on rational or conscious choice, as the theory suggests. The model has also been critiqued for focusing only on negative factors and ignoring positive motivations that prompt healthy behavior. It has also been said that the model focuses on individual factors, rather than socio economic and environmental factors that may prohibit or promote the recommended action (Raingruber, 2014). Limitations of the health belief model include the fact that it does not account for an individual's attitudes, belief or other individual determinants that dictate a person's acceptance of a health behavior. It also does not account for behaviors that are habitual and thus may inform the decision making process. It doesn't take into account behaviors that are performed for non-health related reasons such as social acceptability. The health belief model assumes that everyone has the same amount of information. It also assumes that cues to action are widely prevalent in encouraging people to act and that "health" actions are the main goal in the decision making process (LaMorte, 2019).

The main strength of the Health Belief Model is its use of simplified health-related constructs that make it easy to implement, apply and test. It has also provided a useful theoretical framework for investigating the cognitive determinants of a wide range of behaviors. The Health Belief Model has focused researchers on variables that are prerequisites for health behavior, hence it has formed a basis for many practical interventions across a range of behaviors (Orji, Vassileva and Mandryk, 2012).

The health belief model has been identified as suitable to guide this study. This theory will provide a useful framework for the investigation individual attitudes towards health services provided by the government. It will also provide a basis upon which lived experiences and behaviors may be probed. This theory will provide justifications for the recommendations to be developed in this study, since it posits that people will take action if they believe that particular action available to them would reduce the susceptibility or severity or lead to other positive outcomes.

2.9 Conclusion

Literature examined in this chapter assisted in giving a clear depiction of global and local influencers of attitudes relating to health care. The literature also highlighted factors that contribute to the

development of attitudes. Various global organisations have been used to give a representation of global perspectives and developments in the field. Local constructs were explored as literature of the history of the South African health system was examined. The current role players were also surveyed as well as the contributions they make towards advancing the South African health systems, as well as the attitudes they either engendered or precipitated from their clients. Finally, theory was employed to give an understanding of the phenomenon. The next chapter details the methodology and approach adopted for this study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

Research is a term used to describe any kind of investigation that is intended to uncover interesting or new facts (Walliman, 2017). Research is found in all aspects of daily living and affects public policies. Flick (2015) defines research as the systematic analysis of research questions by using empirical methods such as asking, observing and data analysis. The author further asserts that the aim of research is to make empirically grounded statements that can be generalized or tested, from a variety of approaches. Roller and Lavrakas (2015) suggest that human beings conduct research all the time as they are constantly taking in (gathering) information from the environment, developing it into an interpretive nugget that can then be used to make sense of and react to particular situations.

According to Apuke (2017), research is a scientific and systematic search for pertinent information on a specific topic. It also involves creativity that is carried in a systematic way in order to improve knowledge which consists of human knowledge, culture and society. This implies that research is utilized in enquiries of facts, reconfirms the findings of previous experiments, provide solutions for existing or new issues, support theories as well as propound new theories. It involves the building of knowledge, conducting of experiments to establish the cause and effect of phenomenon and also provides the basis for further study.

According to Holloway and Galvin (2016), the aim of research is to understand, describe and interpret social phenomena as perceived by individuals, groups and cultures. Various research methods are used to explore the behavior, feelings and experiences of people and what lies at the core of their lives. On the other hand, Brannen (2017) asserts that research is typically associated with the process of enumerative induction. The author claims that one of the main purposes of research is to discover the figure associated with a certain phenomenon.

For the purposes of this study, research is considered a means of investigating the lived experiences of individuals at public health facilities, as well as exploring how those lived experiences shape and inform attitudes towards state provided health services. The research activity is linked to the

theoretical framework in the field of health behavior, in an endeavor to gain and understanding of the said phenomenon, as well as to inform future policy and practice in the public health sector.

This chapter focuses on a case study of the held attitudes and lived experiences of the community of Inanda towards state provided health services. A description of qualitative and quantitative techniques used, sampling design and data analysis are presented.

3.2 Research design

A case study design as the most appropriate design as it considers contextual factors that promote a particular set of behaviors. For the intents and purposes of this research project, a case study utilizing mixed methods was adopted. A sample of 50 individuals were invited to complete an online survey questionnaire and 10 more individuals were invited to partake in in-depth interviews. This is a diverse group of respondents, which suggests that the findings of a study of this nature may not necessarily apply to the entire population of Inanda in a generalized manner.

Kalpi and Evans (2019) define a case study as an exploration of a time and space bound phenomenon. It is an approach where the investigator explores a real-life, contemporary bounded system (a case). It is a comprehensive description of an individual case or matter with the purpose to identify variables, structures, forms and orders of interaction between the participants in a situation or in order to assess the performance of work or progress in development (Starman, 2013).

According to Heale and Twycross (2018) case studies allow the researcher to take a complex and broad topic, or phenomenon and narrow it down into manageable research questions. By collecting qualitative or quantitative data sets about the phenomenon, the researcher gains a more in-depth insight into the phenomenon that would be obtained using only one type of data.

Most crucial to the social research process are, the research design and the identification of research methods to be used in collection of data. The research design outlines how topics will be addressed throughout the research. It serves as a structure or framework within which data and information is collected. A research design is a blueprint to guide the research process by laying out how a study will move from the research purpose or questions to the outcomes. It is a comprehensive planning

process used to collect and analyze data in order to increase the understanding of a given topic (Abutabenjeh and Jaradat, 2018). According to Aktar (2016) a research design is the arrangement of conditions for the collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy and procedure. The author goes further to suggest that research design does not only anticipate and specify the seemingly countless decisions connected with carrying out data collection, processing and analyzing, but that it represents a logical basis for these decisions.

The basis of the research design for this research project is the set of research questions that must be answered as well as the objectives to be realized by the end of this study. There is also a direct association between the topic, the research questions and the selected research methods.

The research design ensures that the evidence obtained during this study will provide the enabling mechanism for the objectives to be reached and research questions to be answered in the clearest way.

3.3 Research Approaches

A mixed method study was chosen for this research to enable an in-depth exploration of the lived experiences and attitudes of the community of Inanda towards state provided health services. In this case study a concurrent mixed-method approach was used, with the qualitative component giving context to the quantitative results. The survey which was conducted through electronically administered questionnaires, focused on individual's access to health care, personal experiences as well as attitudes engendered by individuals towards the health services. The in-depth interviews which were conducted telephonically provided a platform where the respondents could elaborate on their individual experiences and how those have shaped their attitudes towards health services. The synthesis of the two sections of the study was undertaken at the time of the interpretations of the results.

3.3.1 Qualitative approach

Qualitative research is multimethod in focus, involving an interpretative, naturalistic approach to its subject matter. It involves the studied use and collection of a variety of empirical materials such as case studies, personal experiences, introspective accounts, life stories, interviews, observations, history, interactional and visual texts, all which describe routine and problematic moments and meanings in individuals' lives. Aspers & Corte(2019) define qualitative research as any research that uses data that do not indicate ordinal values. Qualitative research helps researchers to access the thoughts and feelings of the research participants, which can enable the development of an understanding of the meaning that people ascribe to their experiences (Sutton & Austin, 2015).

Qualitative research methods are said to not be 'hypothesis driven'. The researcher is often tempted to put themselves in the position of the participant in order to understand the world from the participant's perspective. This risks the authenticity of the findings as they are likely to be assessed as biased by the researchers own experiences or opinions (Hammarberg, Kirkman & de Lacey, 2016). These authors further postulate that in quantitative circles, qualitative research is viewed with suspicion and considered 'light weight' because it involves small samples which may not be representative of the broader population. Qualitative research is said to be more dynamic, than static. This suggests that qualitative researchers limit their findings to the particular group of people being studied instead of generalizing it (Eyisi,2016). The author also states that replicability is another problem that is associated with the qualitative approach. It is believed that users of this approach write fiction because they have no means of verifying their true statements. Also since the approach is characterized by feelings and personal reports, it is believed that it cannot give reliable and consistent data when compared to using quantifiable figure. Finally the author claims that the non-use of numbers by qualitative researchers makes it difficult and impossible to simplify findings and observations.

3.3.2 Quantitative approach

Apuke (2017) suggests that research deals with at least a single question to a phenomenon. This implies that research exists as a result of answering a question about a phenomenon. For example, what are the attitudes of individuals towards state provided health care in KwaZulu Natal? Therefore research investigates such issues by critically collecting data, analyzing and discussing the results in order to draw conclusions. The questions of research could be: descriptive: How many people utilize public health facilities in KwaZulu Natal? How many hours do they spend at the health facilities on a single visit? Or the questions could be inferential: Does arriving early at the health facilities reduce the time spent in queues? Does reporting serious illness result in you being prioritized over other patients?

Quantitative research methods are concerned with collecting and analyzing data that is structured and can be presented numerically. The main goal is to present accurate and reliable measurements that allow for statistical analysis. It deals with data that can be measured and is highly operative in answering “what” or “how” of a given phenomenon. The questions in quantitative methods are direct, quantifiable and often contain phrases such as what percentage? What portion? To what extent? How many? How much? Etc. (Goertzoen, 2017) Quantitative methods emphasize on objective measurements and numerical analysis of data collected through polls, questionnaires or survey (Babbie, 2010). Quantitative research is said to be independent of the researcher, and as a result it is used to objectively measure reality. It creates meaning through the objectivity uncovered in the collected data.

The advantages of quantitative research include the fact that findings are likely to be generalized to the entire population, as the method involves large, randomly selected samples. Another advantage to note is that data analysis is far less time consuming as it often can be done using recent computer software (Rahman, 2017).

The disadvantages of quantitative research include the fact that the reliability of data is highly dependent on the quality of answers as well as the structure of the data collection tool, such as the survey. Also this type of research is very rigid and does not allow for any flexibility in the course of the data collection as well as other research stages. This method does not capture the emotions and behavior of the respondents, which can sometimes be interpreted as important in validating the verbal

responses given (Queirós, Faria & Almeida, 2017).

3.3.3 Mixed method design

Mixed methods research is the type of research in which a researcher combines elements of qualitative and quantitative research approaches for the broad purposes of breadth and depth of understanding and corroboration (Schoonenboom & Johnson, 2017). Mixed methods research is a research design or methodology in which the researcher collects, analyzes and integrates both qualitative and quantitative data in a single study or a multiphase program of inquiry (Johnson, Onwuegbuzie & Turner, 2020). According to Regnault et.al., (2018) mixed methods research allows a research question to be studied from different perspectives. The researcher is able to combine the rich subjective insights on complex realities from qualitative inquiry, with the standardized, generalizable data generated through quantitative research.

A critical strength of the mixed method research approach is that it typically capitalizes on data reflecting individual lived experience in the qualitative strand. This ensures that the results are considered from the patient's perspective (Regnault, 2018). Theorists believe that this approach provides researchers with opportunities to compensate for inherent method weaknesses, on inherent method strengths and offset inevitable method biases. It enables a greater degree of understanding to be formulated that if a single approach were adopted (Almalki, 2016).

Challenges associated with the mixed method research include the issue of skills; It is critical that researchers are aware of their skills set and whether they are able to cope with the demands of utilizing a mixed methods approach (Almalki, 2016).

3.4 Data collection

During the period of this study, countries all over the world, including South Africa declared national states of emergency, which was to enable them to manage the global COVID-19 pandemic. Across

the globe, countries implemented measures that restrict mobility of people, banned public gatherings and rolled out security forces to oversee the implementation of these measures (Peace and Security Council report, 2020). It is under these difficult circumstances that this study was conducted, which dictated that the data collection tools which were utilized in this study needed to be those that do not involve physical contact between the researcher and the participants. It was these considerations which informed the selection of electronically administered surveys and telephonic interviews.

3.4.1 Survey

A database of regular community members was obtained through the local ward councilor and Operation Sukuma Sakhe Ward Task Team. Fifty out of sixty-three individuals agreed to take part in the survey study. The inclusion criteria utilized when identifying participants included a few important elements; the participants had to be adults, residing in Inanda, who confirmed to having the public health system as their primary service provider. The questionnaire was prepared in English and translated to IsiZulu which is the language spoken by the vast majority of residents in Inanda.

In an effort to adhere to the stipulated COVID-19 regulations, the questionnaire was administered electronically through the WhatsApp Messenger application. It was critically important that the participant in this part of the study were individuals who owned or had access to a smart phone which was compatible with the identified application. Furthermore, it was important for the participants to have access to a cellphone network service provider and for their accounts to be credited with data, which would enable them to receive, download and open the questionnaire.

The informed consent was also administered electronically, through WhatsApp. It was completed, before the self-report survey was done.

3.4.2 In-depth Interviews

Form the database obtained from the local authorities, ten participants were invited to participate in the telephonic in-depth interviews. The in-depth interviews were selected as they provided an opportunity to gain in-depth information as opposed to other qualitative data collection instruments such as focus groups. The interviews were semi-structured, which means that the researcher had a

set of open ended questions which she posed, and then allowed the discussions to shape themselves and flow in the direction the participants selected. The interviewer had probing questions which were instrumental when the responses appeared to be not fully engaging.

Qualitative interviews are traditionally conducted on a face-to-face basis, as the natural encounter allows the interviewer to build and maintain rapport with the interviewees, which will in-turn enables the gathering of rich in-depth data. At the interview the interviewee's facial expressions, body language and cue from the physical environment can add to the researcher's understanding. It is because of these reasons that traditionalists criticize telephonic interviews, and argue that they are an inferior data collection instrument which is not suitable for qualitative research (Farooq and De Villiers, 2017.) Despite the challenges stated concerning telephonic interviews, they were identified as the suitable method for this study given the declared national state of emergency and its parameters.

3.4.3 Observation

Observation is one of the most important research methods as it may be regarded as the basis of everyday social life for most people. Humans are diligent observers of behavior and of the material surroundings. They watch, evaluate, draw conclusions and make comments on interactions and relations. However, when observations are conducted in a formal research, its needs to be carried out systematically, purposefully and on scientific grounds (Ciesielska, Boström and Öhlander, 2018).

Observation is one of the oldest and most fundamental research method approaches. It involves collecting data using one's senses, especially looking and listening in a systematic and meaningful way (Smit and Onwuegbuzie, 2018). When one of the senses is hindered, observation is therefore also obstructed. When conducting telephonic interviews, the researcher is unable to see the respondent and thus unable to observe their non verbal communication. However, when the data collection is done in an conducive venue, on a face to face basis, the researcher is able to observe gestures the participants may be communicating, such as the tone of the voice, pauses in speech, the raising or lowering of ones voice to emphasize a point as well as the energy or excitement carried in the words spoken.

Maintaining full cognizance of the limitations of this study, especially those pertaining to the observations possible, the researcher made all efforts to observe the emotions and assertions that were embedded in the respondents' speech.

3.5 Data analysis

Data analysis is described as the process of bringing together order, structure and meaning to the mass of collected data. It is described as a messy, ambiguous and time-consuming process which bears elements of fascination and creativity (Vosloo, 2014). It involves working to uncover patterns and trends in data sets, and it involves explaining the patterns and trends. (Sosibo, 2012)

The quantitative data collected through the online surveys in this study was analysed using Google forms built in tool for analyzing quantitative data. This was supplemented by the use of Microsoft excel spreadsheet which enabled the researcher to view and create graphs of the data that was to be analyzed.

The qualitative data was analyzed using the NVivo software. NVIVO is a software that allows researcher to organize and analyze a wide selection of data to bring order, structure and organization. It allows for the fast and easy analysis of datasets during studies (Edhlund and McDougall, 2019). NVivo software provided a set of tools that assist the researcher could use in the analysis of qualitative data. It increased the effectiveness and efficiency of learning (Bazeley and Jackson, 2013). The software was instrumental in the coding process, which formed an important part of the sorting and arranging the data in a coherent manner which made it easy to spot common themes throughout the interviews.

3.6 Ethical considerations

The ethics approval to conduct this study was obtained from the University of KwaZulu Natal's Humanities and Social Sciences Research Ethics Committee (HSSREC). The local ward councilor was consulted and request for permission for the study to be conducted in his area. The researcher

scrutinized and undertook to comply with the University of KwaZulu Natal's Code of Conduct for Research.

This study did not involve vulnerable groups such as any individual who is a minor, or intellectually or mentally impaired. The study did not intentionally target any specific group of the population some of whom may be deemed vulnerable, but the study was extended to the public at large. The researcher went to great lengths to ensure no deception in the data collection tools and processes.

All information obtained from the participants was collected through their consent, which was expressed through an electronically administered informed consent form as well as verbal consent during the in depth interviews. The participants were not requested to commit acts which impacted on their self-respect or which caused them shame, embarrassment or regret. Great lengths were also taken to ensure no respondent felt pressure or stress as a result of any part of their participation. All participants were informed that their participation was voluntary and if they at any point wish to withdraw their participation, they could do so without fear or obligation. The respondents were also informed that their responses would be treated in a confidential manner.

The identities of the participants were protected through the use of pseudonyms which were allocated to each participant. The interviews and questionnaires were made available in IsiZulu, which is the prevalent language in the area of Inanda.

3.7 Limitations

Limitations to this study include the fact that only the attitudes and lived experiences of patients were considered as having an influence into the overall attitudes of community members towards state provided health care. The experience and challenges faced by the workers and management within state health institutions was considered or explored in depth at this point, but they too have an impact on the attitudes and experiences of the patients.

The responses provided by the respondents were affected by their experiences during the recent COVID-19 pandemic period, depending on whether those experiences were good or bad. The respondents did not respond in manner that revealed their general attitudes, but portrayed their emotions based on their recent experiences, or experiences of a close friend or loved one.

It was impossible for the researcher to conduct face to face in depth interviews during the period of this study as the South Africa was still under the lock down regulations imposed as a measure to minimise exposure and risk of COVID-19 infection. The study entailed in depth interviews conducted telephonically, and an electronically administered survey.

3.8 Conclusion

This chapter presented an outline of the research methods and the research design that was adopted for this study. A rationale was developed to use a case study approach. An online survey involving 50 individuals from Inanda was utilized. Furthermore, ten indepth interviews were conducted involving 10 individuals also from Inanda, but who had not participated in the online survey. The study used both qualitative and quantitative research methodologies. The approach that was used to collect data was google forms, using its built in data analyzing tool alongside the Microsoft Excel spreadsheet to analyze the data. The questionnaire was sent through WhatsApp messenger to individuals who are part of the study population. In-depth interviews were conducted telephonically with 10 respondents, and this data set was analyzed using NVivo software.

The next chapter will constitute data presentation, analysis and interpretation.

CHAPTER 4: DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Introduction

This chapter presents the findings of the study. A mixed method study was conducted in Inanda KwaZulu Natal, to determine the attitudes and lived experiences towards public health services. The data collection was conducted concurrently where the quantitative data was collected through an online survey which targeted fifty adult participants residing in Inanda through WhatsApp messenger. The qualitative data collection was conducted through ten in-depth interviews which were conducted telephonically. The results of the two phases of the study are in this chapter presented sequentially. The first section presents the descriptive statistics of the participants' attitudes towards state provided health services. The participants' usage of and knowledge of available resources, services and structures at public health facilities are also presented. Finally, this section investigates perceptions of the participants in relation to the staff at the health facilities is presented.

The second section of this chapter presents the thematic content analysis of the in-depth interviews conducted in the second phase of this study. This section presents the lived experiences of the participants when utilizing public health facilities. It also sets forth the attitudes that have been developed through the lived experiences.

The objectives of this study were:

- To examine the attitudes held by the community of Inanda (KwaZulu Natal) towards state provided health services
- To explore the lived experiences of the community when utilizing public health facilities.
- To establish the impact of these lived experiences on the lives of the patients.
- To draw conclusions and make recommendations on how patient experiences may inform both practice and policy.

The main components of the health belief model; threat perception and behavioral evaluation were used to contextualize the findings of this study, as they provided a deeper understanding and prediction to the various health behaviors.

4.2. Phase 1: Attitudes and lived experiences towards state provided health care services:

The identified population for this study was black, Zulu speaking adult individuals residing within Inanda. The participants consisted of individuals who were unemployed and were on the ward Councillor's data base of indigent households. A questionnaire was administered through WhatsApp messenger to 76 adults, who reside in Inanda. After completing the online informed consent forms, indicating their willingness to participate in the study, the individuals completed the questionnaires. The participants were given a period of one week in which to complete the online survey, after which it would be closed-off so that it does not accept any more responses. Once the number of responses reached 50 the survey was closed and no further responses were recorded. The questionnaire was made available in IsiZulu which is the language spoken by the majority of the people of Inanda.

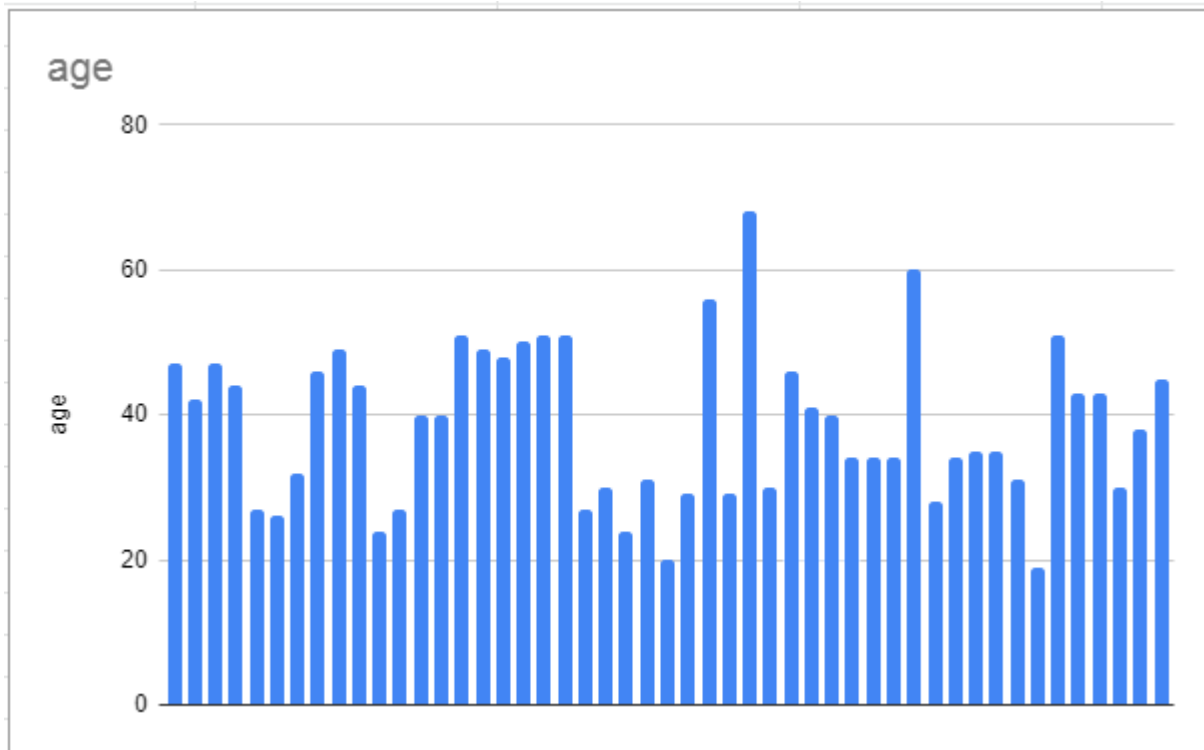
Data collected from the responses was analyzed using the Google forms built in analyzing tool as well as Microsoft Excel spreadsheet. The results were presented in the form of graphs and narratives. The four main sections of the data collection tool were:

- Personal (Biographical) Data
- Access to public health facility
- Feelings towards the public health facility/public health system(emanating from experiences)
- Usage and knowledge of resources, services and support structures available at the public health facility.

4.2.1 Personal (Biographical) data

The respondents were asked how old they were at the time of completing this questionnaire. Figure 4.1 depicts the respondents ages.

Figure 4.1 Respondents ages at the time of completing the questionnaires.



The participants' ages ranged from 19 to 68 years, with the majority (90 percent) being between the ages of 20 and 50 where; 13 participants were between the ages of 20 and 30 years of age, 12 between 30 and 40 years and 20 between 40 and 50 years. This indicates that the participants of this study are individuals who are mature and thus assumed to be of mental capacity to make their own decisions regarding health practices, and are able to develop their own attitudes towards health services. In order to be sufficiently competent, one needs to have the mental capacity to make decisions, but also should be accountable of the decisions in the

specific situation (Grootens-Wiegers et.al., 2017). It was thus important for this study that the participant be neither too young nor too old, to ensure sufficient mental vitality.

All of the participants of this study were Black, and they spoke IsiZulu as their primary home language. Though no part of the questionnaire required the participants to provide information regarding their employment and economic status, it can be assumed that the majority of the participant were unemployed and were of a low economic status as they were on the ward councillor's data base of social relief (Food vouchers) beneficiaries.

All of the respondents were individuals who either owned or had shared access to a smart cellphone, with access to a network service provider. The respondents also had to have access to internet connectivity either through the purchase of Data, or through connecting to a WiFi mobile hotspot. This enabled them to receive, complete and submit the survey.

4.2.2 Access to public health facilities

The participants of this study were asked if they had access to a public health facility. They were also asked if they utilized the services provided at the health facility, and to indicate their most convenient mode of transport when travelling to the public health facility, which gives a basic idea of the floor plan between the homes and the health facilities.

It emerged that 30 (60%) out of the 50 participants have access to a public health facility within walking distance, and only 31 percent reported to taking a single taxi when going to the clinic. They indicated that the public health system was their only hope, as they were unable to afford private medical cover. However forty percent indicated that they had alternative means to access health services other than the public health system.

The right to access to health care services is a basic human right enshrined by the constitution of South Africa for all citizens. Section 27 of chapter two states that everyone has the right to have health care services including reproductive health care (Assembly, 1996). The figure given above indicates that the area of Inanda is relatively well resourced with regards to health facilities. This suggests that the distribution of health facilities allows that most people from different parts of Inanda are able to walk to a facility near them. However, this cannot be seen as an indication of well-resourced centres. Though the facilities may be well spread out, it cannot be assumed from this study that it indicated a well-resourced health sector in Inanda. Studies by Mathew & Mash (2019), Maphumulo & Bhengu (2019) and other which are cited in the previous chapter indicate that issues centering on a lack of resources still remains a challenge in the South African health system at large. There is a small percentage of respondents who stated that they use multiple modes of transport in order to reach the health facilities nearest to them.

4.2.3 Usage of public health facilities

The findings of this survey indicate that 47 percent of the participants visit the clinic each time they have an ailment. A total of 39 percent indicated that they do not visit the health facility each time they need to while the left portion (13 percent) were unsure. The concern lies with the 39percent who do not access health services each time they need to. The second phase of this study intends to among other things, establish the reason individuals will resist visiting health facilities even when they need to, as it is the case with the big portion of the participants.

Of the 50 participants who completed the online survey, 31 reported that they had visited the clinic at least once during the past three months. The sample of 50 which was selected is too small a number and the findings cannot be generalized to the wider population, however the qualitative phase of the study provided support and a rationale behind this phenomenon. A further 27 participants, which translates to fifty-four percent reported that they felt happy about visiting the clinic. However thirty-five percent reported that they

were unhappy about their visits to the clinic, and a further thirteen percent reported to feeling indifferent about it, meaning whether they went to the clinic or not, they did not experience positive or negative feelings towards it.

4.2.4 Feelings towards the public health facility/public health system(emanating from experiences)

The majority of the participants felt that going to the community based public health facility was a worthwhile exercise. However, 27% indicated that they felt that their visit to the health facility was worthless and that the service they received was not clearly beneficial, but they are unsure if it made the impact they expected on their health status.

Figure 4.2, illustrated below, is a graph depicting the how the participants reported to feel towards visiting health facilities.

Figure 4.2 Graph showing how participants feel towards visiting the clinic



Half of the respondents reported that it was not the first time that they received the type of service that led to their overall view of the facility. A further 44 percent reported that the experiences which led to

their view of the facility were common. This can be interpreted as there being a portion of the community, who constantly feel that their visit to the clinic is not worth their time. This is a big concern, as the government has initiated, adapted and modified a number of quality improvement plans for the health sector (Maphumulo and Bhengu, 2019). When asked if they were happy with the services rendered by their health facilities, only thirty-six percent reported that they were happy. The rest reported that they were unhappy and that they felt that some improvement was needed.

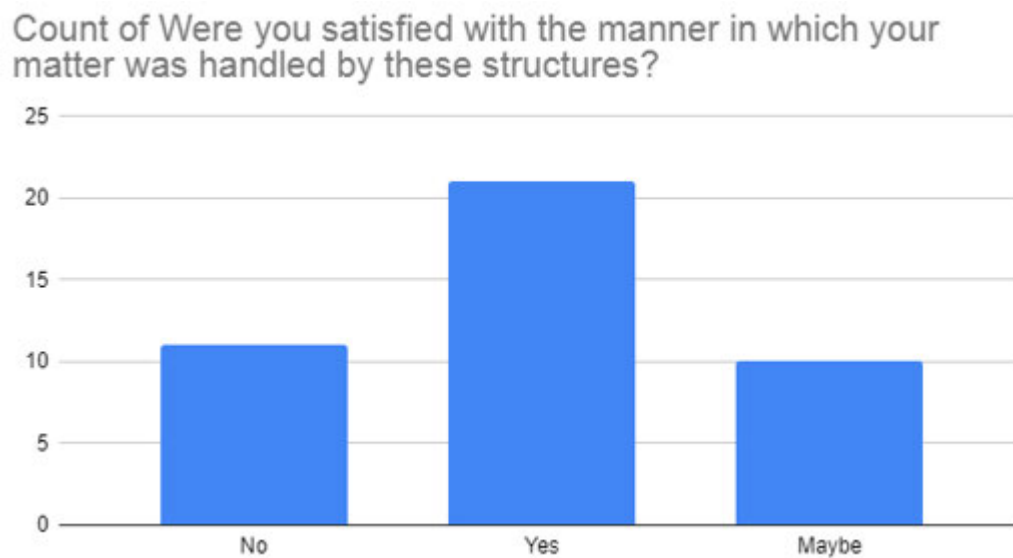
4.2.5 Usage and knowledge of resources, services and support structures available at the public health facility

Clinical governance is a term that refers to everything that helps to maintain and improve high standards of patient care. It is centered on improving care and it puts patients' experiences at the heart of clinical care. It is also about developing true partnerships between managers and clinical staff, and between clinical staff and patients (Connell, 2014). Clinic committees are health governance structures, created to provide an avenue for communities to give input and feedback into the planning, delivery and organization of health services and they play an oversight role in the development and implementation of health policies legislated by the National Health Act of 2003, the committees are made up of civil society representatives and health care professionals of each facility, and they allow community concerns to be elevated through the structures from local to district to provincial and finally to national level (Soul City Institute, 2020).

When asked if they knew about their local clinic's governing structures, 52% of the respondents reported that they knew about these structures. The rest of the participants, which make up 48%, reported that they did not know about such structures. Of the portion who admittedly knew about the structures, only 61% reported that they had a good idea of the functions of such committees. When asked if these committees functioned effectively, fifty-five percent stated that they did not know if these structured functioned effectively or not. This suggests that they had never utilized the services of these structures, in order to know if they are effective or not. This assertion is supported by the fact that when the participants were asked about the accessibility of these structures, forty-nine percent reported that they did not know whether the clinic governance structures were accessible or not. The respondents were then asked if they had contacted or utilized the clinic governance structure

and 65% reported that they had never attempted to contact these structures. Of the 35% who claimed to have had communication with the structures, the graph below indicates their level of satisfaction regarding the matter they were reporting to the structure. (eight participants did not provide a response to this question)

Figure 4.3 Satisfaction with the manner in which the reported matter was handled by the clinic committee



When asked how accessible the clinic management was to the public, fifty-eight percent stated that clinic management was accessible.

4.3 Phase 2: Attitudes and lived experiences towards state provided health care services:

Data analysis is said to be the most complex phase of qualitative research. Thematic analysis provides a highly flexible approach that can be modified for the needs of many studies, providing a rich and detailed, yet complex account of data (Nowell et.al., 2017).

This study used thematic analysis. This required the transcription of the telephonic interview recordings and followed coding stages. The transcripts were read several times to identify potential themes and codes. The themes and codes identified are presented below;

Figure 4.4 Themes and codes

THEMES	CODES
4.3.1 Access to the health facilities (Clinic)	<ul style="list-style-type: none"> • Travelling Time • Mode of transport available • Cost factor
4.3.2 Awareness of services offered	<ul style="list-style-type: none"> • Health Education • Screening and treating ailments • Reducing spread of communicable disease
4.3.3 Experiences at the health facilities (Clinics)	<ul style="list-style-type: none"> • General encounters • Impact of COVID-19 • Treatment by Health Care Professionals • Long waiting times • Dispensing of medication
4.3.4 Effect of experiences on the community's health	<ul style="list-style-type: none"> • Increased defaulter rates • Increased morbidity

4.3.5 Feelings evoked

- Frustration
- Anger
- Fear
- Demotivation
- Hurt
- Embarrassment
- Mistrust

4.3.6 Suggested quality improvement strategies

- Reduction of time spent at the clinic
- The training of nurses on how to treat patients

NVivo was identified as the suitable software to help identify the themes and codes for this study. NVivo was instrumental and used in the analysis of the transcript and through it relevant themes were identified.

A series of in-depth interviews were conducted with ten participants. The researcher secured appointments with the participants when she would phone them and conduct the interview. This was done to ensure that at the time of the interviews the participants were in an environment that did not have distractions, so they could focus on the discussions they were engaged in. All the participants were called before the date and time of the interview, and were reminded of the time and date of the telephonic appointment.

4.3.1 Access to health facilities (Clinics)

All of the participants who were part of the in depth interviews indicated that they have access to a public health care facility. The participants interviewed were from different parts of Inanda which included Newtown A, Emaplazini, Umzinyathi and Amatikwe. It emerged that in each of these areas there was a clinic available to serve the community and a majority of the participants reported that they do utilize the clinics in their vicinity for their various needs. This is observed in the responses from various participants as cited below;

Participant 3 said:

As a young male who sometimes gets into trouble and gets injuries because of the places I frequent, I do use the clinic for that kind of assistance. I'm not a person who gets sick often, I only use the clinic when I have injuries. Even at night, when we get injured at the places we go to, the clinic is the place where we go to for help.

Another participant said:

Most times I visit the clinic to collect my treatment for hypertension. I have hypertension. I don't normally fall sick, maybe I'm still going to get sick and visit the clinic for that (Laughs)

Participant 1's response resonated with Participant 3 and said:

I use the clinic when I am not okay, or when I need to research for something as a learner, then I go to the clinic to get information and also if someone at home is sick, I will accompany that person when they need to go to the clinic

According to Bettercare (2020), access to healthcare means having the opportunity to use the health services. For an individual to be able to use health care the service needs to be near them, the opening hours need to be appropriate, the staff needs to have the right mix of knowledge and skills, there needs to be appropriate equipment and the service needs to be such that every person can afford it and does not have to sacrifice a necessity in order to access it. This definition is was the following points address to ensure access to health in Inanda.

431.1 Travelling Time

The participants concurred, stating that they mainly walk to the clinic. They stated that their walk to the clinic ranges between thirty minutes and one hour.

Participant 5 said:

I'd say it can take me about 30 minutes to travel to the clinic, walking on foot. Sometimes when I have money I take a taxi.

431.2 Mode of transport available

Even though the participants reported that when they visit the clinic, they walk; they did also mention times when they use a taxi as a mode of transport. Those who reported using taxis stated that it is not a frequent occurrence, and it only happens on rare occasions. Even though the area of Inanda has a number of Bus companies that service the public , including the Durban Transport Municipal Bus service, and Combined Transport bus services. Operating there are also the recent transportation options such as Uber, Taxify and Bolt transporting services, however, the most common type of transport used are the local mini bus taxis.

431.3 Cost Factor

When there arises a need for the community to utilize public transport, the most commonly used mode of transport is the local mini bus taxi. For the sake of relevant, we will look at the various prices that only the mini bus taxi charges in the area. The estimated cost for a single person travelling from their home to their nearest clinic and back home again is approximately R12. This figure was quoted by a number of people residing in different parts of Inanda and utilizing different clinics.

The clinic that I use, Qadi Clinic is very close to my home. I walk for fifteen minutes only. But sometimes when I have to do things like XRay or something, then I have to go to a different clinic, Inanda Newtown C clinic then I travel by taxi. The fare is R6 to go and R6 to come back. (Participant 7, aged 35).

This was elaborated by Participant 10 who said:

I sometimes walk to the clinic because it's not very far. I walk for about thirty minutes. If I am using a taxi, it costs me R14 return price. Transport has never been the reason for me not to go to the clinic since it is so close. (Participant 10, aged 37).

The factors determining patients access to a health facility bear an impact on the experiences of a patient once at the clinic. If we consider a person who has travelled on foot for about forty-five minutes to reach the clinic, who arrives there and still has to spend more time standing and waiting in queues, there is a high probability that that person is not likely to view their experience with the clinic as a good one. Participant 2 elaborates:

What made me to dislike going to the clinic, especially since there is this disease, Corona. We are made to stand outside in the sun for a long time. You arrive at the clinic being moderately sick, until you get very sick because you are standing in the sun. Whether it's hot, or it's raining, we are standing outside. There isn't even a shelter for us to stand under.

Experiences such as these affect the patient's attitudes towards the entire system of the health facility. Rootinc.com (2020) asserts that experiences directly correlates to how individuals are treated in a particular environment. They further claim that attitudes which are driven by emotions are the most difficult to change. COVID-19 has presented itself as a calamity which was unexpected, which could not have been predicted at the time the facility structures were developed, hence some of the patient experiences, such as queueing outside in unsheltered environments are adjustments that had to be enforced given the sudden situation presented. However, experiences such as these ought to urge the health ministry to develop policies which make provision for 'business unusual', or unforeseen circumstances. The government through its various departments should develop peculiar policies and procedures to aid the

facilitation of the adjustment of usual practices to those suitable to the unpredictable, unknown circumstances in an unpredictable world. According to the health belief model, individual beliefs about health and health conditions play a role in determining health related behaviors. Key factors which affect an individual's approach to health include possible barriers preventing access to health. This means that an individual's perceived barrier to health, or the absence thereof, has a high probability of influencing that individual's health behaviors.

4.3.2 Awareness of health services offered

Inadequate knowledge and incorrect attitudes can directly influence practices and lead to delayed diagnosis, poor infection control practice and spread of disease (Wahed et.al., 2020). Empowerment is the most important intervention in health promotion, so it is of high importance for the health institutions to meet patients' needs and desires for information and knowledge, in an interactive manner and with an empowerment approach to promote health (Svedberg, Hansson and Svensson, 2009). It is thus important for patients to be informed about the services that are available at the clinics.

4.3.2.1 Health Education

The community of Inanda has the realization and appreciation that the clinics, as government institutions are places where one can get information regarding health matters. This can be seen in the participants' comments as stated below:

Participant 1 said:

...I use the clinic to get information as a learner...they are also able to explain things to me that I need to know. They also are able to teach me things that I did not know, they are also able to answer my questions regarding health related things I do not know

Ignorance was also expressed by some participants. For instance, participant 9 had this to say:

I don't know all of the services available at the clinic, but sometimes it happens that when you go there, you find them (the nurses) teaching about all kinds of communicable diseases like HIV and STIs, that is what I sometimes see, and find.

The patients demonstrated no confidence of their knowledge regarding educational services available at the local clinic. They are unsure of the information sharing sessions they sometimes witness. This indicates that they view those practices as special occurrences and not as something they should come to expect on a daily basis.

4322 Screening and treating ailments

The participants were well aware that screening and treating ailments were services one can expect to get at the clinic. This is portrayed in their responses:

Participant 1 said:

...I get to be taken care of...

Attesting to this was participant 2 who said:

...You can check for TB, HIV test is also available. You can also be treated for flu and there are also eye doctors to attend to you...

In their responses the participants indicated an awareness of programs available at the clinic, which prevent the spread of communicable disease.

Participant 1 said:

...they are able to help me if I need things like condoms, and they deal with you in a confidential manner.

This indicated that the participant is aware of services available at the clinic which one can employ to protect themselves and reduce the possibility of HIV infection. Participant 2 displayed knowledge regarding the spread of TB and HIV and reports about what one may do to acquire knowledge about their status regarding both diseases. This is what participant 2 said: ...there at the clinic there is the TB department, if you want to check for TB and get treatment you can go there, also HIV, if you want to check your status they can do that. Even if you have a flu you go inside the clinic, they will help you...

According to the Integrated Clinical Services Management program for the achievement of Ideal Clinics, there exists three main streams in the public health system, there is the Acute Episodic Care stream which deals with all illnesses that patients visit the clinic for, including flu, running stomach, STI treatment, etc. There is also the Chronic Care stream, which helps patients to manage their chronic illnesses, this includes sessional checkups, dispensing of chronic medication, drawing blood for blood tests etc. Lastly there is the Preventative/Promotive Care stream which provides services to expectant mothers, mother and babies, this includes scheduled antenatal visits for monitoring the development of the unborn baby, immunization of babies and children, birth control programs and information, etc.(Department of Health, n.d.).

The participants' responses indicate that all three streams of the integrated clinical services management program are catered for at the clinics, meaning that relevant care is ideally provided.

The Health Belief Model suggests external factors which have an influence in the health behavior of an individual include exposure to information which can prompt an individual to take action regarding their health. The health belief model therefore advocates for information sharing and educational sessions which are conducted at the facilities as they provide patients with critical information which should motivate them to take action towards attaining good health. Another key factor suggested by the health belief model as contributive to an individual's decision making process towards health action is that individual's perceive susceptibility to illness. Health screenings are hence the actions individuals will practice when considering their susceptibility to illness.

4.3.3 Lived experiences at the health facilities

The participants were asked to share their experiences at the health facilities. This was done in order to establish what their lived experiences were further more to understand how those experiences may have an effect of their attitudes towards state health services.

4331 General encounters

The participants were asked to share in detail what their general encounters were like when they visited the public health facilities. They were asked to give a detailed description of any factors that emanate from their experiences at the clinics which either encourage them to use the clinic or which discourage them to use the clinic.

Participant 3 who normally visits the clinic for injuries sustained said:

...the clinic I go to, some nurses when you get there you find them just having their tea breaks, that is why sometimes even though the clinic is good, but I decide I should just stop using the clinic. Because even if one is sick, then you start thinking....ahhhh, those people (the nurses) will be busy with their own thing and not paying attention to us as the patients.

Participant 4 also shared how he feels about utilizing the local clinic and shared a common experience he encounters. He said:

I hate going to the clinic. Because when you go to the clinic you have to leave home early in the morning, but you come back home at sunset! This is because their service is not right, its very poor, everything there has delays. It takes an hour for you to just check BP alone, then you queue again to go and see the doctor so you can be attended to and get treatment....

Participant 5 also shares his comment as he concurs with participants 3 and 4when he says:

Sometimes I really just feel fatigued when I think about going to the clinic, and I just can't bring myself to go to the clinic. Sometimes you even miss your appointment because of these feelings. Sometimes when you get to the clinic and you report, like maybe if I have something developing as a result of being on treatment, but they just don't help you, that is most irritating.

The participants all mentioned factors that cause their visits to the clinic to be a real burden, but they all reported that one thing forces them to visit the clinic despite not wanting to, is the fact that they know that they need medical care, and they want to take care of their bodies, but they do not have an alternative option. Some repeatedly stated that if they had the money, they would visit the private doctors for their medical needs.

The Health belief model asserts that it is difficult to convince people to change a behavior if there is nothing for them to gain. People will hold on to a behavior if they feel that they will gain something. This is the case with the participants of this study and probably with a big portion of the community of Inanda. The experiences they endure at the facilities are unpleasant, and many have expressed their contemplation of not utilizing the health facilities further, however, their perceived benefit from visiting the facilities out weight their desire to quit, hence they decide to find coping strategies which they can utilize when they become victims of the harsh treatment, but they utilize the clinics

nonetheless.

4332 Impacts of COVID-19

The participants were asked, as regular clinic users, if the COVID-19 pandemic had brought any changes to their clinic experience. If it did, were those changes at the benefit of the patients or at their detriment.

Participant 9 said:

...Since the lockdown started, things seemed to move quicker for us because all those who came to get treatment and medication are attended first. They are told to wait outside the clinic, then their cards are taken and their medication is brought to them while they are waiting outside, so after that I was happy.

Some of the patients attending the various clinics have an appreciation for the changes brought by the COVID-19 protocols, some feel that it has made the situation even worse than before.

Participant 1 said:

...Now with the COVID 19, we wait longer to be attended to. We have to wait outside and the heat is too much sometimes. You get to the clinic with just a minor sickness but leave there feeling worse because of having to wait in the sun for such a long time. Sometimes it's even cold and raining. There is no shelter provided....

COVID-19 has presented itself as a perceived barrier to health. It is that factor that makes health behavior appear hard to do. It is not just a physical difficulty of not being able to visit the facility, but it is also a social difficulty, as it bears traces of stigmatization. If one visits the facility and present with COVID 19 symptoms, guidelines indicate that they are to be isolated and tested for COVID 19

(New South Wales Government,2020). This can be a source of stigmatization for patients, as they have to return to their communities, and they may be ostracized and said to have the Corona Virus. According to the health belief model, this is enough to stop individuals from visiting the facility.

4333 Treatment of patients by health care professionals

Besides the general experiences at the health facilities, the participants were asked to respond specifically to the question of how they are treated by the health care professionals when they visit the clinic. It is noted that the responses were based on how the nurses treated them, regardless of the fact that there are other health care professionals who also see patients when visiting the clinic, such as Clerks, Counsellors, Doctors, etc.

All the participants voiced a concern and dissatisfaction at the way they are normally treated by the nurses. Some stated that the nurses give preferential treatment to those who appear to be their friends or family member, attending to them first when they arrived late at the clinic. Others were unhappy at the way the nurses speak to them, stating that it leaves them feeling embarrassed and angry.

Participant 10 said:

Sometimes when you fall behind on collecting your medication and you think about going, you quickly retract those thoughts because you think, those people (the nurses) will really attack me verbally and leave me feeling low and embarrassed.

It also emerged from the participants that not all nurse are the same, and that there are those who treat them with courtesy and kindness. The participants stated that when they are seen by those kind nurses, they leave the clinic feeling fulfilled and content, and also motivated to honor all appointments. When the patients are treated in a dignified manner, they are even willing to accept responsibility for some of the challenges they face at the clinics.

The treatment of the patients by the health care professionals is another health barrier which makes clinic visits difficult. This too has social consequences as when the patients are humiliated by the harsh words spoken to them in the presence of everyone else, that patient needs to have the courage to still be among the same people who witnessed her being belittled. The amount of discomfort felt by the patients when mistreated by the clinic staff may cause visiting the clinic to be hard.

Participant 2 said:

...It all went very well, the services were good. I was very much satisfied because the nurse who was assisting me was very kind and open. I think sometime we (the patients) are to blame by the way we talk to the people who are supposed to be rendering services to us, we get easily irritated and we are not patient.

When the patients are treated in a kind and considerate manner, they are more willing to visit the health facility again. Their experiences are no longer considered by Health belief theorist as perceived barriers, but are now looked at as perceived benefits. This is because the patient will value the physical benefit they will get from utilizing the clinic more than their expected experiences. This is seen in the response given by participant 2, stating her level of satisfaction with the service she got from the clinic which she attributes to the nurse's kindness.

4334 Long Waiting times

Long waiting times are the outcry of every participant who took part in this study. The participants attribute this long waiting time to a number of factors, including staff just not caring and not having an interest in serving the patients, or staff prioritizing their own friends and leaving people who arrived early in the queue while seeing these friends and family first, the new COVID-19 regulations, supposed staff shortages and a number of other factors.

Participant 9 said:

When its break time, you stand in the queue while they (the nurses) all go for a tea break, instead of taking turns...

Participant 8 attests to the comment made by participant 9 regarding the displeasure they get from queueing for long periods. Participant 8 said:

Some of the things that discourage me is the cutting of the line, where some are being called in by the nurses from the back of the line and they get help first, leaving us there waiting for hours...sometimes the nurses visit each other during working hours just to talk and we have to wait as patients. This makes me very angry and it turns us into bad people. We end up fighting with the nurses and with each other, some even stop going to the clinic because of this.

Prolonged waiting times is a phenomenon that affect a vast majority of community members utilizing the public health facility. This is an indication of a deficiency in the functionality of facilities which hinders the functions of facility. This affects policy and practice, as it leads to patients refusing to utilize the clinic, which leads to an increase of poorly managed illnesses, increased defaulter rates and general high morbidity rates. This also results in facilities being constantly inundated with medical cases that are difficult to manage, constantly dropping figures of patients who are sustained on antiretroviral treatment and other challenges which add strain onto the health system. According to (Onoruoiza et.al., 2015), non-compliance to treatment leads to that disease becoming resistant or uncontrolled, which further leads to complications. Non-compliance also increases the cost of treatment, induces inefficient use of health resources and compromises treatment outcome. The author further states that money expended on drugs and time spent on consultations is wasteful when patients fail to comply with health information.

4335 Dispensing of medication

Unlike the other issues which appear to be similar throughout all the clinics the participants mentioned in this study, the dispensation of medication is not conducted in a uniform manner throughout all the clinics. It emerged that some clinics give out medication liberally as per the patient's needs, while some clinics do not give to the satisfaction of the patients.

Participants 7 said

We now know that if you are sick, the clinic you must use is Inanda Seminary, because you will get all the medication, even if a child has fever, a cough and a running tummy, you will get all those medicines, but on this side, they will tell you to go home and make your own remedies of glucose for a running tummy or lemon and sugar for a flu. You will not get medication. Another lady I was speaking to yesterday uses Nozaza clinic not Newtown A clinic, because she says the same thing. You will go in the morning and return with just one

bottle of medicine.

Participant 10 also shared a similar view and responded as below:

The nurse even says we like to come to the clinic for a small thing like flu, instead of making water with lemon and brown sugar for cough and flu.

Some patients also reported that when they were given medication, some of the medication had been taken out. What appears to be the problem with this is that the patients are not given reasons why they would be given treatment that has been “halved”, so the patients are left to make their own conclusions such as what was proposed by participant 7 when she said:

...the issue of treatment, we (the patients) are not sure if it is done in the proper way, for example the pain tablets that are in the box, you can see that some sheet of tablets have been taken out, maybe originally there were 4 sheets of tablets inside, but you only get two. So we never know if there is a genuine shortage, or they (the nurses) take them out and keep for themselves, we never know. But we get the feeling that they take them out not to give to other patients, but rather to keep and share with their friends. The government gives all resources for us to benefit, but they take some for themselves

These raise the complaint patients feel dissatisfied with the quantity of medication they get, they feel it is not what they are entitled to and hence they are unable to recover from their illness in the manner in which they could have if they had been given complete packs of medication.

4.3.4 Effect of experiences on community's health

The participants stated clearly that they rated the service they get from the clinic as poor and in need of improvement. The experiences they shared indicated that many individuals encountered negative feelings concerning clinic visitations. The participants' attitudes towards health services were negative, and many indicated that they no longer desire to use the clinics, but are compelled by their life circumstances. The participants were then engaged on their perception of the effects of these attitudes and experiences on their overall health.

4341 Increased defaulter rates

The participants in this study indicated that there are issues such as unmet expectations regarding the quality of care, which have led them to stop taking their medication in the correct way. The participant expressed that this commonly arises from their displeasure in visiting clinics. As stated before, they don't enjoy visiting the clinic due to the extended amount of time they spend in the queues, but also because of the abusive treatment they receive from the staff.

Participant 10 is an HIV positive patient, who is supposed to be taking medication daily, but she stopped collecting her medication in April 2018 due to how she was treated at the clinic. She stated that she used to work at an early childhood development centre, and they could not afford to take many days off because you were not paid for days you did not work. So after an incident at the clinic where she drew blood, but was told she needed to draw some more, she found it hard to keep honoring the appointments because she was being shouted at by her employer because of shortage of staff and also she was losing money, so she just stopped going to collect her medication. She states that she feels she could not afford more days off, as they were already earning very little. This is what she states about this experience:

What I discovered is that they (the nurses) have no patience with the patients. You find the violently shouting at you saying "You don't care about your life! And this and that, when you get sick and you come here in a wheel chair, we don't care, we will chase you away and send you home", so you see they really speak badly towards you, so even when you see that I have missed by appointment by maybe 2 months, and I need to go and collect my medication, then you think, ey these people will "chew me and spit me out" so I know sometimes we make our mistakes of not collecting on time, but even after we have made our mistakes, you think, ey, how will I be treated when I return to the clinic, so I have stopped collecting my medication completely.

Participant five, who also collects chronic medication for an illness she did not disclose stated that she also experience similar treatment from the clinic staff and on many occasions she has contemplated just stopping this whole thing of going to the clinic regularly, and just living by God's grace.

She said:

I feel very frustrated since I have to go there every two months. Sometimes I feel like just giving up and not go for my medication, but I can't because I need the treatment.

Participant 2 is still holding on to her will power to collect her medication despite the traumatic experiences, but the fact that she frequently thinks about quitting, is a warning sign that if things do not improve, she may not be able to hold on for much longer, and her name will soon be added to the list of defaulters.

4342 Increased Morbidity

When patients cannot utilize the clinics as they need, it means to the health system that there are individuals who should be getting medical care, but are not. This is an infringement of individual right to access to health care, which leads to a poor management of diseases and increases morbidity. When asked how the experiences at the clinic affect their health the participants responded in the following manner:

Participant 7 said:

It has a big impact because you end up preferring to go to the chemist to just buy over the counter medicines. So sometimes you might do this only to find that your illness was serious and needs to be handled by doctors. The chemist will give you what you ask for, but you don't know that death is slowly eating at you, until you find yourself so sick that you are bedridden, by then it will be too late.

Commenting on the state of her health, participant 10 said:

This has shaken my life, even the way I feel, I can feel that my body is weak. I don't know I cannot speak for everyone, but I know people who have lost their babies because of the negligence at the clinics...

Patients' experiences at the health facilities have presented a barrier to healthcare. Participants have indicated this and some indicating that the barrier has emerged stronger than their perceived benefit for visiting the clinic. One of the health belief model's key constructs, perceived severity refers to

the sense of seriousness of the disease, before an individual will comply with the parameters of that disease that individual must perceive that the disease can have mortal consequences. Efforts must be made to raise awareness about the consequences and implications of disease, aiming to provide encouragement to clinic utilization.

4.3.5 Feelings evoked

The various feelings evoked from the participants experiences at the clinics are serious and unfitting in the case of where services are meant to be provided to beneficiaries. The main purpose for the existence of the health department is to ensure the provision of quality health care to South African citizens. Such services should be rendered in a way that does not stir up negative emotions.

435.1 Frustration

Frustration has been used a number of times in describing how the participants feel when they visit or think about visiting the clinics. Participant 5 said “I feel frustrated since I have to go there every two months”

435.2 Anger

Anger is another common emotion felt by the participants. Participant 8 state that some things make her and other patients very angry which is out of her character. She said “This makes me very angry and it turns us into bad people. We end up fighting with the nurses and with each other, some even stop going to the clinic because of this.”

435.3 Fear

Some patients become fearful when at the clinic. The some of the participants indicated that sometimes when they are shouted at, they get so scared of being embarrassed like that and the possibility of being chased out of the clinic, they get confused, and they do not know what to do, and

they end up doing the wrong things and failing to follow simple instructions because of the fear and intimidation. Respondent 5 said “my head just spins and I get so afraid, they tell me to enter one room, and I see myself entering a different room, because my head just spins.”

4354 Demotivation

Demotivation is a feeling experienced by many who have gone through the harsh treatment at the clinics. At time the feeling of demotivation is greater than the patients’ desire for good health and as a result, they default treatment.

4355 Hurt

The participants indicated that often times they leave the clinics feeling hurt. The manner in which the nurses speak to them hurts them and most times they just quietly allow the nurse to speak in that hurtful manner, for the sake of their health. So they keep quiet just so they can get the assistance they came to the clinic for and return home, feeling wounded and not wishing to return to the clinic again.

4356 Embarrassment

The treatment many participants receive when visiting the clinics leaves them with feelings of embarrassment. This is because everyone is addressed in front of all other patients and other staff members too. Participant 10 stated that she relinquished thought of going to the clinic because “those people (the nurses) will really attack me verbally and leave me feeling low and embarrassed”.

4357 Mistrust

When considering their experiences and those of others around them, some participants experience a lack of trust towards the clinic. They begin to doubt if the facilities are capable of giving them a quality service that they can trust. Participant 8 stated that “there are

always complaints about the clinic, even from the community. So as a community we end up not liking the clinic and not trusting it because of the service it gives us”.

According to the health belief model, all the feelings that are evoked by the participants’ experiences may be viewed as perceived barriers to health behaviors. The feelings felt by the participant lead to an attitude that encouraged the disuse of the facility. Study.com (2013) suggests that emotions are the driving force behind attitudes and behavior and they play a large role in how individuals are influenced. They claim that emotions are often the determining factor in attempts to change attitudes and behavior. According to Meier (2019) individual changes in happiness, anger and fear correlate with changes in attitudes and patience. The participants displayed negative attitudes towards state provided health services, and these attitudes were affected by the experiences they encountered when they attend the clinic.

4.3.6 Suggested quality improvement strategies

The participants were requested to identify strategies to improve the services at the public health facilities. This is based on their experiences and they were to identify ways in which the government could adopt to close the gap and deliver health services of an acceptable standard.

4.3.6.1 Reduction of time spent at the Clinic

The first suggestions which the participants made were those which ensure the reduction of time spent at the clinic. This is because long waiting time was one of the biggest mentioned challenge that most patients are faced with.

Participant 3 said:

We need ambulances. The government needs to supply more ambulances so that patients do not wait long for an ambulance to arrive. A lot of people have died while waiting for an ambulance and we end up asking our neighbor's with cars to transport us.

Participant 4 also share what she felt could help in reducing time spend

at the facilities. She said: Participant 4 said:

Honestly, I do not know about improvement. Maybe if the nurses would take turns for tea breaks instead of all going together.

Other participants felt that if the number of staff was increased, maybe that would help to shorten the time spent in queues. Participant 7 even went further and stated that perhaps if qualified local people were employed as nurses they would not treat the patient in this manner, since they know that they are all members of the same community and they know each other's families and they are likely to meet each other in public spaces.

4362 The training of nurses on how to treat patients

The participants emphasized the importance of how they are treated at the clinics is to them. Those who have stopped going to the clinic have not stopped because of factors other than the treatment they get from the health officials. The participants proposed that the health professional need to have regular training on how to treat the patients. At these trainings they will get an opportunity to be reminded of the impact they need to make in the community and also encouraged to treat their patients with care and respect at all times.

Participant 9 said:

I used to work at a call center and we were taken on workshops regularly, which helped us to revive our love for our jobs. I learned that workshops really help boost workers confidence.

4.4 Conclusion

This chapter has presented and analysed the attitudes and lived experiences of the research sample towards state provided health services. The data was collected using the mixed method approach, where 50 participants were invited to complete the electronically administered survey and 10 participants were invited to be part of the telephonic in depth interviews.

Participants in both the qualitative and the quantitative parts of the study indicated that they all had access to public health facilities. It emerged that most of the participants are able to walk to their nearest facilities. This indicates that the area of Inanda has sufficient public health facilities to serve its population. Furthermore, a majority of the participants prefer to walk to the clinic, rather than take the local transportation available to them. The participants also shared their experiences at the public health facilities, which is an indication that these facilities are utilised by the community.

It also emerged from the analysis of both the survey and the in-depth interviews that there seems to be inadequate communication of important information from the facilities to the patients. Patients are not informed about crucial matters which pertain to the level of service they receive, the amount of time they may expect to spend in the queues, and other important issues. This has led the patients to develop negative attitudes towards the public health system.

There was a noted issue of the shortage of resources which includes human resources, and this has affected the patients negatively. The issues of staff shortages causes pressure to be mounted on the staff available, leading to a perceived attitude of uncaring towards the patients and a lack of concern about patient wellbeing. This includes the slow performance of their duties, extended tea and lunch breaks, the abandonment of patients while all are on tea and lunch break. It is these main ideas that were identified as having the most impact in creating negative attitudes towards state provided health services. The next chapter discusses the findings and proposes recommendations for the phenomenon.

The attitudes and experiences of patients at the public health facilities have served as barriers to health, as they have cause disinterest from the patients. Only those who possess a strong a strong sense of perceived severity and perceived benefit are encouraged to, despite the difficult circumstance, are still able to timeously honor their clinic appointments. Many interventions need to be conducted in increasing patient exposure to health information that will prompt them to take action towards maintaining their health. The interventions must place emphasis on the benefits of engaging in health behavior as well as the consequences and severity of illness.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The purpose of this mixed method case study was to establish the attitudes and lived experiences of the community of Inanda towards state provided health services. In this chapter the conclusions are derived from the findings of this study and are herein described. The conclusions are based on the study purpose, research questions and results of the study. The implications of these findings and the resulting recommendations are explained. This chapter also includes an overview of the study and research approaches adopted. This chapter includes a discussion of the limitations of the study, areas for future research and a brief summary.

5.2 Overview of the study

The study was an exploratory, descriptive and contextual mixed method study. A case study approach was adopted as the researcher delved to learn more about the attitudes and lived experiences towards state provided health services in Inanda. The data collection was extensive and it drew from multiple sources such as the survey, the interview and the observations made (Williams, 200). This allowed for in depth exploration of the phenomenon. The researcher adopted a concurrent data collection approach to realize the objectives of the study. Informed consent forms were developed using google forms, and were sent to the participants using the WhatsApp Messenger application to 76 potential participants. The survey was also administered using the WhatsApp Messenger application as contact data collection was disallowed due to the national COVID-19 pandemic. The questionnaires also were sent to 76 individuals to allow for possible non-participation, but only fifty responses were captured in order to remain within the stipulated research parameters. The qualitative part of the study included 10 individuals who were invited to participate in a series of in depth interviews which were conducted over the telephone.

Both data sets were analyzed and the main themes identified. Themes emerging from the quantitative

data were compared to those emerging from the qualitative data, and the overriding themes were thus identified, based on the similarities.

In analyzing the quantitative data, the researcher undertook to use the google forms built in analysis tool, together with Microsoft excel spreadsheets. The aim for this was to reveal the underlying patterns, trends and relationships of this study's contextual position (Albers, 2017). Analysis by means of statistical techniques assists the researcher in investigating variables and their effect, relationship and their patterns of involvement within the given context of this study (Lutabingwa and Auriacombe, 2007). The qualitative data was transcribed, then, using the NVivo software the researcher undertook the coding process. The coding was conducted in order to identify and extract the themes and codes from the data. The trustworthiness of the study was ensured to ensure the quality of the findings. Ethical considerations were respected.

This study was successful in achieving its objectives and its findings answered the key questions to the study which were:

- What are the attitudes held by the community of Inanda towards state provided health services?
- What are the lived experiences of the community of Inanda when utilizing the public health facilities?
- What are the impacts of these experiences on the lives of the patients?
- What conclusions can be drawn and what recommendations can be made pertaining to how patient experiences may inform both policy and practice?

The findings and the recommendations described below are centered on the experiences of sixty participants of both the quantitative and qualitative approaches, the research questions, the objectives of the study and the themes emerging from the data analysis.

5.3 Summary of the data

A total of six themes consisting of twenty-six codes emerged from both the quantitative and qualitative data. The findings of this study were discussed according to the themes that emerged from the data.

Themes:

1. Access to health care facilities (Clinics).
2. Awareness of services offered at the health facilities.
3. Experiences of individuals at the health facilities.
4. Effect of the experiences on the community's state of health.
5. Feelings evoked by the experiences.
6. Suggested quality improvement strategies.

5.4 Themes and their implications

5.4.1 Access to health care facilities

It emerged from this study that the Inanda has a total of seven public health facilities. Of these facilities two are under municipal authority, four are under provincial authority and one is a faith based clinic. These facilities are supported by non-governmental organizations (NGOs) which are funded to provide support and assistance in the implementation of health services in the area. These NGOs have a key role in promoting and advocating for relevant global health research, resource mobilization and they are mandated to making strong and lasting inroads into reducing the disease burden on the worlds most affected populations (Delisle et.al., 2005). Amongst other duties these NGOs, provide health services in mobile clinic vehicles at community level.

The participants, who were selected from different parts of Inanda indicated that they have easy access to public health facilities. The majority of the participants identified walking as the main and preferred method of accessing their local facilities. It emerged that the participants utilized the clinics for a number of reasons including; collection of medication, minor and major ailments, assistance in the case of injuries, child immunizations, research purposes and others. This indicates that the facilities are equipped to address the immediate needs of the community.

The participants did not report any challenges in their ability to access any of the public health facilities, however they indicated their desire to shift away from the public health system, but were unable to afford private health services. The participants willingly shared information regarding their socio-economic statuses, and indicated that if they were able to afford private health services, they would utilize the private health sector services instead of the public health service. Their pronounced reluctance in utilizing the clinics, does not emanate from an inability to access the facilities, but is rather motivated by other stimuli.

The facilities are situated in close proximity to the patients, as such patients do not have to worry about financial contributions when contemplating visits to the facilities. Hence their socio-economic status cannot be regarded as a barrier to access health services. Contributing further to the facile access to health facilities is the realization that services are offered at no cost as per the mandate of the National health act 61 of 2003, which makes provision for free health care to all citizen utilizing public health clinics (Leatt, Shung-King and Monson, 2006).

The participants expressed a level of comfort and satisfaction with the regards to the accessibility of the health facilities.

5.4.2 Awareness of services offered at the health facilities

The participants showed satisfactory knowledge regarding the services that are available at the public health facilities. This was observed in the quantity of services each participant reported to accessing at the clinic. When asked if they were aware of other services offered at the clinic other than what they normally visit the clinic for, the participant reported to know only a few. This suggests a lack

of general knowledge of services provided at the facility, as patients know only what they utilize.

It emerged that the majority of the patients are not sufficiently informed about service delivery at their clinics. The facilities are mandated to have functional clinic committees which are governing structures responsible for handling issues between the public and the facility. The clinic committees are a platform where patients may tender their complaints, or compliments regarding their experiences at the clinic. Qualitative and quantitative findings indicated that participants do not have sufficient information to exercise this empowerment tool at their disposal. Two participants reported that they did not know how to access facility management to present a complaint, so when the need arises, they are unable to report the case to management for intervention and customer service. This indicates that the public health sector at large has not done enough to market its services as needed. There exists an imbalance in the community's knowledge of some programs over others.

5.4.3 Experiences of individuals at the health facility

The patients reported experiences of an unpleasant nature when visiting the public health facility. Though some did take accountability of contributing to some of the unpleasant encounters, through their impatience, inability to follow strict instructions, and other actions they sometimes conducted to provoke the health care professionals, however the participants reported receiving more anguish and abuse rather than care and support from the nurses.

The participants reported the unpleasant experiences to be extreme and frequent and oftentimes actuated by innocent acts on the part of the patient. They frequently felt neglected by the staff and sometimes were completely ignored and not assisted in time. The participants described the unprofessional conduct of the nurses, of visiting each other for small talk during the consultation times, resulting in the patients having to wait while listening to the insignificant exchanges. This depicted the nurses as uncaring towards them.

The participants of this study asserted that it is only some of the nurses who inflict this harsh treatment on them as patients. They reported a handful of nurses who love their jobs, who have a genuine concern for the patients and who go out of their way to assist the patients. The participants associated their experiences at the clinic with the temperament of nurse that would be serving them, noting that there are more negative experiences than there are positive ones.

Other sources of agony at the public health facilities emanate from the amount of time spent at the facility. The participants raised their concern about the facilities not functioning efficiently, with the majority of their time spent in queues. The participants claim to arrive at the facilities early to join the queues, but still leave the facilities late. Each of the consultation stations visited is flooded with long queues. The participants reported not being accommodated accordingly at the facilities as they have to queue outdoors where there is not shelter, which is particularly difficult in the harsh weather of extreme heat, extreme cold or rain.

There was an issue raised of nurses calling certain patients from the back of the queue to be served first. The participants are cognizant of vulnerable groups such as the elderly or disabled deserve to be served first. However, reports indicate that some of the people pulled to the front of the queue do not fall into any of the vulnerable categories; this leaves them with an impression that the nurses have preferential treatment which unfairly prioritizes some over others.

COVID-19 has accelerated negative experiences at the facilities, as the requirements for the observation of related regulations such as maintaining social distancing, the queues have become longer. The waiting times have been extended as there always must be minimum numbers of patients in a given space. For chronic patients, the experience has been different as participants collecting medication reported less queueing as measures are in place for them to quickly get their medication and swiftly vacate the facility, thus keeping the numbers of patients inside the facilities low, however for services other than the collection of chronic medication, things have not shown any improvement.

Challenges with the dispensing of medication were reported, with the claim that most facilities, do not dispense medication to the satisfaction of the patients, but the patients are advised to make home remedies to treat minor ailments. As a result of the prevalent negative experiences at the health facilities, the participants ranked the public health facilities as having poor service.

5.4.4 Effect of the experiences on the community's state of health

The experiences encountered by the participants, who are representatives of the larger community of Inanda, have negative and even detrimental impacts on the health of the community. Many have decided to stop utilizing the health facilities, resulting in missed follow up appointments, non-

adherence to treatment, and general disruptions in the implementation of health services to the community.

Some of the participants declared that they stopped going to the clinic to collect their medication as a result of how they had been treated at the clinic. They also reported that they were aware of how discontinuation of treatment affects their bodies, however they were not prepared to be humiliated by the nurses again. The participants who had stopped attending the clinic, reported that they could feel a slight deterioration in their health and that their bodies were feeling weaker. They reported that they now prefer to ask their neighbours and friends who are being treated for similar illness to share their leftover medication. The participants have a strong belief that as long as they are taking the 'borrowed' treatment, they would be okay. It doesn't matter if the treatment regime not the same as what they would have received.

The participants also reported an increase in morbidity as they were more reluctant to visit the clinic for services and also because of extended time spent in queues. One patient reported that he knows a few people who have died while waiting to be transported to the hospital, the ambulance took too long to arrive and the consequence was the patient's death.

5.4.5 Feelings evoked by the experiences

A range of emotions were expressed by the participant which they attribute to their experiences at the health facilities. Most participants reported feelings of frustration at not being able to control and improve or speed up processes during their visits. The participants feel anger towards the nurses for the injustices they witness. They also experience fear as they get intimidated and threatened that they will be sent back home sick. Above all else, the patients feel demotivation and fatigue towards the health system all together. The feelings of hurt and embarrassment are also a common experience. The participants feel that the nurses use their position of power to oppress and intimidate patients.

The health facilities are no longer a place of safety for the community. The participants stated that they no longer trust the facilities to be able to provide the best care for them.

5.4.6 Suggested quality improvement

The participants suggested ways to reduce the time spent in queues. They suggested that the nurse take turns when going for tea break and lunch. They suggested an increase in the number of staff at the facilities. The participants also suggested that the nurses be sent to customer services trainings on a regular basis to help them reignite a love for their jobs and also to capacitate them on how patients should be treated.

5.5 Summary

The study confirmed that the community of Inanda has developed negative attitudes towards state provided health services. These negative attitudes emanate from the experiences encountered when visiting the clinics. The attitudes are also intensified by the powerlessness felt by the community to do anything to improve their situation at the facilities. The attitudes held by the community stem from a sad realization that as patients in Inanda are compelled to develop ‘tough skin’ against the harsh way in which the nurses deal with them, or seek private medical assistance.

The daily experiences of Inanda communities at health institutions leave psychological wounds that are on some people un-healable. The community at large witness much injustice and inequality, however, they feel silenced and as those who do not have a voice to speak against such. The community has devised to utilize individually suited coping mechanism towards the situation. This sometimes includes their retirement from accessing the entire public health system, which bears the most severe consequences.

The community indicated limited knowledge on available options to curtail the negative experiences and promote positive encounters at the facilities. They perceive structures such as clinic management, and clinic committees as unreachable thus unable to address the situation.

5.6 Recommendations

The study makes the following recommendations for improving the experiences and thus changing the attitudes of the community towards public health systems. The recommendations may be effected in Inanda and rolled out to other parts of the country in an effort to improve national patient experiences and attitudes. The recommendations are proposed with an aim to provide solutions to the research problem discussed and investigated in this study.

5.6.1 Marketing of services

The government as the service provider of public health needs to employ strategies to advertise and market services available within the public health sector. Much of this has been seen in some of the department's bigger programs, such as the HIV/AIDS program, which has made great strides and holds the title of largest HIV treatment programme in the world. The benefits have included a decline of 55% in AIDS related deaths since 2005 (UNAIDS, 2017). An approach of similar rigor needs to be adopted when communicating other services that are offered at the public health facilities. The prioritization of programs needs to be revisited to ensure that the programs of a lesser priority do not end up being completely eliminated from the awareness and promotion strategies. A big need was identified from the responses of the participants for a comprehensive marketing plan of all services offered at the facilities. These could be done in the form of audio promotions of radio stations, audio recordings of creating jingles and slogans to be played at the facility during the day, especially to target the youth, print media in the form of posters and pamphlets strategically placed and distributed at the patient reception points. The staff of the facility should at regular interval

creatively engage with the patients in an effort to present and promote certain programs and services. Community engagements need to involve health slots where services are presented in plain language and communities encouraged utilizing them.

5.6.2 Marketing of available structures

A similar approach must be employed when marketing clinic structures. The community needs to be made aware of support structures available for their assistance in any issue they may encounter. As much as it is important to the community to know all the services offered, it is equally important for them to be empowered with the information of how issues they encounter may be addressed for their benefit. There needs to be clear communication in all facility spaces of how complaints are handled and how to report incidences. The contact numbers of key regulatory structures need to be displayed at all patient reception areas including each consultation room as well as on patient clinic cards. This will enable patients to anonymously present all complaints without the fear of victimization or intimidation. Marketing of such structures may be done through print media of banners, posters and pamphlets, through radio stations and also by the committee and clinic management frequently addressing the patients and encouraging engagements between the facility and the public served.

5.6.3 Implementation and enforcement of consequence management

Consequence management includes measures to protect the public's health and safety, restore essential government services and provide relief to individuals affected by damage, loss, hardship or suffering (CIPemia, 2020). It is recommended that all facilities implement a management strategy that will address all the misconduct reports of the staff. Critical to consequence management strategy is the support that needs to be offered to the staff, to encourage ethical conduct when dealing with patients. The government has a constitutional mandate to strengthen the country's democracy by enabling oversight, accountability and governance in the public sector, thereby building public confidence. It is thus recommended that the facilities implement a consequence management system based on; the setting and communication of clear expectations in relation to how they conduct their

duties, proactive observations to be conducted by management to monitor adherence to the communicated expectations and finally the implementation of appropriate consequences for any conduct not within the scope of what was agreed up. This will create positive attitude among the staff towards their work. It will also create patient confidence in the health sector and encourage consistency in utilization of the facilities.

5.6.4 Improved communication

It is recommended that communication between the facility and patients be enriched which will inform the attitudes of patients whilst at the facility. Important information such as a temporary shortage of staff due to absences for various reasons, maintenance of infrastructure causing certain services to be unavailable or delayed, daily expected waiting time need to be communicated to the patients on a daily basis. This will keep the patient informed about momentary challenges encountered by the facility, hence appeals for patient patience will be more likely to be heeded.

Improvements in the manner in which staff communicate with patients must be encouraged. They nurses need to practice effective communications strategies which include the cognizance of one's body language, tone of voice, the words spoken and other factors which depict a means of communication to an individual. The nurses need to be friendlier to the patients, quick to listen and advise accordingly. All reasonable measures need to be taken to ensure the patients feel comfortable enough to present any challenges they might have encountered and strive to find a solution.

5.6.5 Improved resources and infrastructure

It is recommended that the state makes an effort to provide and maintain resources and infrastructure needed at the facilities for the benefit of the patients. The maintenance of equipment must be a priority, to ensure assets are kept in good working order and are therefore able to benefit the community. Budgetary adjustment need to be made in order to provide supplementation of resources, including appropriately qualified human resources when necessary. The regular training of health care professionals is an investment towards the improvement of human resource which stands to be

of great benefit to the patients.

5.7 Limitations

Certain limitations identified in the study are discussed below;

5.7.1 COVID 19 pandemic

This study was conducted during a period when the world was facing a health calamity. This affected this study as the data collected was most likely affected by certain thought and emotions which were heavily influenced by the pandemic. At a time where individuals lost friends and family members and were grappling to understand current health messages. The pandemic affected certain aspects of this study such as the data collection processes, which impacted on the strength of the quality of data collected.

5.7.2 Setting for interviews

The setting was found to be inappropriate having interferences. There were a lot of interruptions during interviews such as call waiting indicating calls attempting to come through, and the home environment of the respondent was often noisy and full of background sounds. Network connectivity also caused a challenge as the interviewer and interviewee were unable to hear each other.

5.7.3 Government perspective not presented

The study did not make provision for the government to present on the matter from its perspective, as well as share measure taken to improve health system, challenges encountered and planned quality improvement plans. The study was conducted solely with a patient centered approach.

5.7.4 Data collection timeframe

The timeframe for data collection was not sufficient. There was not enough time to fully explore the data collection tools possible for this study. Focus group discussions would have been an efficient tool which could have added much enrichment to the data.

5.8 Recommendations for further research

In the light of the limitations identified and the findings of this study, the following are recommended as future research subjects:

- Attitudes and lived experiences of health care professionals towards state provided health services.
- Can patients and health care professionals have a mutual benefit relationship?
- How communities protect government resources.
- Do treatment defaulters value their lives?
- The effectiveness of public health awareness campaigns
- The impacts of workshops on staff attitudes and behavior change.

5.9 Conclusion

This study on attitudes and lived experiences towards state provided health care services in the case of Inanda, KwaZulu Natal, found that the community of Inanda has negative attitudes towards state provided health services. The community has no trust in the public sector health system and do not believe the nurse perform their duties with their interests at heart. The majority of the community members would rather not use the public health facilities, but most are compelled to use them as they

are unable to afford private health cover.

The lived experiences encountered by the community at the public health facilities are substandard. The health care professionals regularly use abusive language towards the patients, often raising their voices as if to shout at them and causing embarrassment and shame. The health care professionals do not show respect towards the patients, often speaking in any manner to any individual, regardless of their age. These experiences have presented challenges to the patients oftentimes resulting in discontinuation in the utilization of the health facility. Those who do utilize the facilities despite these experiences have admittedly stated that it takes a lot of self-encouragement for them to honor their appointments, stating that they have contemplated quitting a number of times.

It is concluded that interventions need to be effected with regards to this phenomenon. Investigations into factors contributing to claims against health care professionals need to be conducted and remedying strategies put in place. Impacts of such conditions need to be mitigated at all costs in order to ensure free access to health services without intimidation. Empowerment and capacity building sessions need to be conducted with an aim of avoiding further resurgences in this behavior.

This study informs policy and practice as it provides a clear description of how the community views the public health sector. Much budgetary investments are made each year towards the improvement of healthcare to South Africans, however until the issues outlined in this study are addressed, progress towards the health system envisioned by the National Health Insurance will remain cripplingly slow.

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feedback studio Thabisile Khuboni Attitudes & experiences towards public health services

CHAPTER 1

1.1 Introduction

The ⁵⁴White Paper on the Transformation of Health System in South Africa, published by the South African Ministry of Health to Parliament in April 1997, presents to South Africans the objectives and principles which are the basis for the Unified National Health System. This Unified system is capable of delivering quality Health Care to the people of South Africa. The ¹⁰White Paper also presents implementation strategies which are designed to meet the basic health needs of all South Africans, given the available resources (Department of Health, 1997.)

The ⁹National Health Act 61 of 2003 is an act that seeks to shape the functions of the health system that is structured and uniform with the Republic of South Africa. The Act accomplishes the responsibilities imposed by the Constitution of South Africa, in Chapter 27 of the Constitution, stipulating that all South Africans have the right to quality health care, food, water and Social Security¹⁶ (South Africa, 2006.) The government is therefore mandated to take actions, that are in line with existing legislation and that seek to benefit citizens, considering the

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CHAPTER 1
Introduction
The White Paper on the Transformation of Health System in South Africa, published by the South African Government to Parliament in April 1997, presents to South Africans the objectives and principles which are the basis for the Unified National Health System. This Unified system is capable of delivering quality Health Care to the people of South Africa. The White Paper also presents implementation strategies which are designed to meet the basic health needs of all South Africans, given the available resources (Department of Health, 1997.)

The National Health Act 61 of 2003 is an act that seeks to shape the functions of the health system that is structured and uniform with the Republic of South Africa. The Act accomplishes the responsibilities imposed by the Constitution of South Africa, in Chapter 27 of the Constitution, stipulating that all South Africans have the right to quality health care, food, water and Social Security (South Africa, 2006.) The government is therefore mandated to take actions, that are in line with existing legislation and that seek to benefit citizens, considering the government resources that are available, to ensure these human rights are realized. (South Africa, 2006.)

One of the general functions of the Department of Health is the rendering of health services, and these include social, physical and mental health care to all citizens (South Africa, 2002.) South Africa offers free health care at its public health facilities; however the facilities often face the challenges of poor management, under staffing and inadequate infrastructure. This greatly affects the quality of health care available at these facilities (Karen, 2019.)

Despite the many attempts made by the government to ameliorate the quality of health services at the public institutions, in 2009 media communities reported that public health institutions were still unable to provide services that meet the needs of the patients. National Department of Health, 2012.) This has resulted in the loss of interest witnessed among patients utilizing the health care system (Zubane, 2011.) It also led to an evident decline in the willingness for the public to utilize state provided health services at the public health facilities. This study therefore

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Appendix 3
Gatekeeper's Letter:

03 September 2020

The Ward Councillor
Ward 44
Inanda

This letter serves to request permission for me to conduct a study in ward 44 Inanda.

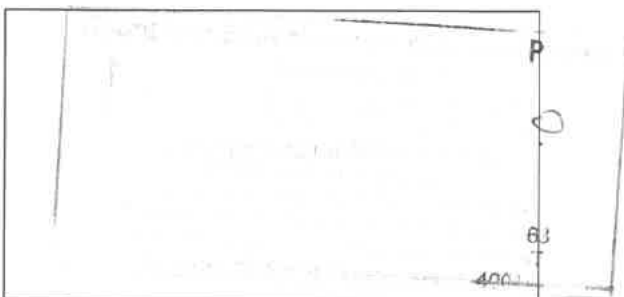
I Thabisile Goba hereby request permission to conduct a study in your ward. The topic of this study is Attitudes and Experiences towards state provided health services in the case of Inanda, KwaZulu Natal. The purpose of this study is to establish the attitudes that the community has regarding state provided health care. This study also seeks to explore how those attitudes affect the acceptance of the services by communities.

A set of 50 questionnaires will be randomly administered to the community with an aim of getting non narrative data regarding this topic. Over and above that 10 participants will be purposely selected and interviewed about their experiences at the state health facilities. The Respondent's participation in this study will be completely voluntary and they will not be put under any obligation to remain in this study. Should they wish to withdraw from participating in the study at any time you will be allowed to.

~~Participation will be confidential, and the respondent's identity will only be known by myself the researcher and my supervisor. Their identity will not be documented anywhere in the study or the findings and reports of the study.~~

A copy of the study findings will be made available to you at the end of the study..

Thank you



Questionnaire - Thabisile Goba (200201890)

Attitudes and experiences towards state provided health services

I BHEKOKWAKHE W PHEWA ward councillor for Ward 44 have considered your request, and **do / do not** (Circle appropriate) give my consent for you to undertake your study as per the request above.

1. Do you use public or private health services?
Mark only one oval.

For further clarification contact me on 079 328 5935

Signed.....

Date 03/09/2020

2. How far is your local clinic from your place of residence?

Councillor Bhekokwakhe Welcome hewa
Mark only one oval.
Ward No. 44

03/09/2020
Can Walk to the clinic

OFFICER IN CHARGE OF ADMINISTRATION OF OATHS
TRUSTEES MUNICIPALITY
EX OFFICIO DISTRICT OF DURBAN IN
TERMS OF SECTION 6 OF ACT 16 OF 19
(AS AMENDED) CITY HALL SECRETARIA
Dr Phelekezelle Mthethwa

3. Do you visit the clinic every time you have an ailment?

Mark only one oval.

- Yes
- No
- Maybe

4. When was the last time you visited your local clinic?

Mark only one oval.

- Less than a month ago
- 2 - 3 Months ago
- 3-5 months ago
- Other: _____

5. How do you feel about visiting your local clinic?

Mark only one oval.

- Happy - I visit the clinic each time i need to
- anguished - i try to avoid it as much as possible
- indifferent - it makes no difference whether i go or not.

6. How can you describe your most common experience at your local clinic?

Mark only one oval.

- worthwhile - I received the relevant and needed care and service.
- worthless - I did not receive the relevant and needed care and service.
- unsure of the service that was offered.

7. Was this the first time you experienced such a service, or you had a similar experience previously?

Mark only one oval.

- It was the first time I experienced such a service.
- It is not the first time I experienced such a service
- It is a common experience not only to myself but to others as well.

8. Does your local clinic have structures (eg. clinic committees) which assist with dealing with complaints/compliments?

Mark only one oval.

- yes
- no
- I do not know

9. Do those structures function effectively?

Mark only one oval.

- Yes
- No
- I do not know

10. Are those structures accessible?

Mark only one oval.

- Yes
- No
- I do not know

11. Have you ever utilised/contacted these structures

Mark only one oval.

- Yes
- No

12. Were you satisfied with the manner in which your matter was handled by these structures?

Mark only one oval.

- Yes
- No
- Maybe

13. How accessible is the clinic management to the public?

Mark only one oval.

- Accessible
- Not accessible
- Other:

14. Does your local clinic openly display important information and notices for the public to view

Mark only one oval.

- Yes
 No
 Maybe

15. How happy are you with the services available at your local clinic?

Mark only one oval.

- Happy
 Unhappy
 Indifferent
 Needs improvement

16. Do you have an alternative source where you can get medical attention?

Mark only one oval.

- Yes
 No

17. Is this alternate source readily available for you to use?

Mark only one oval.

- Yes
 No
 Maybe

18. would you recommend your local clinic to someone new in the area?

Mark only one oval.

- Yes
 No
 Maybe

19. How do you feel about the medication dispensed at your local clinic?

Mark only one oval.

- Effective
 Not effective
 I do not know
 i have never received any medication

20. How helpful is the staff at your local clinic?

Mark only one oval.

- Helpful
 Not helpful
 I do not know

21. How approachable is the staff at your local clinic?

Mark only one oval.

- Friendly and approachable
- not friendly and unapproachable
- I do not know

22. On a scale of 1 - 5 how would you rate the overall experience one can get from your local clinic

Mark only one oval.

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Google Forms

Thabisile Goba 200201890

Attitudes and lived experiences towards state provided health services in the case of Inanda, KwaZulu Natal,

**Appendix 1
Interview Guide**

Good day.

My name is Thabisile Goba, a master's student at the University of KwaZulu Natal. I would like to ask you some questions based on your overall experience when visiting public health facilities. May I kindly request that you provide me with as detailed a response as you can as that will assist me to understand your experience and how it made you feel.

Questions.

1. How far is the nearest health facility from your home?
2. Approximately how much do you spend when travelling to and from the health facility?
3. Can you list some of the services you know to be available and that you have access to at the health facility?
4. When was the last time you visited the health facility for some medical care?
5. What factors encourage or discourage you from visiting the health facility?
6. What was your experience at your last visit to the health facility; can you share it with me?
7. How did this experience make you feel?
8. Generally, how do you view services at state health institutions? Is this shaped by your experiences at the health institutions?
9. How has this and other similar experiences influenced any future visits you may need to make to the health facility.
10. How will the answer given above affect your overall health?
11. What are some of the attitudes held by your neighbours/friends/family/community members towards this health facility?
12. How can the services at the health facility be improved so the facility is more patient-friendly?
13. Is there anything else pertaining to your visits at the health facility that you would like to share with me?

Thank you for your time. Your responses have been very helpful and they have provided me with relevant information that I require for my study.

Thank you.

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Department of Chemistry
The University of Chicago

Department of Chemistry, The University of Chicago

The University of Chicago Library is pleased to announce the acquisition of a new copy of the book "The Principles of Chemistry" by Sir Isaac Newton. This book is a classic work in the field of chemistry and is highly recommended for students and researchers alike. The book is available in both print and digital formats. For more information, please contact the library at (773) 936-3100.

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UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL For research with human participants

INFORMED CONSENT RESOURCE TEMPLATE

Note to researchers: Notwithstanding the need for scientific and legal accuracy, every effort should be made to produce a consent document that is as linguistically clear and simple as possible, without omitting important details as outlined below. Certified translated versions will be required once the original version is approved.

There are specific circumstances where witnessed verbal consent might be acceptable, and circumstances where individual informed consent may be waived by HSSREC.

Information Sheet and Consent to Participate in Research

Date: 02 September 2020

Greeting: Dear Community Member

My name is Thabisile Peaceworth Goba from The University Of KwaZulu Natal, Howard College Campus - School of Built Environment and Development studies, cell phone no 0794841973 and email 200201890@stu.ukzn.ac.za or tkhuboni@gmail.com.

You are being invited to consider participating in a study that involves research on the attitudes and lived experiences towards state provided health services in Inanda. The aim and purpose of this research is to learn about the lived experiences of individuals using the public health system and also to establish the attitudes those lived experiences may affect on the individuals and finally to establish what influence those experiences and attitudes may pose on the individual's access to health services. The study is expected to enroll sixty (60) participants in total, 50 will complete and online questionnaire, while 10 will participate in telephonic interviews. All the participants will be from Inanda. It will involve the following procedures; the questionnaires will be sent through whatsapp, where the participants will select the correct answers and submit back to the researcher. After this process, the 10 individuals will be called at a time convenient to them and the interview will be conducted telephonically. The duration of your participation if you choose to enroll and remain in the study is expected to be two months.

The study may involve the following risks and/or discomforts as you may be asked questions pertaining to your experience at the health facilities and the emotions those experiences evoked. We hope that the study will create the following benefits; it will inform future policies and practice based on the community's personal experiences, which will assist in improving services at the health facilities.

This study does not bare potential to any perceived risk to the participant. However the participants will be protected by keeping their identity confidential and not disclosed to any person expect the supervisor.

In the event of any problems or concerns/questions you may contact the researcher at 0794841973 or 200201890@stu.ukzn.ac.za or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Participation in this research is voluntary and participants may withdraw participation at any point, should they feel unwilling to continue participating, and that in the event of refusal/withdrawal of participation the participants will not incur penalty or loss of treatment or other benefit to which they are normally entitled. Withdrawal from participating in this study has no potential consequences. The participant should just notify the researcher that they do not wish to continue with the study, the researcher will immediately terminate the participant from the study.

No costs will be incurred by participants as a result of participation in the study. No incentives or reimbursements will be given for participation in the study.

The identity of all the participants will be protected and not revealed to anyone except the researcher and the supervisor. The data will be stored in a lockable cabinet inside the supervisors office. It will be kept for a period of 5 years.

CONSENT (Edit as required)

I (Name) have been informed about the study entitled (provide details) by (provide name of researcher/fieldworker).

I understand the purpose and procedures of the study (add these again if appropriate).

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at (provide details).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Additional consent, where applicable

I hereby provide consent to:

Audio-record my interview / focus group discussion	YES / NO
Video-record my interview / focus group discussion	YES / NO
Use of my photographs for research purposes	YES / NO

Signature of Participant

Date

Signature of Witness
(Where applicable)

Date

Signature of Translator
(Where applicable)

Date



UNIVERSITY OF
KWAZULU-NATAL
INYVESI
YAKWAZULU-NATALI

Miss Thabisile Peaceworth Goba (200201890)
School Of Built Env & Dev Stud
Howard College

Dear Miss Thabisile Peaceworth Goba,

Protocol reference number: 00005942

Project title: Attitudes and lived experiences towards state provided health services in the case of Inanda, KwaZulu Natal.

Exemption from Ethics Review

In response to your application received on [redacted], your school has indicated that the protocol has been granted **EXEMPTION FROM ETHICS REVIEW**.

Any alteration/s to the exempted research protocol, e.g., Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through an amendment/modification prior to its implementation. The original exemption number must be cited.

For any changes that could result in potential risk, an ethics application including the proposed amendments must be submitted to the relevant UKZN Research Ethics Committee. The original exemption number must be cited.

In case you have further queries, please quote the above reference number.

PLEASE NOTE:

Research data should be securely stored in the discipline/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study

Yours sincerely,

[redacted signature]

Prof Ernest Nene Khalema
Academic Leader Research
School Of Built Env & Dev Stud

UKZN Research Ethics Office
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Website: <http://research.ukzn.ac.za/Research-Ethics/>

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