ACCESS TO HEALTH CARE FACILITIES DURING COVID-19: PROBING EXPERIENCES OF NTABENI A RURAL COMMUNITY IN PIETERMARITZBURG, KWAZULU-NATAL

by

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DEDICATION

This dissertation is dedicated to every young girl who has a dream to be educated and independent one day. I want to say it possible.

DECLARATION

I, Hloniphile Talent Ndlovu know that plagiarism is to use another's work and present it as my own, and that this is a criminal offence. This thesis does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers.

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ABSTRACT

Anthropologists have critically taken an interest in studying the political economy of health and healthcare of people especially in forgotten communities. This incorporates admittance to medical care offices and reception of medical care. While they concur that the South African public medical care framework has gone through key changes, they also agree that the implementation or the realization of such important policies have become fragmented, and exacerbated inequalities in relation to access to health care and related facilities. This happens at the heart of solid constitutional and legislative policy frameworks which are in place to guarantee the right to access to healthcare. These constitutional and legislative provisions of guaranteed health care access remain a panacea and, as a result, most poor people are still unable to enjoy this international human right to health care and health facilities. The unprecedented arrival of COVID-19 brought South African health inequalities to light as most people could not access medical health care and health facilities at the time of their need. *This qualitative study titled "Access to health care facilities during COVID-19: Probing the experiences of Ntabeni, a rural community in Pietermaritzburg, KZN",* draws on critical contributions of anthropology as a field of study and uses two theoretical frameworks, namely, social constructivism and access theory, as guidelines for the study. Data was collected from thirty (30) purposely sampled participants from the Ntabeni community. The recruitment included both males and females that were deemed fit to participate in the study as guided by ethical considerations of the study. Research findings revealed that the community of Ntabeni could not access health care during the COVID-19 lockdown levels 5 and 4 restrictions in South Africa, and this took a toll on their health. COVID-19 and lockdown regulations/restrictions exacerbated inequalities because poor community members of Ntabeni encountered barriers of affordability, accommodation, awareness, availability and accessibility of health care and facilities. Community members of Ntabeni felt excluded as human beings and as voters who were promised access to free medical health care. The study recommends that: the department of health should prioritize health and access to health care and facilities for the Ntabeni Community which is caged by poverty, unemployment and many health issues. These issues threaten the survival right of all human beings. Government should remove user fees at public hospitals to maximize access to health care and facilities for indigent people. The provision of a wellness or mobile clinic should be expedited as they will also accommodate those who cannot cater for their medical needs. This will make health services more accessible and affordable.

Future anthropological research is needed to understand the factors that inhibit communities from accessing universities and contributing to the high rate of unemployment. Other studies could potentially look at the impact of the Msunduzi Integrated Development Planning, which is supposed to positively impact the lives of the members of Ntabeni community in terms of their socio-economic needs.

Keywords: Access, Healthcare, Health facilities, Covid-19.

Table of Contents

CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 INTRODUCTION

Access to medical care and medical facilities in the Republic of South Africa is a Constitutional right (Act. No.108 of 1996). Section 27 of the Constitution provides for that everyone has the right to healthcare and medical services, including conceptive medical care, and no one may be denied emergency medical treatment. This Constitutional right remains a concern because of structural issues such as poor access, which is perpetuating poverty and inequality. This Constitutional commitment was meant to redress the legacy of Apartheid, which racially, geographically and economically excluded people from accessing health care and facilities. Remote rural areas are still experiencing such exclusion after 27 years of democracy and voting for decentralized service delivery including health care and health care facilities. McLaren et al (2013) agree that South Africa's politically sanctioned racial segregation history leaves huge racial inconsistencies in access to healthcare. Regardless of post-apartheid health strategy to expand the quantity of healthcare facilities access to healthcare is still divided based on race and status. McLaren et al (2013) further argues that, even when access to health services are free, poor people still incur financial and time related expenses that still affect their ability to utilize such free services. McGrail and Humphreys, (2009) also confirms that most communities are still not able to access government health services because of their geography and the distribution of health services. The long distances make it costly to access the nearest facilities resulting in many people not enjoying the provision of Section 27 of the South African Constitution.

McLaren et al (2014) stated that a lot of South Africans live within 7km of the closest open center, and 66% live under 2km away. In any case, 15% of Black African grown-ups live more than 5km from the closest facilities as opposed to 7% of coloreds and 4% of whites. There is a link between economic condition and proximity to public facilities. The most unfortunate will generally dwell farthest from the closest center, and the cost implications of accessing healthcare services has detrimental effects on their wellbeing. Examples abound of decrease in use of medical services

due to distance. This is a bigger factor for men than it is for women. Much has been done to review inconsistencies in South Africa since the end of apartheid. However, little progress has been seen in medical care access. This chapter offers the background to this study and outlines the research problem. It also discusses the significance, objectives, assumption and limitations of the study. The chapter further introduces the theoretical frameworks used in the research.

1.2 BACKGROUND AND OUTLINE OF THE RESEARCH PROBLEM

Nevhutalu (2016: 33) avers that access to health care facilities has historically been a human rights concern in South Africa. It was a socio-economic dilemma that racially excluded black communities during colonial times. It was exacerbated during the apartheid era and is still an unresolved human rights issue in the current democratic dispensation. Morris-Paxton et al. (2020) and Harris (2011) noted in their publications that rural and urban South Africans continue to face differing levels of access to health care and facilities daily. Grut et al. (2012) state that rural sectors are the least fortunate, most under-served and generally neglected.

The problem that prompted this study is that the Ntabeni community is defined by socio-economic conditions which have historically excluded them from benefiting from several service delivery, including access to health facilities and health care. The context of this research is healthcare access and COVID-19. The study's originality stems from the fact that COVID-19 has created more research opportunities as it exposed that the health care support system in South Africa has challenges.

The problem that this study investigated is validated by the Access to Health report (2018:2) which was commissioned by the South African Human Rights Commission. This report observed that South Africa stays an inconsistent society, where the quality and type of administration individuals receive in general will be determined altogether by their financial status and the capacity of relevant facilities, rather than the criticalness of their needs. Most South Africans rely on general health facilities in order to access medical care services. Most South Africans are trapped in poverty which makes private medical care unaffordable, leaving public health care as the only option. The General Household Survey Statistics report of South Africa (2016) declared that the health sector is responsible for providing healthcare services to 45 million people or 82 out of

every 100 people who cannot afford private medical care. This population is inclusive of people in rural and "forgotten communities" who are largely dependent on social grant to escape poverty. The Household survey (2012) also stated that Africans fall outside the medical aid net and are to a great extent reliant upon public medical care. The quantity of individuals who rely upon the public health systems in South Africa is probably going to be a lot higher in the coming years.
This problem has been historically confirmed by World Health Organization (WHO, 2010, 2014, 2021) reports, which agree that poor access to health care and being excluded from accessing health care and facilities continue to be the daily experience of most people in Southern Africa. The WHO (2021) report found it disturbing that most people, particularly, in rural communities are still excluded from accessing adequate health care. This has been the case during the COVID-19 pandemic. However, most people have been experiencing such exclusion long before the pandemic, due to their geographical location and the non-responsiveness of public health policies, coupled with the lack of good governance. As argued by WHO, elements of good governance should ensure that every person and community is granted uncompromised access to health care facilities without any socio-economic or geographic exclusion. The issue of admittance to medical care not just during the COVID-19 pandemic is a basic liberty enshrined in Section 27 of the South African Constitution (108 of 1996).

As indicated by McLeran et al. (2013), when health services are given for free, money and time related expenses of getting to nearby centers may still represent a huge obstacle for poor and vulnerable people, resulting in poor health care for the less fortunate. The least fortunate generally dwell farthest from the closest centers, and their inability to bear the costs of traveling to health facilities brings down the quality of medical care and access. Thomas et al. (2020) argues that while the condition of the South African health facilities and care has been questionable, the advent of the COVID-19 made it far worse because it revealed that health care facilities are not equipped to respond to the urgent health needs of the people. It also revealed that such facilities are short staffed, not accessible in terms of operational issues and their intensive care units are not ready to respond to societal emergencies. Okereke et al. (2020) implied in their examination that before the speedy blow-out of the Coronavirus pandemic, admittance to healthcare fluctuated as nations have diverse healthcare arrangements. Although a few nations have great existing health frameworks and open health systems, others have endured a few misfortunes.

A research study directed by Siedner et al. (2020: 1) argued that the World Health Organization acknowledged Coronavirus as a universal pandemic. This life-threatening global pandemic created a state of emergency that put many countries at a complete standstill. The delivery of services to people was rationalised under strict regulations, limiting free movement of people to destinations of their choice, thus, affecting their access to health facilities and care. This international call was announced by the World Health Organization supported by states to minimise the accelerated spread of the infection. This was crucial as countries witnessed and recorded daily fatalities because of overwhelmed health facilities and behaviours of people who did not believe that COVID-19 was infectious and deadly. The WHO (2020) defined COVID-19 as an epidemiological incident that revealed that most South African Health facilities were not equipped to respond to the diverse health needs of its people, despite claims by the African National Congress (ANC) that it has dignified health care and services in terms of care for the historically marginalised.

Cited in Maphumulo and Bhengu (2019: 2), Young (2016) contended that "general health facilities show various deficiencies like huge postponements, bad quality healthcare movement, old and structurally depleted, and vulnerable illnesses control, and avoidance rehearses". Kama (2017) cited in Maphumulo and Bhengu (2019: 3) aver that access to health by poor or the needy people has caught the attention of media houses. Media houses have recorded quite a number of difficulties that people have encountered when accessing health care and facilities in their times of need. The Sunday Tribune (08 March 2015:2) stated that there were many incidents of people dying due to distance from the public medical care facilities or as a result of being denied admittance to medical care services. The Department of Health in most parts of South Africa has faced court cases and the public protector for cases that have been reported by people who did not receive access to the health facility as well as health care at the time of their need. For example, the family of a 35-year-old woman faulted a tertiary emergency clinic staff in KwaZulu-Natal for her death after she was purportedly dismissed from the health care facility regardless of her being truly sick. The media house similarly uncovered the case of a 1-year-old child who passed away on his grandmother's back because they stayed far away from the medical and hospital services in one of the districts in Cape Town. Another episode involved a youngster who gave birth on the entryways of a health care facility since she was not allowed entry. Times LIVE (14 June 2018) reported concerns raised by specific people regarding the lack of staff in medical clinics that

prompts lethal deferrals in medical procedures. Work excess created setbacks for patients. For example, patients who were impacted by the absence of oncology specialists and equipment, and waiting list for surgery or diagnosis, also because of the lack of equipment. According to the report, the significant delays for medical mediation possibly led to unexpected problems and losses. In other words, the report declared public health facilities a "death-trap for the poor".

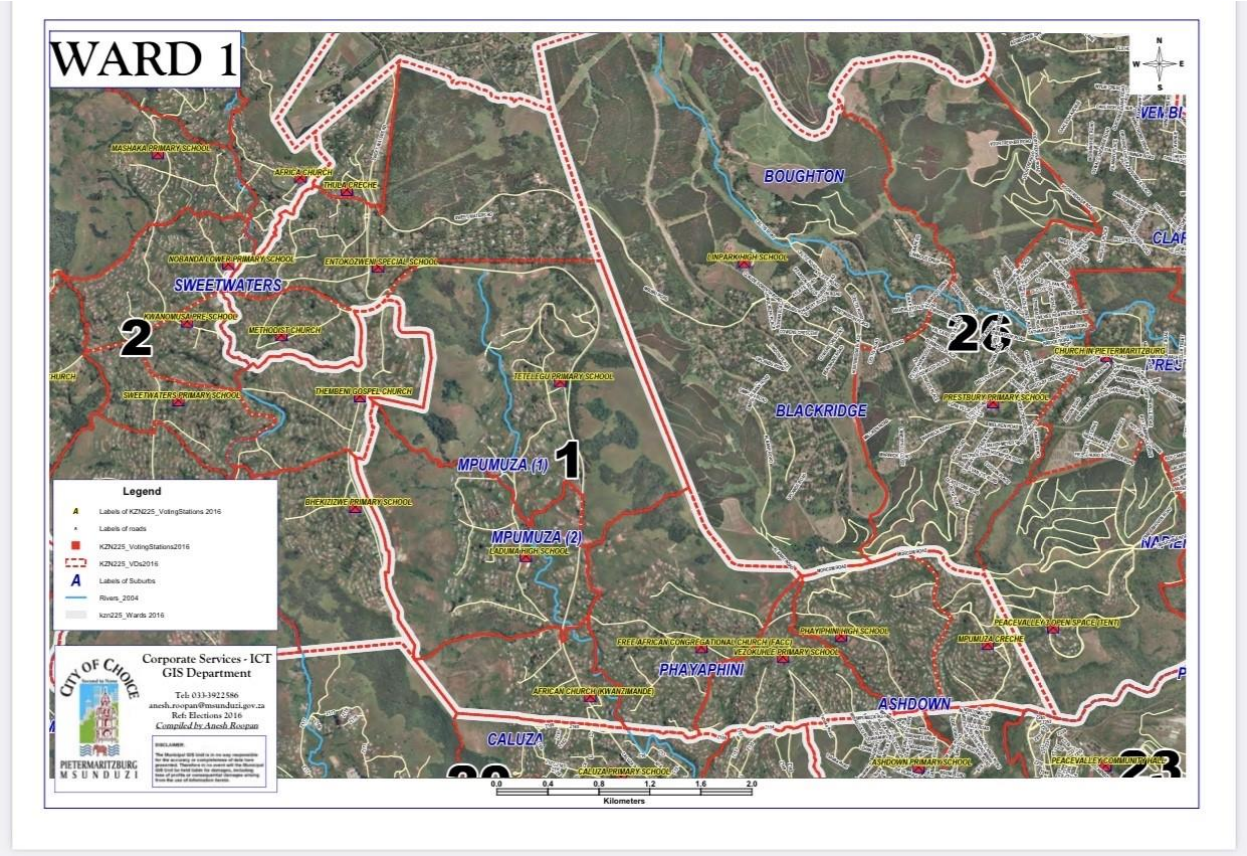
1.2.1 CONTINUITY OF SUCH STUDIES

In their publication titled "Inequities in access to health care in South Africa", Harris et al. (2011:103) concluded that future research should be steered towards understanding access barriers from the user perspective so that gathered experiences will be used to expand health-care disparities that are experienced by rural, low and middle-income countries. Marten et al, (2014) cited in Burger and Christian (2020: 43) assert that the South African medical care framework is distinctly split between the public and private sectors. This means that the nation is socio-economically partitioned. Most recipients of private medical services are wealthy, skilled, educated and individuals with medical aid, while the poor/low quintiles are beneficiaries of the public sector. It is important, therefore, to study their experiences in terms of access in order to accelerate the roll out of the National Health Insurance which advocates for equal provision, access and affordability including for rural communities. Burger and Mchenga (2021) supported the continuation of these studies by first confirming that South Africa is one the mostly racially and economically unequal countries in the world, mainly because of its history of apartheid and because of corruption and the mismanagement of state resources. It is important to conduct empirical studies in order to record the experiences of the marginalized, the vulnerable and the poor who suffer the brunt of not being able to access health care, health facilities and could not afford to pay for private services, which the elite enjoyed during the COVID-19 pandemic. Burger and Mchenga (2021) further stated that it is therefore pertinent to examine the extent to which the COVID-19 pandemic has affected these groups disproportionately. The health system mirrors existing inequalities, which are marked by deep divides and polarization following fractures in the social landscape". Mbunge (2020) asserts that it is important to collect experiences related to the COVID-19 in South African mostly on rural communities because they had limited access to medical care, did not have transportation as a result of hard-lockdowns, experienced death in their families, anxiety, acute panic, poverty, and sigma associated with positive test results.

1.3 RESEARCH SITE

This study was conducted in a rural, informal settlement/community called Ntabeni, Pietermaritzburg. This is a poverty-stricken area, occupied without any municipal permission. This the result of the delays in the redistribution of land which has dragged on in South Africa for years. This community area falls out of the Municipality Demarcations Act (27 of 1998). Ntabeni remains inadequately resourced and needs basic health services. Ntabeni, in the same way as other rural areas in South Africa has a major problem of limited and dysfunctional health facilities. This settlement (Ntabeni) is served by four essential medical care centers that are about 30 kilometers from one another. For genuine medical issues, individuals typically travel to Edendale, Grays or Northdale hospitals where there are general health services. Getting to these healthcare services centers is costly because of the cost of transport fares.

FIGURE 1: MAP OF THE NTABENI RESEARCH AREA:



1.4 THE SOCIO-ECONOMIC PROFILE OF NTABENI

Ntabeni community is an informal settlement that is situated at MPUMUZA. It is a very poor area. It has a high rate of HIV especially because the community is not educated about HIV. They do not seem to use protections that are meant to protect individuals from HIV. This is a major problem as they keep spreading the disease by being sexually active with one another, and because they are a small community, they change partners amongst themselves, which increases the rate at which HIV is spread. Alcohol and drug abuse among teenagers are also prevalent, which sets a bad precedence for younger people. The level of alcohol use in the community is unacceptable. Young people do not use their time productively but spend most of it in taverns and drinking their futures away. The abuse of alcohol and other substances also contributes to many recurring incidences of prolonged violence and gang wars that last up to a month or more and leads to the loss of many lives. There is also a concerning level of gender-based violence linked to alcohol abuse, as drunk men return home and abuse their wives and girlfriends physically and emotionally.

The birth rate and teenage pregnancy in the Ntabeni community is very high. One finds that an individual who does not work has 5 to 6 children. They continuously reproduce without any source of income. They also do not give their children the required attention. Children can be found with lice and scales because they have not bathed for a long time. The children are underweight, meaning they are not well fed. New and breastfeeding mothers are sometimes found drinking and smoking at the risk of theirs and their newborn's health. Furthermore, the whole community's health is poor. This is mainly because of the abuse of alcohol and drugs. This is an informal settlement, there are no clinics or libraries nearby. There are no fun activities for the youth to spend time on. There are no sports centers, such as netball courts where girls can go and play netball, or soccer grounds where boys can go and play soccer. There is no community hall where young people can go engage in productive activities, such as religious or other activities that could improve their lives. As a result, they are drawn to alcohol and drugs, unprotected sexual activities. The community is also marred by high level of school dropout resulting in high unemployment rates.

1.5. DELIMITATION OF THE STUDY

Miles and Scott (2017) define the delimitations of a study as an indispensable piece of the research plan since they indicate stopping points. They let the reader know what is included and excluded in a study and why. The community of Ntabeni is the focus of the study, thus, the research findings will not be generalized as the experience of all communities in Pietermaritzburg, South Africa but only as that of the community under study. Data collection only purposively sampled community members from this community not from neighboring communities. This study is also limited to the COVID-19 level 5-4 lockdown period in South Africa and does not include any other lockdown levels periods.

1.6 ASSUMPTIONS OF THE STUDY

The assumption that this study has made is that the Ntabeni Community is a vulnerable community in terms of its geography because residents are often reminded that they invaded the land that they should have occupied in terms of the Municipality Demarcations Act (27 of 1998). Informal settlements and inner-city 'slum' buildings often experience inadequate provision of services. Those living in casual settlements experience insufficient lodging, need admittance to fundamental services for their upkeep. They frequently face dangers of expulsions among other service delivery challenges. In fact, they are characterised by poor living conditions as well as social and economic exclusion and this is a critical challenge that is facing South Africa. Weimann and Oni (2019:3) highlighted in their research findings that informal settlements in South Africa are by and large characterized as areas containing unregulated and impromptu abodes where occupants need secure residency and subsequently need admittance to satisfactory essential services before government mediations. Khan et al (2012) sited in Buthelezi (2019:9) note that the helpless populace faces a greater number of obstructions to medical care access than the rich populace. There is also an imbalance in the entrance of medical care benefits, the poor are eclipsed by the rich and their health is not focused upon. People that live in informal settlements often have a compromised health, and their life expectancy is threatened by poverty, unemployment, inaccessibility of health care systems and distances between them and health establishments. Their socio-economic profile falls below the poverty line as most of them are unemployed and depend on social grants. It is, therefore,

important to ask “forgotten communities” like Ntabeni Community to narrate how they accessed healthcare services/systems/establishments during the COVID-19 pandemic.

The World Health Organization’s (2011) report cited in Weimann and Oni (2019:6) observed that informal settlements are often susceptible/vulnerable to ill-health conditions as a result of spatial development, which is inappropriate. See the following table depicting structural, geographical and health conditions of informal settlements.

TABLE 1: A TABLE DEPICTING STRUCTURAL, GEOGRAPHICAL AND HEALTH CONDITIONS OF INFORMAL SETTLEMENTS.

	Characteristic	Sub-Characteristic	Possible Outcome	Associated Health Condition
House	House size/space			
		Crowding	Exposure to infection	Tuberculosis (TB)
			Socio-emotional vulnerability	Mental health
			Lack of living space	Injury, burns
	Structure			
		Noise	Affects sleep and concentration	Mental health; irritability
		Damp/leaks	Mould	Respiratory illness e.g., asthma
		Ventilation	Exposure to infection	TB
	Inadequate onsite services	Waste	Pests (pesticides), pathogens	Bites, skin conditions
		Sources of energy	Indoor pollution	Exposure to carcinogens
			Illegal electricity connections	Injury, burns
Home	Living environment	Crowding	Socio-emotional vulnerability	Mental health
	Socioeconomic status			
		Dissatisfaction/frustration	Mental wellbeing, substance abuse e.g., alcohol	Mental health e.g., depression, stress; violence
Neighbourhood	Environmental	Poor site location	Environmental risk e.g., flooding, exposure to heavy metals	Mental health; exposure to carcinogens
		Density of houses	Fires; exposure to infection	Burns, injury, infectious diseases
	Services	Access to facilities	Limited access to healthcare	HIV, TB, HIV/TB coinfection
	Inadequate infrastructure			
		Lack of water	Storage of water	Infectious diseases
		Lack of sanitation	Use of other means, e.g., bush	Gender violence, crime
		Lack of drainage	Contaminated water	Infectious diseases
Community	Social networks	Social stressors	Gender inequality	HIV risk; interpersonal violence
			Frustration	Crime, substance abuse

Parikh et al. (2020:1) concluded that South Africa has approximately 2.2. million informal settlements which account for 13% of all families. Given the nature of land tenure arrangements and high mobility of residents in those settings it is likely that the number could potentially be significantly higher. Urban migration, access to health, social and economic opportunities and poverty are major causes of informal settlements, as dwellers cannot afford access to formal housing schemes. Informal settlements in South Africa are characterised by inequalities in access to services such as health, energy, water and sanitation.

Chowdhury and Koike (2009: 6) argues that as a result of poverty, unemployment, inaccessibility of health care systems, facilities/establishments, many rural communities have relied on ethnomedicine in order to respond to their health issues but there are those that still need bio-medical remedies. Ishtiaq et al. (2021:2) states that plants have been a crucial part of human existence since human beings began to rely on plants for necessities like food, grain, fuel, medication, sanctuary and so forth. In various parts of the world, especially in rural areas or casual settlements/regions, therapeutic plants have been used to treat different illnesses and plagues. Zank and Hanazaki (2017: 1) concur that therapeutic plants are likely to treat less difficult medical issues that do not need medical care, such as gastrointestinal issues, general pain, flues and colds. Kumar et al. (2021: 2) argues that across the world, individuals depend on conventional neighbourhood information on therapeutic plants for essential medical services. The utilization of plant species as conventional medications gives a decent option to medical care systems. These medical plants are every now and again detailed as protected, modest and effectively accessible from the environmental factors. Cited from Rakotoarivelo et al. (2015:2) the World Health Organization (WHO) revealed that an expected 80% of the populace in emerging nations rely upon customarily involved medicinal plants for their essential medical care.

1.7 THE SIGNIFICANCE OF THE RESEARCH STUDY

The purpose and significance of this study is to investigate the issue of access to healthcare during the COVID-19 pandemic, by probing the experiences of the destitute population in Ntabeni. The findings of this study will provide insight, explanations, and possible solutions to access to healthcare challenges and vulnerabilities experienced by the Ntabeni community. The study will

also show the inequality that is still present between different races and rural communities. There are still the very poor and extremely rich. The gap between the rich and the poor is still wide.

1.8 THE RELEVANCE OF THIS STUDY TO ANTHROPOLOGY

This study is focused on the anthropological collection of experiences of rural communities about access to health care facilities during the COVID-19 pandemic. This study located itself in medical and social anthropology which allows anthropology researchers to research health issues of people including the extent to which they have access to medical care and health facilities. Panter-Brick and Eggerman (2017) confirm that studies of health access and health care are anthropologically relevant. They first provide that the discipline of medical and social anthropology draws upon anthropological theoretical approaches that focus on recording people's health experiences. Medical and social anthropology profoundly adds and widens information about medical problems and health admittance to encourage worldwide discussions and similar examination of human life, wellbeing, health and structures that would enable or hinder people from accessing urgent medical attention when they need them. Medical and social human studies sit at the intersection of the humanities, sociology and natural sciences, attempting to change our appreciation of "what has an effect" on people's health and success. Bienhl and Petryna (2013) and Farmer et al. (2013) demonstrated in their examinations that medical anthropology characterizes itself as offering a group focused perspective on the world regarding health and access matters. Panter-Brick and Eggerman (2017) further affirm that medical anthropology embraces far-reaching interests. research directed by anthropologists produce top to bottom information about how individuals access health and achieve health related choices. It additionally gives a multifaceted, authentic, and improvement of focal point on health about individuals and their social orders.

Anthropologists have critically taken interest in studying the political economy of health and medical care and this incorporates admittance to medical services centres. Anthropologists have been generally dedicated in extending the extent of anthropological enquiry (managing incalculable issues connected with explicit illnesses, suffering, health of minorities, conceptive and sexual wellbeing, organ exchange, health system guideline and administration and bio-coherence), and they have been fruitful in doing so through multi-sited ethnography and interdisciplinary exploration. Ji and Cheng (2021:2) argues that anthropologist see that inequality

becomes one of the most basic hindrances to working on worldwide health, which is something beyond a biological, issue hence anthropologists have applied a holism principle in their health-related research which has contributed critical insights.

These two interrelated fields in anthropology allowed the researcher to understand how the Ntabeni community, which shared a lot of vulnerability in term of their socio-economic index and health related challenges, accessed health care, facilities/establishment during the COVID-19 pandemic, which threatened life expectancy due to the daily mortality rates. These anthropological fields will allow the researcher to translate the responsiveness of policies and treaties that enshrine access to medical care as the basic human rights that should not be limited by one's socio-economic status. Nasiripour and Mahmond (2011) depicted the taxonomy also known as dimensions of access to healthcare should be an uncompromised basic human right as enshrined by many policies and related commitments. Through these two fields, anthropology as a subject as well as a scientific research calling will be seen telling the story of Ntabeni at the time that is most critical in the entire world. The contribution of anthropology as a field of social science and research is supported by Sapkota (2020: 39) who noted that "Coronavirus has become frightening pandemic and tainted individuals in a disturbing rate. Doing research and practices and its effects on human existence is one of the main issues in anthropological concern." Max and Emma (2020) cited in Sapkota (2020) alluded that COVID-19 has led community members towards inequality as they could not access services which became expensive during this unprecedent time. Coronavirus has become an unnerving pandemic affecting individuals' ways of life. People from poor socio-economic background were most likely to contact coronavirus and die from it. Poor families are further to be expected likely to live in crowded housing, live in poverty, and lack access to health care (Derek:2020 cited in Sapkota (2020: 41". Research findings which will be discussed in the last chapter of this thesis will prove that anthropology is the study of man across time and space.

1.9 RESEARCH OBJECTIVES

The study's primary objective is to investigate how the Ntabeni community experienced or accessed healthcare facilities during the COVID-19 pandemic.

SECONDARY OBJECTIVES OF THE STUDY

- To collect data on the persisting health issues affecting most people in Ntabeni Community
- To record factors that permitted or restricted access to healthcare facilities during the COVID-19 lockdown levels in South Africa.
- To understand how community members responded to restricted access to healthcare facilities in the community.
- To probe whether they travelled to other nearby communities to access health facilities and healthcare or opted for ethnomedicine.
- To record solutions that community members proposed for improving healthcare access.

1.10 RESEARCH QUESTION

PRIMARY QUESTION OF THE STUDY

- How did the Ntabeni community experienced or accessed healthcare facilities during the COVID-19 lockdown levels in South Africa?

SECONDARY QUESTIONS OF THE STUDY

- What were/ are persisting health issues affecting most people of the Ntabeni Community?
- What are the factors that permitted or restricted access to healthcare facilities during the COVID-19?
- How did the community respond to the restricted access to healthcare facilities in the community?
- Did the community access health facilities and healthcare, did they travel to nearby communities or opt for ethnomedicine?
- What solutions can be recommended to improve healthcare access for the community?

1.11 DEFINITION OF KEY WORDS

- **Rural communities**: According to Summer (1986) rural communities are geographic areas that are situated outside towns and urban societies.

- **Access to quality health care:** The World Health Organization (2010) explains access to quality health care as a basic human right that is central to citizens' wellbeing, life expectancy and is inclusive of social protection.
- **Access to health care:** Donabedian (1972) characterized admittance to medical services as the use of administrations and recognized inception, or first use, and continuation, that is, the resulting utilization of medical services. Covid-19 level restrictions: Writers, for example, Garcia et al (2021) characterize Coronavirus limitations as law or decisions that oversee the development of individuals and the usefulness of all construction and associations.
- **Access to health facilities:** Access to health facilities implies having the opportunity to have and utilize medical services (Vitacare, 2021). A decent perspective about access is as far as affordability, accessibility, and acceptability.

- **COVID-19:** Sapkota (2020: 40) defines Coronavirus disease (Coronavirus) as a transferable sickness communicated between individuals in a mathematical web structure proportion. It is an irresistible infection brought about by a recently discovered Covid. A huge number of people who got infected were experiencing mild to direct indications and recovered without unique treatment. The virus that causes COVID-19 is fundamentally sent through droplets created when a contaminated individual cough, sniffles, sneeze or breathes out. These droplets are too weighty to even consider lingering in the air, and right away fall on floors or surfaces. One can be infected when exposed to infected persons or surfaces, with the mouth, nose and eyes being the easiest entry points of the infection into the body.

1.12 INTRODUCTION OF THEORETICAL FRAMEWORK AND RESEARCH DESIGN

Founders of anthropology recognized the importance of theoretical frameworks for their research to avoid bias and to strive for the rigor of research findings. This study utilizes the social constructivism theory and access theory. These two theoretical frameworks contributed to the wording of research objectives and questions. As the principal investigator of the research, I relied on these theoretical frameworks to generate themes for analysis.

Qualitative research is considered applicable to this proposed study. Mohajan (2018) notes that qualitative researchers are keen on individuals' experiences and subjective points of view. Zohrabi (2013) declares that subjective exploration is a kind of friendly action that enables people to reveal and share their experiences, in order to understand the social reality of individuals. Anthropologists conduct qualitative research to explore societal and humanistic issues. They solicit qualitative data by asking why and how questions from the participants. The interpretive paradigm is methodological applicable to the study because the research design is qualitative.

Sampling technique: Purposive sampling was used to recruit between 30 to 50 research participants for this study. The choice of a sample size of 30 to 50 research participants was a precautious decision to limit exposing myself to COVID-19 through engaging in longitudinal ethnographic research on a larger sample. **The inclusive criterion** was that the sample was limited to the people of Ntabeni Community. **The exclusion criterion was** that people living outside of Ntabeni could not participate in the study**.** The purposive sampling enabled an equal representation of people who are members of the Ntabeni community.

Data collection: qualitative unstructured and in-depth, face-to-face interviewsinterviews were used to collect data. This data collection method is allowed in anthropological and qualitative research because they elicit people's experiences and allow the researcher to be inductive on the subject by probing for clarity on given narratives. The collected data were not tape-recorded, but I, as the principal investigator, took the responsibility to record them on the data collection instrument.

Data collection plenary and ethical considerations: Conducting research during COVID-19 requires strict ethical and health considerations. All major ethical considerations as well as COVID-19 protocols outlined by the university as well as the department of health were followed thoroughly. Research participants were recruited with respect and dignity. During data collection, the principal investigator produced ethical clearance, gatekeeper clearance and took research participants through their rights as listed in the endorsed consent form. Those who could sign were

asked to sign their consent forms, while an 'X' was written for those who could not sign due to literacy challenges. I sought permission to consent for them on their behalf.

Data analysis: Thematic analysis was used in this study. All processes involved in thematic analysis would be discussed in the methodology chapter. **Psychosocial consideration**: This study invoked emotions because access to health care and facilities was studied as a critical variable in the study however research participants were assured that should they need any counselling, I was ready to arrange debriefing sessions through the student support division of the university because it has professionals' psychologists. While provision of professional counselling was promised to all research participants, this study thus report that research participants were not in distress during data collection hence no one that was admitted to the psychological support division.

1.13 STRUCTURE OF DISSERTATION

The dissertation is structured into six chapters:

Chapter One: This chapter were cover the introduction**,** background to the study, statement of the problem, the purpose of the study, research objectives and research question, the significance of the study. This chapter also highlights the delimitation and limitation of the study and the assumptions of the study.

Chapter Two: This chapter is the literature review of the study.

Chapter Three: This chapter will delineate the contribution of theoretical frameworks in the study.

Chapter Four: This chapter discussed research methodology covering; research design, target population, and sampling procedure discussed in detail based on studies conducted.

Chapter Five: This chapter discusses data analysis, presentation, and interpretation of findings based **o**n the information gathered from the informants through a qualitative study.

Chapter Six: This chapter were cover the summary of findings, discussions of the findings, conclusions and recommendations based on the finding of the qualitative study. It will also provide suggestions for further studies similar or even the same as this study.

1.14 CHAPTER CONCLUSION

This chapter outlined the issues in medical services in South Africa. It also described the study location and justified the focus on the experience of Ntabeni in accessing medical care during Coronavirus level 5-4 lockdown. Moreover, it outlines the research questions and objectives, as well as the delimitation of the study, amongst other things.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

As argued by Morris-Paxton (2020) access to health as characterized in the World Health Report of 2010 implies that all individuals, irrespective of where they live, have sufficient and dependable right to medical care. Equal and fair access to healthcare stays a panacea on the grounds that regardless of expanded urbanization, 38% or a greater amount of South African populace dwells in the provincial area of the nation and they are not impacted by the roll of positive medical services. Proficient medical care services are concentrated in the urban areas. This results in a severe imbalance between urban and rural services. Neely and Ponshunmugan (2019) agree that South Africa's health care system reflects broader disparities which mostly affect rural communities. This a resulted of South Africa's economy and neoliberal policies which has divided the society into the haves and the have-nots. The South African democratic dispensation has not closed this service delivery gap with a bitter apartheid history. The haves have access to good health because they can afford it while the have-nots face many access challenges because of stagnant poverty and inequality. Even though government seems to be trying but the current state of access and equity proves government to be inadequate in realising the provisions of Section 27, which is the Constitutional right for all South Africans both rural and urban communities. This chapter reviews the literature and critical debates which are relevant to the study.

2.2. THE PURPOSE OF A LITERATURE REVIEW

A literature review is a piece of academic writing demonstrating knowledge and understanding of the academic literature on a specific topic placed in context. A literature review establishes familiarity with and understanding of current research in a particular field before carrying out a new investigation (Machi and McEvoy, 2008). Conducting a literature review requires an assessment of coverage, strengths and limitations of literature. In a literature review, it is good practice to summaries and analyses previous research and theories; identify areas of controversy and contested claims; highlight any gaps that may exist in research to date.

2.3 ANALYSIS OF POLICIES REGULATING ACCESS TO HEALTH CARE AND FACILITIES IN SOUTH AFRICA

2.3.1 THE 1948 UNIVERSAL DECLARATION OF HUMAN RIGHTS

The provisions of the universal declaration of human rights elucidate that the right to health is a human right and human dignity. The provision or the acceleration of health to people as both human rights and a due dignity is not influenced by age, gender, socio-economic or ethnic background because health is our most basic and essential assets. Heads of States committed to this international treaty under the mandate of ensuring equitable access to health care and facilities/establishments and to redress injustices that excluded others because of race, religion, political affiliation, gender, geography and socio-economic index. This universal declaration is translated into domestic legislations and policies. Hence, South Africa has participated in the Millennium Development Goals and further committed to the National Development Plan vision 2030 which is also advancing the National Health Insurance. The 1948 Universal Declaration of Human Rights additionally referenced health as a component of the right to a satisfactory way of life (craftsmanship. 25). The right to health was again perceived as a basic freedom in the 1966 International Covenant on Economic, Social and Cultural Rights, in homegrown regulation and approaches, and at worldwide gatherings. Despite our age, orientation, financial or ethnic foundation, we believe our health to be our generally fundamental and fundamental resource.

2.3.2 SECTION 27 OF THE SOUTH AFRICAN CONSTITUTION (NO. 108 OF 1996)

The South African Constitution remains the supreme law of the country, and it also serves as a protective measure for all South Africans. Section 27 of the Constitution provides that the State should respect, guarantee, advance and fulfill the opportunities treasured in the Bill of Rights, which consolidates that human have the right to access to healthcare. The Constitution further provides that the State ought to take reasonable measures, within the limits of its resources, to achieve the steadily developing of the rights to have access to health care services, including reproductive health care. The Department of Health, alongside the provincial department of health have the commitment to provide healthcare services to the country. In order to ease of access and reduce demands on hospitals, clinics at local level are to provide immediate/urgent basic health

care services. Clinics are to refer appropriate cases to hospitals assigned to receive patients from particular areas. These hospitals in turn are to refer complex matters to larger designated hospitals which are equipped to deliver certain expert services.

2.3.3 POLICY ON THE QUALITY IN HEALTH CARE FOR SOUTH AFRICA (2007)

The South African legislated policy on quality in health care (2007) was enacted and endorsed to improve the state of equitable access to health care and facilities to all South African citizens. The situational analysis that informed this policy revealed that, the public health area was engulfed in various challenges that undermined equitable access to healthcare. Some of these include under-utilization or overuse of services, system issues, varieties in services, absence of assets, lack of resources and treatment, insufficient utilization of assets, lack of proper record and documentation, deficient referral system, disrespectful staff, insufficiencies of medicine/drugs, as well as poor healthcare delivery systems. These factors were listed as shortcomings that endanger the health and lives of all people who may want to access health care and facilities. They also add expenses for the medical care framework and lessen efficiency. To accomplish its much-needed change and dignified health care service, government committed to partner with all stakeholders and health care professionals to accelerate this policy implementation. Citizens, irrespective of their race, geography or socio-economic index were identified as direct beneficiaries of equitable health care. This commitment was to be realized by all spheres of government. What is most critical to note is that the commitment was within the scope of good governance which is the objective of the democratic dispensation. Equitable access meant guaranteeing that the entire populace approaches quality medical care. This implies tending to the lopsided appropriation of medical service assets of the nation, just as the wide variety in care all through the medical services framework. The call was to focus on the vulnerable members of society, such as, women, children, old people, people with disabilities and those with other underlying health issues.

2.3.4 THE NATIONAL HEALTH ACT 13 OF 2021 AND ACCESS TO EMERGENCY MEDICAL TREATMENT

This Act gives impact and content to the right to access medical care services as accommodated in the Constitution. The Act traces the laws that oversee public, common and local government concerning the arrangement of health services in South Africa through all circles of administration.

The Act also recognizes and create responsibilities in terms of the provision of medical treatment in cases of medical emergencies. Corresponding to Access to Health Care Emergency medical therapy, the Constitution and the National Act stipulates that no one may be dismissed or rejected for any emergency medical treatment and access by any healthcare provider, healthcare work or health establishment. The rules of public and private facilities do not apply in respect to access to emergency medical treatment. Access also includes being able to access health facilities as a walk-in patient or having access to the ambulance system in case of emergencies.

2.3.5 THE SOUTH AFRICAN NATIONAL DEVELOPMENT PLAN VISION 2030

This vision is a responsive agenda to the performance of South Africa's health system which has proven to be poor since 1994 despite good policies and relatively high spending as a proportion of Gross Domestic Products (GDP). Service is uneven between the public and private areas. The preamble of the agenda explains that it is a democratic as well as policy concern that 8.3 million people from rural communities are not able to access health care and medical facilities/establishment because of many factors that are impeding elements of good governance, the South African Constitution and other domestic policies and acts. The inability to get fundamental health services and local health system to work successfully has contributed to the failure of the health framework. The NDP vision 2030 Agenda is thus enacted to broaden the scope of accelerated access to health care facilities.

2.3.6 THE TAXONOMY OF ACCESS TO HEALTHCARE SYSTEMS

Nasiripour and Mahmondi (2011: 5-6) assert that the taxonomy of access to healthcare systems should be understood as follows. Buthelezi (2019: iv) aver that the dimension of accessibility is important when it comes to accessing health facilities.

1. **Availability:** implies that a healthcare service or product should be accessible and available continuously in the healthcare system. This means that medical services should be available in the required time and place. It should consider the suitability or unsuitability of health services in an appropriate place and time including all factors related to specific services given to patients and the distance of medical centres, which is an access index. It should be easily measurable.

2. **Accessibility:** implies that the accessible healthcare system should deliver quality medical care services or items which are accessible in terms of distance or transportation requirements.
3. **Timelines/accommodation** suggests that a medical care administration or products ought to be open, accessible or reachable with the expeditiousness fitting the patient's necessities.
4. **Adequacy**: infers that a medical care administration or item is applicable and meets partners (patient, specialist or others) expectations.
5. **Affordability:** mans that accessing medical care is not too much of a financial burden on the patient and is consistent with patient's monetary assets.
6. **Appropriateness:** refers to a medical care administration or item that does not ignore the social or other individual attributes of a patient.

2.4 HEALTH ACCESS FROM THE VIEWPOINT OF THE WORLD HEALTH ORGANIZATION AND OTHER SCHOLARS:

The WHO (2010) states that there is a close connection between neediness, weakness, illness and restrictions in access to health services. Health is one of the central basic rights of everyone, and a vigorous and available health system is vital to satisfy this right. Malakoane et al. (2020) state that access to health care facilities and care implies that government and other stakeholders should ensure that public policies concerning public health are implemented to ensure that citizen and voters are granted access to medical care and support as and when they need it. Access to healthcare facilities implies that previously marginalised rural communities have access to healthcare without struggling for access and uncompromised care. Their research findings revealed that access to healthcare facilities is also hindered by the administrative processes that delay people from receiving treatments for health issues that are affecting them. For example, patients having to book for three months to see the doctor. Such waiting periods imply delayed access, which has detrimental effects on the lives of people who need urgent health access and care. Booysen (2003 and 2010) states that disparities in healthcare and access present a major obstacle in realizing human rights and international conventions that support the call for access to uncompromised healthcare by people as ordinary citizens and electorates.

Booysen (2003 and 2010) further stated that South Africa as a signatory in the Universal Declaration of Human Rights (segment 25), the United Nations Covenant on Economic, Social and Cultural Rights (segment 12) and the African Charter on Human and People (area 16) has not gained huge headway in guaranteeing that rural community networks have positive access to healthcare facilities like those in urban communities. Okeng Ebi (2016:5) asserts that the right to access to medical care services is revered in Section 27 of the South African Constitution as one of the financial privileges secured by this Constitution. He further acknowledged that while the African National Congress government has prioritised these rights since 1994, evidence on the ground proves that South Africans have not celebrated access to health facilities amid legislations, policies and programmes that have been endorsed to realise this right. Okeng Ebi (2016:6) further observes that the Economic and Social Rights by the South African Human Rights Commission and the seventh report of the Studies in Poverty and Inequality Institution (SPII), revealed that most South Africans dwelling in rural areas have not benefited from this constitutional right. Research findings also revealed that the means to realising these constitutional rights have been affected by geographical areas, lack of skilled personnel (doctors), especially in rural communities, and not having enough medicine in such facilities.

Malakoane et al, (2020:3) observes that since the emergence of popular government (democracy), the South African government has been putting sanctions, approaches, methodologies, and plans to reinforce general health framework execution and improve service delivery. Nonetheless, access to health facilities and medical services has stayed poor. At the same time, South Africans face a burden of life-threatening/infectious diseases and hereditary illnesses that need free and robust access to government health facilities. Issues of poor access or compromised access to healthcare or health facilities imply a policy disaster and a lack of accountability on the part of government to accelerate the rights to health and care. Malakoane et al. (2020) argued that it is disturbing that several health facilities in South Africa are still not defending the mortality rates of people. The status of urban health facilities that can promote longevity shows that inequality also contributes to the number of mortality cases recorded in most rural communities due to lack of access and emergency care at their local health facilities. This anthropological study investigated experiences associated with access to healthcare facilities during the COVID-19 by the members of the Ntabeni

community. The mentioning of COVID-19 includes all lockdown levels that South Africans have been subjected to, from alert level 5 to alert level 1, as announced by the South African president.

2. 5 URBAN-RURAL INEQUALITIES IN ACCESS TO HEALTH CARE SERVICES

Urban-rural imbalances in access to medical care services is enduring in South Africa, and in almost all cases discriminate against the poor. In specific cases, aberrations are much more terrible in rural regions, although levels of service delivery admittedly are consistently worse in rural areas. Individuals in rural areas are for the most part more subject to public and other medical care services than on private services, contrasted with individuals living in urban regions. There is limited evidence of substantial intra-urban disparities, with inequality being worse in smaller urban settlements (i.e., towns) as opposed to larger ones (i.e., small cities and metropolitan areas). The poor condition of public healthcare facilities in rural areas, negatively affects the wellbeing of patients. These facilities are designed to be service efficient as opposed to nurturing patients. Therefore, this dissertation is aimed at understanding existing challenges that affect patient wellbeing. In addition, it seeks to outline strategies of improving patient wellbeing, which were inform the design of a new model of public healthcare facility in rural KwaZulu-Natal.

In South Africa, there have been critical upgrades in the medical care framework starting around 1994, for example, the presentation of free Primary Health Care (PHC) for all. The underpinning of general health frameworks are the essential medical care centers that structure the principal line of access for some people requiring health support services (Jobson, 2015). South Africa's medical services 2 framework additionally comprises of a private area, which include medical professionals who offer the types of assistance found in the private area, being supported by the memberships of people who have a place with medical aid plans (Jobson, 2015). Ultimately, various non-legislative associations (NGOs) add to the health field, with extensive contribution towards HIV/AIDS and tuberculosis (TB) care that amounts to around R5.3 billion yearly (Jobson, 2015). Regardless of the developing health facilities, South Africa remains affected by various medical conditions, particularly in rural regions. Rural people experience huge hindrances to getting to medical care, including finances, lack of vehicle, and distance to the closest health facilities, just as limited services accessible in these areas (Gaede and Versteeg, 2011). In addition, understaffing and the poor condition of infrastructures in numerous rural areas add to existing imbalances among

rural and urban health facilities, and this impacts the overall healthcare status of South Africa (Gaede and Versteeg, 2011).

2.6 BARRIERS TO ACCESS TO PROPER HEALTHCARE

2.6.1 PLACE OF RESIDENCE

A few studies have shown that people who live near a medical care center are bound to use it and have more awareness of health services (McLaren et al., 2014). Closeness to medical care has additionally been demonstrated to be a significant element influencing health outcomes. Distance to healthcare facilities has been linked to increased maternal and baby mortality, reduced inoculation inclusion, increased negative pregnancy results and diminished preventative use (Tanser et al., 2006). Interestingly, vicinity is also linked to increased recurrence of utilization of medical care offices. Working on topographical admittance to PHC can along these lines have an immediate bearing on further developing unfriendly health results. In South Africa, 24 years into democracy, the private healthcare area remains, to a great extent, racially characterized, which can compound boundaries assuming health facilities are situated a long way from neighborhoods that depend on open area services. Government has made huge progress in bringing essential health centers nearer to communities, yet they remain difficult to access for individuals who do not live within walking distance or cannot access transportation (Tanser et al., 2006). Although the increased nearness of essential health centers to individuals has improved access and usage by rural dwellers, it has also brought about new difficulties (Nemet and Bailey, 2000).

2.6.2 COST

Cost has been a significant hindrance in to accessing medical care people in rural South Africa. In addition, to this is the high-rate unemployment of the population of South Africa (Statistics South Africa, 2017). In addition to the fact that there is a conference charge, or the use brought about on medication, there is likewise the admission spent to arrive at the health facilities, with the total sum spent for treatment being expensive. Cost remains an obstacle to accessing essential medical care for some rural destitute individuals in South Africa, notwithstanding the country's health arrangements having made efforts to improve imbalance in the health framework, with charges for essential medical services for low-income people removed in 1994 (Wilkinson et al., 2001). Information gathered during 2003 - 2004 from a rural family study shows that low-income people

are confronted with major obstructions in getting to medical care than higher-income families, regardless of the assistance being free (Nkosi et al., 2007). As a rule, neediness increases individuals' vulnerability to medical affliction. A rural family study discovered that individuals from high-income families were more likely to seek medical care than sick individuals from the most unfortunate families. This suggests that individuals from poor families prefer to seek medical care only when they have no other choice in other to avoid related expenses (Nkosi et al., 2007). Adding to their financial burden are transport expenses of getting to the health facilities, either utilizing public vehicle (transports) or nearby taxicabs and private vehicles, with costs increasing as the cost of fuel rises.

2.6.3 POVERTY

Poverty is a significant hindrance to individuals with regards to getting to health services, with a significant difference between two types of destitution: outright and relative. Outright neediness refers to the lack of basic necessities of life (Mbokazi and Bhengu, 2012), while relative destitution is the powerlessness to keep a good way of life as set by society (Mbokazi and Bhengu, 2012). Outright neediness is for the most part found in country areas of South Africa, while relative destitution is by and large perceptible in metropolitan regions. A few rural men in South Africa are confronted with outright neediness, and in this manner think that it is undeniably challenging to visit or access health services. Poverty in all parts of South Africa, and all around the world, is associated with poor health seeking behaviors (Coovadia et al., 2009). Lack of money can be an obstacle to accessing medical health centers. When medical care is needed but deferred or not received, men's health deteriorates, which may lead to loss of income and higher medical services expenses, which add to neediness (Peters et al., 2008). The connection between destitution and admittance to medical services should be visible as a feature of a bigger cycle, where neediness prompts chronic sickness and infirmity keeps up with neediness. The presentation of client charges, or cost increments, can prompt diminished use of health services among men. Luckily, in South Africa, the creation of free PHC led to reduction of client expenses and keeping in mind that this included poor rural men. There were circumstances where medical expenses (cost) have been related with improvement and advancement in the quality of healthcare services (James et al., 2006). General health and health services, alongside food, water, disinfection and different

resources, like information and education, can be viewed as vital conditions for great health among men (Ensor and Cooper, 2004).

2.6.3 EDUCATION

Education is known as a measure of success that could potentially enhance the level of affluence while the low education levels also imply poverty and other economic hardships that are prevalent in Africa. Numerous health educations programs that arose during the 1970s were viewed as successful only among the most educated and economically advantaged. It was deduced that these groups had higher levels of education and literacy, personal skills and economic means to receive and respond to their health needs (Nutbeam, 2000). People who are less educated are more averse to visit health facilities and face a greater number of hindrances getting to health services than those with more education.

2.6.4 MEDICAL INSURANCE

Heads of States in Africa have realized that they must expediate the roll of medical insurance so that they have nots could have access to health care and services that are accessed by those that are living an affluent live. This call has presented many problems hence not many countries in Africa have succeeded in realizing human right agenda. People with higher income will undoubtedly have a standard provider of medical care incorporation. One of the most significant financial benefits of being employed (besides income) is health insurance. Individuals with medical insurance will undoubtedly see their professionally trained doctors and get standard screenings for blood pressure and cholesterol and get preventive care (Goodman, 2015). South Africa is endeavoring to fill this opening by introducing the National Health Insurance (NHI), which aims to provide widespread health inclusion where everyone receives quality medical services irrespective of their economic status. Nonetheless, the greatest test to the NHI has been the inconsistent conveyance of health experts between the private and public area, and among rural and urban. Most rural dwellers do not visit clinics, while individuals in urban areas who have better job opportunities and earnings better are likely to have medical cover and to use medical care benefits more. People that have medical aids access private health facilities that are more proficient and helpful than general health services. Thus, not having medical aid schemes does not give rural people the privilege to use health services as frequently as they would like. This means that those

that cannot commodify health care continue to pay the prize of death and other related medical issues (Brown et al., 2000).

2.6.5 WORKFORCE SHORTAGES

Medical services workforce shortage negatively impacts on access to medical services in rural communities. One measure of healthcare access is having a regular source of care, which is dependent on having an adequate healthcare workforce as argued by Brown et al., (2000). A few health services investigators/researchers have confirmed that African countries do not have reliable health service centers that meet the needs of its people. Rural communities are also affected by workforce shortages and not many health professionals prefer to work in rural communities. There is always shortage of staff hence the rendering of health services is always a disaster.

2.7 CHALLENGES OF QUALITY IMPROVEMENT IN THE HEALTHCARE OF SOUTH AFRICA

There is overwhelming evidence that the idea of healthcare in South Africa has been sabotaged by various challenges that negatively influence medical care quality. Improvement in quality thought suggests less slip-ups, diminished delays in care conveyance, improvement in viability, extended piece of the general business and lower cost. Decline in quality healthcare has caused individuals to lose trust in the healthcare frameworks in South Africa. Countless issues in the South African medical care systems can be tracked back to the politically endorsed racial segregation period (1948-1993) in which the medical benefits structure was particularly partitioned, according to the four racial social occasions (black, mixed race, Indian and white) (Baker 2010:79). The apartheid government created 10 Bantustans (the alleged ethnic nations) into which Africans were segregated, and all of which had their own department of health with their professional bodies.

This led to deterioration in health system delivery because of lack of resources, and poor communities were especially affected (Chassin & Loeb 2013:462). Huge efforts have been made to improve the quality of healthcare delivery in South Africa since 1994 elections, but a couple of issues have been raised by everyone as to public establishments. Among the many, the following seven issues are discussed in this article: postponed holding up time considering lack of HR, adversarial events, vulnerable tidiness and defenseless defilement control measures, extended

arraignment because of avoidable bungles, absence of resources in medicine and equipment and inadequate record-keeping.

2.7.1 PROLONGED WAITING TIME BECAUSE OF SHORTAGE OF HUMAN RESOURCES

A huge weakness in sub-Saharan African health systems is inadequate with regards to human resource. Africa is said to have one health worker for every 1000 people as opposed to 10 for each 1000 in Europe (Fonn, Ray and Blaauw 2011:658). Barron and Padarath (2017:4) saw that medical issues in South Africa are worsened by conflicting movement of health specialists between the private and public facilities coupled with conflicting spread of public health professionalism among the sectors. In an audit coordinated by Tana (2013:82), individuals decried the lack and absence in health workers which they portrayed as provoking physical and mental weariness and in some cases to further deterioration of their medical condition.

2.7.2 ADVERSE EVENTS

Different occurrences announced were patients who created problems and at times died, because they were turned away from the public healthcare (long distance in-between) from the public healthcare facilities or denied permission to medical care. The Sunday Tribune (08 March 2015:2) reported on a 35-year-old individual who reported on the family of a 35-year-old woman that blamed tertiary hospital staff in KwaZulu-Natal for her death after she was allegedly turned away from the hospital despite being gravely ill. Kama (2017:2) uncovered the example of a 1-year-old kid who passed away on his grandmother's back after they were turned away from three different healthcare facilities in one of the townships in Cape Town. In another episode in the same township, a teenager gave birth on the pavement outside the gates of a health facility because she was not allowed access (Kama 2017:2).

2.7.3 POOR HYGIENE AND POOR INFECTION CONTROL MEASURES

As alluded by Young (2016:20), public healthcare workplaces show different shortcomings like critical deferrals, low quality healthcare transport, old and. poorly maintained infrastructure, and poor disease control and prevention practices. As shown by Dunjwa (2016:1) and the South African Medical Association (2015:36), most workplaces had issues such as most facilities had problems such as poor waste management, lack of cleanliness and poor maintenance of grounds

and equipment. In a study by Nevhutalu (2016:138), patients and staff confirmed that some departments had an unacceptable physical environment (e.g. dirty toilets) for delivery of quality health care.

2.7.4 INCREASED LAWSUIT BECAUSE OF AVOIDABLE MISTAKES

There has been a development of medical carelessness leading to lawsuits against the Department of Health and provoking huge payouts which have placed further strain on the health budget spending plan. At a medico-legal summit in Pretoria (09-10 March 2015), Health Minister Dr Aaron Motsoaledi depicted these cases as coming to 'crisis' level: 'The possibility of the crisis is that our country is experiencing an incredibly sharp augmentation - actually an impact in medical unruliness suit - which isn't concerning ordinarily known examples of thoughtlessness or carelessness' (Kollapen et al. 2017:3). In a report exhibiting medico-legitimate cases paid by government in each domain in South Africa (presented at the summit by the acting Chief Litigation Officer of the Department of Justice and Constitutional Development), the total payout for suits in 2015 was R498 964 916.72; the Department of Health in KwaZulu-Natal paid up to R153 612 355.49 and in excess of 5 billion rand in in pending claims against the province (Kollapen et al. 2017:16).

The South Africa Nursing Council also reported a rise in misconduct cases against nurses, which indicates that the rights of both patients and families were violated (National Department of Health 2013:38). Kukreja, Dodwad and Kukreja (2012:11) further checked the pace of carelessness indictment claims including the nursing community, although there have not yet been any scientific studies conducted in South Africa concerning the nursing community.

2.7.5 SHORTAGE OF RESOURCES IN MEDICINE AND EQUIPMENT

TimesLIVE (14 June 2018) uncovered concerns raised by members of the public against medical centers that prompts deadly deferments in basic operation. Work backlog causes extended delay for some patients awaiting treatment, such as cancer patients who are affected by the lack of oncology doctors and of equipment, and long waiting lists for surgery or diagnosis, also because of the lack of equipment. According to the report, the long waiting times for medical intervention potentially exposed patients to development of complications or even loss of life; public hospitals, in the words of the report, have become ‘a death-trap for the poor’ (TimesLIVE 2018:5). A study

by Mokoena (2017:67) revealed about the lack of material resources, equipment and supplies (e.g. glucometers for monitoring blood glucose and needles for lumbar puncture in investigating or diagnosing meningitis), resulting in prolonged patient stay in the hospital. Participants also mentioned that the scan machine was not in proper condition, and that patients were therefore referred to other hospitals for investigations or they had to wait until the machine was fixed, resulting in delayed diagnosis and treatment (Mokoena 2017). Manyisa and Van Aswegen (2017:36) reported that the lack of administrative equipment and skilled professionals adversely affects the quality of care offered in health institutions.

2.7.6 POOR RECORD-KEEPING

Kama (2017:80) points out that poor record-keeping creates silly difficulties for patients. Now and again, patients' files are missing or lost, and instead of healthcare workers revealing and explaining this to the patient, they basically let the patient wait and waste their time (Kama 2017:80). In the worst cases, the medical history of the patient is lost, which can create further problems resulting to wrong diagnoses and occasionally death of a patient (Kama 2017:80). As the Mercury reported (09 April 2015), the Pietermaritzburg High Court mentioned a regional facility in KwaZulu-Natal was to give up medical records to a patient's attorney for a case where the patient had in July 2006 passed on (gave birth) to twins in the medical center, supposedly losing one of the twins while the surviving twin experienced cerebral loss because of hospital neglection from healthcare staff (Regchand 2015:2).

The objective of this survey was to highlight the issues that have been raised and which demonstrate the compromised quality of healthcare including frameworks used by government to deal with the nature of health service delivery.

2.7.7 UNEQUAL DISTRIBUTION OF RESOURCES

Presently, of the estimated populace 55.5 million (National Department of Health 2016), around 84% of South Africans depend upon the public health hospitals for their medical needs (Naidoo 2012:149). Only 16% of South Africans have a spot with medical aid and they are dealt with by the private health area (Naidoo 2012:149). The Ten Point Plan made by the National Department of Health (2010-2013) surveyed the cost of insured people in the private area to be 20%, against

80% for uninsured South Africans in the public area (National Department of Health 2014:8). The 16% who have a medical aid plan consume the greater part of the total medical care utilization (National Department of Health 2014:8), while the 84% of the general population depend upon the under-resourced public region. Conflicting dispersal of resources in the healthcare system is in like manner achieved by fast urbanization in South Africa, evaluated right now at 62% of the total people (Turok 2012:8). With health workplaces in urban districts having been arranged and arranged to cater for the current population of people (Kon and Lackan 2008:2272; the sudden union of people in urban areas powers health workplaces to work past cutoff time. This has incited stuffing, and, consequently, to nonappearance of resources and included strain an inside and out overburdened medical consideration structure, considering the way that in South Africa, it is unlawful to deny anyone permission to crucial medical benefits organizations, even undocumented pilgrims (Mokoele 2012:56).

2.7.8 INCREASED DISEASE BURDEN

Like other developing countries, South Africa faces a high number of sickness and is apparently failing to fight them (Kahn 2011:30). The impact of HIV and AIDS in Africa, and in sub-Saharan Africa particularly, has destroyed healthcare structures to the extent that they cannot adjust to the demands of high-quality delivery (Naidoo 2012:149). Various inadequacies and lacks achieved by crack of the healthcare structure, joined with racial and monetary issues, have led to further extension of ailments in South Africa, including HIV and AIDS (Van Rensburg 2014:15). South Africa currently faces various infections with the HIV and AIDS scourge causing high rates of tuberculosis, high maternal and young person mortality, huge levels of hostility and wounds, and a creating non-communicable disorders (for instance cardiovascular diseases, diabetes, progressing respiratory conditions and harmful development) (Mayosi et al. 2012:2030; Pillay-van Wyk et al. 2016).

2.8 SYSTEMS ADOPTED BY GOVERNMENT TO IMPROVE QUALITY OF HEALTHCARE DELIVERY IN SOUTH AFRICA

The transformation to a democratic government in South Africa in 1994 came with a push for transformation in the health services system and announced various strategic plans. The initial step that was taken by the government was decentralization of the health care system.

2.8.1 DECENTRALIZATION OF HEALTHCARE SYSTEM

South Africa, as other developing countries, has accepted a course of decentralization in reconstructing medical and medical care systems (Hendricks et al. 2014:60). The medical benefits framework in South Africa is divided into three levels: national, provincial, local government (Winchester and King 2018). Assessed composition on the benefits and challenges of decentralization, especially in the health region, shows wavering revelations (Alves, Peralta and Perelman 2013:75). A couple of assessments uncovered that decentralization has made positive outcomes in developing countries (Alves et al. 2013:76). In these instances, decentralization supported the capacity of local organizations to negotiate with central government structures for increased resource allocation to previously neglected groups (Alves et al. 2013:76). In any case, various authors acknowledge that decentralization has heightened issues of contrast in sick peoples, provoking low quality healthcare transport. According to Surender (2014:18), separating policy determinants from policy implementers in South Africa has led to a crisis in health delivery. Policy implementers failed to restrict health funds at provincial level, which has led to health funds being re-directed to other spending based on political priorities.

2.8.2 POLICIES AND LEGISLATION

Nevhutalu (2016:79) stated that the 1996 Constitution of the Republic of South Africa, supported by the Constitutional Court, and the preeminent law of the Republic explains the freedoms and obligations of its residents as well as the configuration of public authority. Emerging out of the courses of action of the Constitution is the Patient's Rights Charter, which set a general norm for addressing these privileges. According to Van Rensburg (2014), the National Department of Health drives public health in South Africa and is answerable for health strategy and coordination, based on its mandate from the constitution and the National Health Act (No. 61 of 2003), as corrected. Among other needed projects and approaches, the government incorporated free-health arrangements and an essential medical care system for rural areas.

2.8.3 PROGRAMMES DEVELOPED TO EVALUATE HEALTHCARE DELIVERY

Various principles have been developed in South Africa for evaluating quality medical care delivery. One conspicuous procedure has been the progression of permit as begun by Dr Whittaker

in the pilot Accreditation Program for South Africa which began in 1994 at the University of Stellenbosch. This assessment project revealed that various associations did not adjust to least rules, calling for new highlight on constant quality improvement (Whittaker et al., 2011). This led to the establishment of the Council for Health Service Accreditation of South Africa (COHSASA) in October 1995, functioning as a free, non-profit Organization (Whittaker et al. 2011). COHSASA is composed as a public pleasing effort including purchasers, state and private affiliations and health care providers and is the primary body executing approval in South Africa.

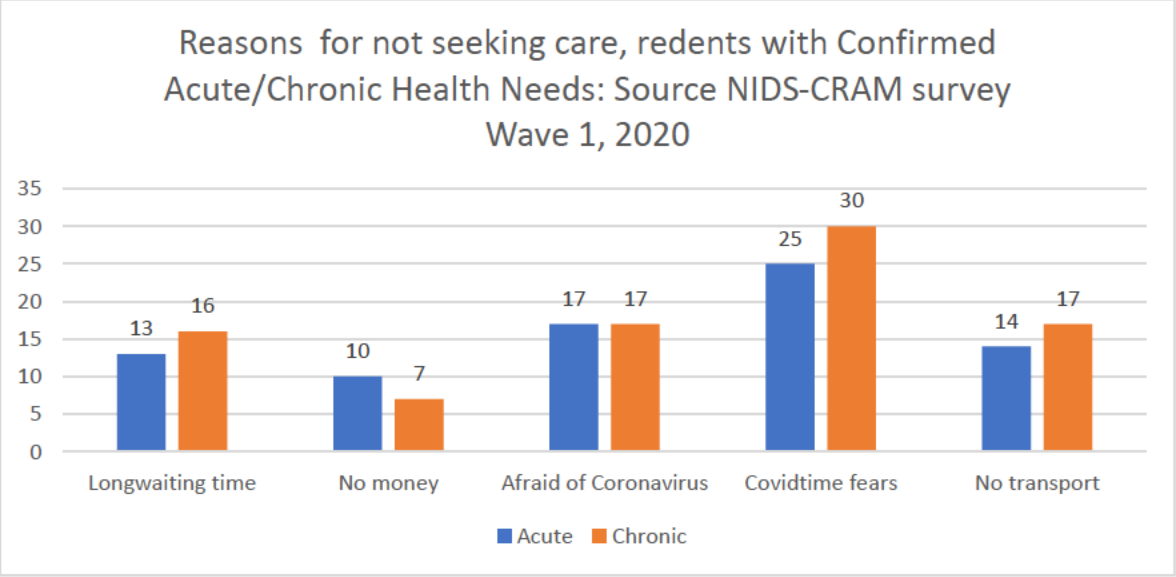
In the Book named The Economics of Health Equity, Mooney and McIntyre (2007:3) attested that access to medical health services have all around fizzled/badly served across the globe particularly to those that are poor and who cannot afford costly/private medical health services which is gotten to and celebrated by rich individuals. Addressing unequitable access to medical care/health remains key to current health strategy globally and in numerous countries. As health services deteriorates the increased disparities in healthcare access in most countries cannot be disregarded Simultaneously the significant contrasts in health between the developed and the developing world has made it an ethical emergency. The rich live longer, better lives than the poor. Health disparities are deteriorating as an ever-increasing number of generally impeded individuals keep on being immediate recipients of medical services as they battle to get access to medical care. Both health imbalances and inconsistent admittance to medical services are dependent upon improvement by friendly activity and social arrangements. Poor financial conditions are at the focal point of access hardship since services to proper health has turned into an indulgence for the rich while poor individuals battle to get to government health centers.

Nasiripour et al. (2011:2) state that access and health care are two key indicators for growth indices in all countries and health is in fact considered an undeniable right of every human. Therefore, all governments are bound and required to provide the minimum level of health care accordingly. Access to medical care implies having good access to the usage of individual health services to achieve the best health result. Access required acquiring entry into the healthcare system, acquiring access to sites of care where patients can get required services, and finding providers who address the issues of patients and with whom patients can gain a relationship considering shared communication and trust (AHRQ, 2010).

2.9 FACTORS THAT IMPACT ON ACCESS TO HEALTH CARE

Burger and Christian (2018) aver that the quality of care in a public facility varies and significant delays, inconsiderate and disrespectful health laborers, and medication shortage in public facilities add to the health consultation observed among the poor This means that poor people tend to spend their last cent to access private facilities because of the undignified service that they receive from public/government facilities. Those that cannot afford the commercialization of medical care suffer due to travelling times as they come from remote/rural areas. Socioeconomic circumstances such as poverty and unemployment exclude people from accessing health care and facilities (Smit, 2020; Lieberman-Cribbin et al. 2020; Rubin-Miller at al. 2020). Findings of the Match survey, (2020) revealed that most people could not access medical care and facilities because of poverty, unemployment, fear of contracting the coronavirus, because of rude health care workers, overcrowded waiting rooms and the because of waiting long hours. The following graph present some of the reasons that were recorded:

FIGURE 2.



Affording transportation has proved to be a factor that hinders poor people from rural communities to access free medical healthcare. Morris-Paxton (2020) agree that regardless of whether healthcare is free, ensured and accessible; transport expenses and distance to travel frequently

influence convenient treatment. Enduring absence of road or lack of repairing of rural roads make it hard for individuals to drive or travel long distances to access medical care. Syed et al. (2013) investigation of cost, accessibility of travel, distance to healthcare suppliers, and travel challenges inferred that metropolitan and rural areas are impacted by time and distance.

2.10 COVID-19 RESTRICTIONS TO ACCESS TO HEALTH FACILITIES DURING COVID-19 IN SOUTH AFRICA

Interest in unpacking access to health care and health facilities during the advent of COVD-19 was the primary objective of this study. Shipper et al. (2020:3) observes that COVID-19 was declared an overall pandemic by the World Organization on March 11, 2020, and it has saved no area of the world. On March 27, 2020, South Africa implemented national lockdown level 5 to curtail the spread of the virus (with levels going from 1 to 5, and 5 being the most stringent lockdown level). This included restricted movements; non-essential working environments were shut, schools were closed, public vehicles were limited. Medical services were considered essential services, and limitations were placed on access to or delivery of medical care services even though rural communities experienced inaccessibility of health facilities and health care. Staunton et al. (2020: 3-4) confirm that on March 15, 2020, President Ramaphosa spoke to the country and publicised a national State of Disaster derived from Section 37 of the Constitution (No. 108. Of 1996) and it was declared with the terms of the State of Emergency Act 1997. This declaration was to limit the spread of COVID-19. "Flattening the curve". However, it exposed the trench of socio-economic inequalities. South Africa is deeply an unequal society that resulted in others not accessing health facilities and healthcare during COVID-19 lockdown restrictions. COVID-19 disrupted the provision of routine healthcare in most parts of the province, mainly rural areas. This includes the regular delivery or access to chronic medication for illnesses such as TB, HIV, diabetes, to mention a few, and the immunisation of new-born babies. Cases related to COVID-19 infections also impacted the inaccessibility of health facilities and care.

Ogunkola et al. (2021:2) state that the COVID-19 pandemic confirmed one of the persisting realities: the medical services framework in Africa is spooky by the issue of access and poor service delivery of medical services to country networks. The COVID-19 pandemic demonstrated that Africa is confronting different difficulties, which incorporate absence of assets, medical

services personnel, poor budget allocation to health, high rates of illnesses, absence of political will, helpless authority and obsolete framework; and every one of these components hinder access to medical services.

Research by Siedner et al. (2020: 7) showed that in South Africa, in rural areas, access to primary healthcare during lockdown measures for COVID-19, revealed that health outreach programs, also known as ambulance visits or mobile clinics, to rural communities were interrupted and dropped significantly during this critical time. Medical practitioners also feared for their lives especially before the roll out of PPEs. Southern African countries have proved to be in a state of a complete disaster. This disease outbreak has uncovered existing social, financial and health gaps which frequently weigh intensely on the individuals who can least stand to bear the weight: the marginalized, the vulnerable, and the poor.

2.11 CHAPTER CONCLUSION

This chapter reviewed the existing literature about access to healthcare in different societies. This chapter also looked at the policies and hinderance to proper access to healthcare. The chapter finally looked at what COVID-19 restrictions are present and how they affect access to healthcare.

CHAPTER THREE

THEORETICAL FRAMEWORK

3.1 INTRODUCTION

This chapter discusses the theoretical frameworks used in this study. This study employed two theoretical frameworks, namely, social constructivism theory and access theory. The chapter will further look at how these theories influenced and limited the study.

3.2 WHAT IS A THEORETICAL FRAMEWORK?

Theoretical frameworks are a critical aspect of a successful study. According to Miller and Pate (2019) a theoretical framework contains thoughts and, alongside with their definitions, existing theories that are used for review. A theoretical framework should show a cognizance of hypotheses and thoughts that are pertinent to the subject of one's investigation and connect with the broader topics being considered. Miller and Pate further communicated that a theoretical framework is most often not something speedily found in a composition. You must review course readings and pertinent research studies for theories and analytic models that are relevant to the research problem you are investigating. The selection of a theory should depend on its appropriateness, ease of application, and explanatory power.

The theoretical framework supports the research in the following ways:

1. An express articulation of theoretical presumptions allows the reader to assess them fundamentally.
2. The theoretical framework links the scientist to existing information. Directed by an applicable theory, you are given a reason for your speculations and decision of exploration techniques.
3. Articulating the theoretical It licenses you to mentally change from just depicting a peculiarity you have seen to making speculations regarding different parts of that peculiarity.

4. Having a theory will assists you with recognizing the cutoff points to those speculations. A theoretical framework determines which key factors impact an issue of interest and features the need to look at how those key factors may contrast and under what conditions.

3.3 SOCIAL CONSTRUCTIVISM THEORY

The theory of social constructivism is pertinent in anthropological studies. It is one theory that locates the studied population at the center of knowledge production, which the research is able to gather through the anthropological recording of people's experience in relation to a particular phenomenon, context and time. As indicated by the theory of social constructivism, social universes develop out of people's interactions with their way of life, society, as well as their context. The recognition of the context in anthropology is critical. It produced detailed data, which Omran, the father of the epidemiological transitions cited in Armelagos, and Barnes (1999) gathered when people narrated their diseases experiences from the times of hunter-gatherers to modern society. This theory holds that information advances through the course of social exchange and assessment of the practicality of individual arrangement. Generally, every conversation or experience between people present an opportunity for new information, or for present data broadened. The exchanging of thoughts that goes with human contact is impacting everything here. The premise of the social constructionists is that information is socially constructed, emerges out of human realities or daily encounters. It captures the narrative theory as it allows people to reflect, drawing mainly on their contextual and personal experiences. Galbin (2014) underscore that social constructivism theory stresses the importance of culture and the context through which researchers can understand what occurs in societies. This theory allows the construction of knowledge from the viewpoint of affected people. This theory is deemed befitting to the study because it enabled the community of Ntabeni to narrate how they accessed health facilities and care during the COVID-19 lockdown level. Their access experience cannot be shared by someone who does not live in this community. The Social constructionist theory allows people affected by an issue to narrate their experiences, which depicts the cause-and-effect analysis. In the context of this study, the Social Constructionist theory enabled research participants to not only reflect on issues of access to health facilities and care; but were also able to reflect on the functionality of health facilities during the time where people in rural communities needed health access and care to be healed from their ill-health. The researcher classified dependent and

independent variables as thematic issues from the narrated experience. This theory contributed immensely to wording of primary and secondary objectives which have been outlined in Chapter one of this thesis. Theoretical perspectives have also shaped the research design that will be discussed on the following chapter and will also be recognized and integrated/aligned in the data analysis chapter.

3.3.1 THE HISTORY OF SOCIAL CONSTRUCTIVISM

Social constructivism was created by Vygotsky. He dismissed the presumption made by Piaget that it was feasible to isolate learning from its social setting. Vygotsky (1934) highlighted the place of language and culture in mental development. He argued that the way we see the world provides frameworks through which we experience, pass on, and perceive reality. He showed the meaning of language in development by displaying that in infants, correspondence is an essential for the development of thoughts and language. Regardless, he suggests that people learn considering significance and individual significance, not just through regard for current realities. Language and the calculated plans that are communicated through language are basically social peculiarities. **S**ocial constructivism is the possibility that a person's collaborations with her current circumstance produce the intellectual designs that empower her to comprehend the world.

3.3.2 RELEVANCE OF THIS THEORY FOR MY STUDY

COVID-19 is an illness that has affected many people globally. The idea of the social construction of the experience of the illness is based on the concept of reality as a socially constructed. This means that the people of Ntabeni have experienced COVID-19 uniquely hence it is anthropologically relevant to collect their experience. Sapkota (2020) alluded to this anthropological contribution in chapter one of this thesis. Ultimately, there is no objective reality, there are only perspectives on it (Ntabeni social class). The social development of the disease experience oversees such issues as the way in which a couple of patients control how they uncover their infections, and the lifestyle varieties patients make to adjust to their sicknesses. In terms of constructing the illness experience, culture, and individual personality both play a significant role. For specific people, a drawn-out illness can make their world more unassuming, more described

by the ailment than anything else. For others, infection can be a chance for disclosure, for reimagining another self (Conrad and Barker 2007). Culture accepts a major part in how a person experiences illness. Major ailments like AIDS, Tuberculosis or breast cancer have clear social markers that have changed overtime how individuals and society view them. This theory shaped the wording of the following objectives which I as the principal investigator felt that they will allow each research participants to narrate their personal experiences.

The study's primary objective is to investigate how the Ntabeni community experienced or accessed healthcare facilities during COVID-19.

SECONDARY OBJECTIVES OF THE STUDY

- To collect persisting health issues affecting most people of the Ntabeni Community.

3.4. ACCESS THEORY

Chapter one and two discussed critical debates of accessibility of health within the scope of vulnerability because of socio-economic inequalities such as poverty, inaccessibility of service delivery and transportation which is within the within the taximan or dimensions of access to health care. Access is defined as the level of fit between the client and the service, the better the fit, the better the access. Using the theory created by Penchansky and Thomas, access is advanced by accounting for the various components of access: accessibility; availability; acceptability; affordability; and adequacy in service design, execution and assessment. These aspects are independent yet interconnected and each is essential to survey the accomplishment of access. As brought about by Penchansky and Thomas, access mirrors the fit among attributes and assumptions for the suppliers and the customers. They assembled these attributes into six ‘As of access: availability, accessibility, timelines/convenience, adequacy, affordability and acceptability/fittingness. Affordability is determined by the way that the supplier's charges connect with the customer's capacity and willingness to pay for services. Availability estimates the degree to which the supplier has the imperative assets, like work force and innovation, to address the issues of the customer. Accessibility alludes to geographic accessibility, which is determined by the way that effectively the customer can arrive at the supplier's area. Convenience mirrors the

degree to which the supplier's activity is coordinated in manners that meet the constraints and inclinations of the customer. Of most noteworthy concern are active times, how phone interchanges are handled, and the customer's capacity to get care without earlier appointments. Finally, acceptability captures the degree to which the customer is okay with the more permanent attributes of the supplier, as well as the other way around. These qualities include the age, sex, social class, and identity of the supplier (and of the customer), just as the analysis and sort of inclusion of the customer.

3.4.1 THE HISTORY OF ACCESS THEORY

More than 20 years ago, Penchansky and Thomas (1981) published an article titled "The Concept of Access: Definition and Relationship to Consumer Satisfaction." In the initial sentence to this article, they note: "'access' is a principal issue in medical benefits methodology and is one of the most frequently elaborate words in discussions of the medical services system. In various system discussions, access is compared with medical care incorporation. Yet the people who have characterized admittance have all included other, nonfinancial, aspects of access in their definitions (Donabedian 1973; Penchansky and Thomas 1981; Millman 1993). We should in any case regularly remind ourselves of the significance of every viewpoint and the interplay between the various perspectives.

The South African government has set extraordinary accentuation on reviewing the financing and instalment components of the current health framework just as the accessibility of health services to accomplish its principal objective of general inclusion. While significant, this spotlight on the accessibility and affordability of medical care dominates other similarly basic issues relating to the interest side of health access (Thiede et al., 2007). Researchers interprets access as a wide and a multi-dimensional idea, as per Penchansky and Thomas' definition (1981), fusing parts of accessibility, moderateness, and adequacy. Inability to completely see every one of these elements of access, and the job each measurement plays in the health emergency, takes steps to subvert health arrangements intended to improve value in medical care access. Availability, also alluded to as actual access, is defined as the connection between the volume and type of services (assets) which exist and the volume and kind of requirements of the customer (Penchansky and Thomas,

1981). This aspect mainly captures the supply-side aspect of health assets and is regularly first-in-mind when policymakers think about access. HR for health (HRH), health facilities, medical inputs and medication access are only a few supply-side issues which would be highlighted under availability.

Affordability, additionally referred to as financial access, relates to the cost of health services and medical aid to the income of patients (Penchansky and Thomas, 1981). It incorporates the customer's impression of significant worth for cash and their understanding of costs, complete expenses (immediate and indirect) and conceivable credit plans. The affordability banter has dominated conversations surrounding the value of medical services (Thiede et al, 2007). The financial danger of weakness - particularly among the poor - and the job of the health system in shielding individuals and families from this danger, are issues which are high on the affordability plan. A social part of the affordability aspect subsequently links medical care costs and the family or individual's capacity to pay. This component of access is accordingly linked to the more extensive subject of medical care financing. The high cost of chronic sickness in relation to earning capacities is another major part of affordability, particularly for the poor. Utilizing the theory advanced by Penchansky and Thomas, access is progressed by representing the different parts of access: accessibility; availability; acceptability; affordability; and adequacy in service design, execution and assessment. These viewpoints are free yet interconnected and each is fundamental to assess the achievement of access. Regardless, I argue that one perspective is missing - awareness. I consider awareness to be an important dimension when studying access to healthcare.

3.4.2 RELEVANCE OF THIS THEORY FOR MY STUDY

The premise of Access Theory as argued by Penchansky, and Thomas (1981) is that access is a crucial notion in health policy and health services research. It allows researchers to understand factors that permitted or inhibited access, which refers to entry or use of health care system at the time needed by users or service beneficiaries. This theory will enable the researcher, from participants' experiences, to analyze all dimensions as well as operating times of the health facilities and how the operating times affected access of health facilities and healthcare, how accommodative were those times, how communities afforded or what compromised the

affordability of services. This theory also shaped the wording of the following research objective of the study:

- What are the factors that permitted or restricted access to healthcare facilities during the COVID-19?
- How did the community respond to restricted access to healthcare facilities in the community?
- Did the community access health facilities and healthcare, did they travel to nearby communities or opt for ethnomedicine?
- What solutions can be recommended to improve healthcare access for the community?

3.5 THE CONNECTION BETWEEN THE THEORETICAL FRAMEWORK AND THE ONTOLOGY AND EPISTEMOLOGY OF THE STUDY

When conducting a study there are two positions that are present: the ontological and epistemological positions. The term 'ontologia' itself originally showed up in 1606 in the work Ogdoas Scholastica by Jacob Lorhard, a German rationalist. According to Eduardo (2015) ontology can be comprehensively defined as the investigation of reality as built in both human and non-human universes. Alternately, ontology has additionally been perceived as a course of "becoming". Finally, ontology has additionally been defined as the arrangement of recorded conditions through which individuals appreciate reality (Carrithers,2010). According to Moore and Sanders (2005) epistemology is the philosophical investigation of the nature, origin, and end of human information. Epistemology is the investigation of, or rules, for how we understand the world and what comprises a legitimate clarification. Through social constructivism theory and access theory the reality (what is true and real) of access to health can be identified and understood. However, through epistemological position, the knowledge of access to healthcare varies from individual to individual and community to community. Epistemology allows for different methods of gaining knowledge, and for this, study knowledge about access to healthcare at Ntabeni was studied through the community lens.

3.6 CHAPTER CONCLUSION

This chapter focused on what is theoretical framework (social constructivism and access theory). It also examined the two theoretical frameworks in-depth. The author also discussed how these two theoretical frameworks are the ontology and the epistemology of knowledge of the study.

CHAPTER FOUR

RESEARCH DESIGN AND METHODOLOGY

4.1 INTRODUCTION

The general aim of the study was to give insights into the discernments and encounters of rural community (Ntabeni) in accessing health services. This research draws on qualitative in-depth interviews to understand the perspectives of individuals on accessing services given the challenges that they face. The chapter also present methods of data collection and analysis, it also outlines the limitations of the study.

4.2 DEFINING RESEARCH

According to Babbie (2010) research is inventive and systematic work embraced to increase the supply of data. It involves the collection, association, and investigation of information to increase understanding of a theme or issue. A research task might be a development on past work in the field. To test the validity of instruments, systems, or investigations, research might duplicate components of earlier undertakings or the task all in all. Research is defined as cautious thought of study regarding a specific concern or issue using logical strategies. Research is an orderly study conducted to depict, clarify, predict, and control the observed phenomenon. It includes inductive and deductive strategies. Inductive research methods explore analyze an observed event, while deductive methods verify the observed event. Inductive systems relate to abstract exploration, and qualitative research are overall the more typically associated with quantitative analyses.

4.3 RESEARCH TYPE AND METHOD

This study was an empirical descriptive study which employed qualitative research methods. Goundar (2012:6) assert that “descriptive research attempts to describe systematically a situation, problem, phenomenon, service or programme, or provides information about, everyday environment of a local area, or portrays perspectives towards an issue." The researcher that conducts empirical descriptive studies can collect a qualitative description of the phenomenon. Qualitative research methods imply a direct concern with experiences at it is ‘lived’ or ‘felt’ or ‘undergone’ through the voice of participants. Qualitative research methods embody

interpretivism as well as the social construction of knowledge through the subject's realities and experiences. The qualitative researcher inundates him/herself in the setting. The setting of inquiry is not invented, they are ordinary. Nothing is predefined or misjudged. Qualitative researchers need the people who are studied to speak for themselves, to give perspectives in words and various exercises. In this manner qualitative research is known to be definite and participatory in nature. Subjective/qualitative researchers takes care of the encounters in general, not as discrete factors. The point of the qualitative research is to understand insight as brought together.

4.3.1. RESEARCH DESIGN FOR THE STUDY/ PHENOMENOLOGICAL RESEARCH

This study employed the phenomenological inquiry. According to Bliss (2016), Phenomenological research is an inductive qualitative research approach that is established in the philosophical suggestion that researchers can gain important insight into the construction of how individuals understand their encounters. It is expected that there is a design or substance to the meaning individuals make of their encounters that can be depicted and that human encounters are otherworldly, physical, emotional, mental, spatial, and so forth. Insightful depictions of these encounters can inform more compassionate healthcare strategies and accommodating new theories. This research design was in line with the constructivism theory which favor the collection of knowledge/experiences from the lens of the subject.

According to Alase (2017) phenomenological research is a profound investigation of what experiences mean to individuals. At its center, it concerns the investigation of ordinary human experiences in order to gain proficiency with individuals' sound judgment, understanding and the meaning they make of their experiences and the experiences of others. Phenomenological research requires a researcher to focus on people's experiences of a phenomenon to obtain comprehensive details that provide a basis for reflective structural analysis that ultimately reveals the essence of the experience. Phenomenological research provides an opportunity for researchers to help people gain a new understanding of the meaning of these phenomena – these aspects of lived experiences. This qualitative research approach is designed to offer individuals insight into peculiarities. It ought to be noted that researchers conducting phenomenological research basically address the significance of their reflecting on their assumptions and of hypotheses about the topic of interest.

Further, it ought to be noted that whatever the branch, these inquiries are commonly embraced to explain the nuanced quintessence of individuals' lived experiences of the peculiarity. This explanation depends on studying, describing, and interpreting individuals' insights, convictions, feelings, and recollections about their experiences.

Phenomenological qualitative researchers gather people's perceptions, feelings and experiences through in-depth/unstructured interviews which are open ended. There are no definitive or exclusive prerequisites. Each research project holds its own integrity and sets up its own techniques and methodology to work with the progression of the investigation. It gives the researcher access to "this present reality setting" by which the researcher cannot "control the phenomenon of interest". The researcher can gather and work with non-mathematical information that tries to interpret meaning from the information which helps in understanding social life through the investigation of designated populaces and spots. The objective of the qualitative practice is a deep understanding of the specific. This is important for the pith of researchers' insight of conducting phenomenological research. Moreover, this research approach is likewise founded on a presumption that a review is going to give a total depiction of an experience and proved the relevance of the social constructivism theory which is discussed in chapter three of this thesis. Through the social constructivism theory and phenomenological research design, I as the research in the study was able to understand the phenomenon of access to healthcare/facilities/establishment from the viewpoint of the community of Ntabeni who volunteered their participation in the study.

Phenomenological research can be based on single case studies or a pool of samples. Single case studies identify system failures and discrepancies. Data from multiple samples highlights many possible situations. In either case, these are the methods a researcher can use. The research chose phenomelogical research because I could observe the subject and access written records. I also chose phenomelogical research is because I could conduct conversations and interviews with open-ended questions, this allows for the researcher to make subjects comfortable enough to open-up. For this study I needed to mine deep information, a researcher must show empathy, establish a friendly rapport with participants. I needed to focus on the subject and avoid getting influenced. For this study it is through the phenomelogical research method that I could achieve all that stated above.

4.3.2 THE RELEVANCE OF THE PHENOMENOLOGICAL RESEARCH DESIGN IN QUALITATIVE RESEARCH AND IN THE PROBLEM STATEMENT

Creswell (2007) recognized five significant stages in directing a phenomenological study. Most importantly, the investigator will decide whether the phenomenological approach suits the issue being explored. Exactly when the research topic is to comprehend the typical encounters of people about a peculiarity, a phenomenological study is fitting. Second, the researcher will recognize a peculiarity that is relevant to the research question. Third, the researcher will for the most part accumulate data through phenomenological interviews with individuals who have encountered the phenomenon. Regularly, information assortment happens through inside and out interviews and various interviews (Creswell, 2007). Different types of information, gathered through perception or audits of diaries and workmanship, can be included also (Creswell, 2007). A fourth step happens during information investigation; researchers begin with highlighting huge proclamations and thus foster meaning from these assertions into topics. These subjects, at the final phase of a phenomenological study, will give a spine to a portrayal that presents the substance of the phenomenon. The fifth step, as van Manen (1990) proposes, is to introduce a meaningful phenomenological depiction that spotlights on a clear model and/or includes an incident in such subtleties as the way in which one's body feels or how things smell. This portrayal would provide the reader with the feeling of being there.

What distinguishes phenomenological from other qualitative research is that with an accentuation on the emotional point of view (as far as cognizance and experiences), phenomenology permits the researcher to consider the lived experiences of human life. A researcher might utilize phenomenology in their systematic search to determine the fundamental properties and designs of cognizance and cognizant experience. Also, an investigator using a phenomenological approach in their research might investigate the connection between the individual and the world and may examine how individuals understand the world through awareness.

But at the same time, it is vital to understand what qualitative research is - a methodology utilized to a great extent in the social sciences to investigate social interactions, systems and cycles. It gives

an inside-out understanding of the manners in which individuals come to understand, act and deal with their everyday circumstances in specific settings. Qualitative research methods allow anthropologists to explore in depth by asking the whys and how questions in their research. Such questions assist anthropologists to uncover unexpected insights which can be collected directly from research participants. Moreover, over time and from diverse perspectives. The significance of qualitative research in the problem statement is that qualitative research makes researcher to have the option to have a commitment with the member, and as a principal investigator I had the option to get every emotion of the informants during interviews.

4.3.3 THE RELEVANCE OF QUALITATIVE RESEARCH IN ANTHROPOLOGY

Qualitative anthropological research comprehends the local setting, and it is vital for interpreting relations and meanings molded within it (Babbie, 2010). By investigating the view of the designated populace, it adds depth to study in general, by and large, by enabling exploring the reasons behind current realities. It could likewise recognize issues and/or patterns which could arise within the designated populace while the review is yet ongoing and could fill in as an instrument of extending itself into being essential for strategy making, yet of strategy applying as well. Its capacity to arrive at marginalized groups depend vigorously upon shared trust between the researcher and the researched, which could be utilized - and is involved this way in certain networks (Babbie, 2010). Focusing on context-dependence of the issues researched, and being designed to be relevant, it is additionally a strong means of interpretation, but requires carefulness as poor examination and utilization of findings takes advantage of the individuals who have given their time, energy, and information to the research.

4.3.4 THE SIGNIFICANCE OF RESEARCH METHODOLOGY IN THE ANTHROPOLOGY.

A core conceptual component of anthropology that is what is "reasonable" apparently is socially and culturally explicit and legitimate in its local setting. An anthropological methodology does not expect to be that, for a model, even biomedical ideas and practices of the Western world are both regulating and all inclusive. Rather, it regards the knowledge and practice of "experts" as locally variable as are the knowledge and practice of lay people and it includes both within the boundaries

of empirical inquiry. The absolute most significant anthropological research for evidence-based medical care has considered contrasts between epidemiological, medical, and well-known ideas of health and infection in specific settings and has in this manner shed light on the difficulties of such distinctions for fitting practice in these settings (Žikić, 2007). Anthropology combines humanist and social science systems. The technique that separates anthropology from different disciplines is ethnography, the qualitative course of exploring inside and out the whys and how is of human culture, conduct, and articulation. Using this ethnographic technique, anthropologists can reveal unforeseen insights that are best gained by studying a theme face to face, in situ, over the long run, and according to different viewpoints. The ethnographic strategy utilizes various information assortment methods including member perception, interviews, focus groups and literary investigation to develop an all-encompassing and logical perspective on the phenomena under study. During their research, anthropologists mention objective facts and seek after points of view from assorted points and in different ways. They notice and talk with individuals from various social classifications who have varying connections to the phenomena under review and conceptualize and react to those phenomena in unique ways. Anthropological inquiry combines information about individuals' contemplations assembled through interviews with information gathered by observing their conduct and social interactions. Anthropologists inundate themselves in the rich, to a great extent, qualitative informational collection that comes out of their research and direct iterative investigations to distinguish emerging topics and gather insights about the meaning of the information. The objective of an anthropological methodology is a valid interpretation of the information that is portrayed, gives significant insights, and can be reproduced.

4.4 SAMPLING TECHNIQUE

4.4.1 SAMPLING TECHNIQUE EMPLOYED

Although human experiences can be investigated through perceptions, shared interactions, and writing and artistic expression, it can also be investigated in phenomenological research by speaking straightforwardly with individuals in conversational, unstructured/in-depth interviews. Nicolaides (2015, p. 182) contended that "profound and powerless" discussions with members assisted them with exploration and exchange concerning how every one of them experienced and

comprehended their experiences with ambiguity. In the case where interviewing is arranged, researchers used semi-structured interviews with open ended questions that assist participants to explain their experience. They were asked for concrete examples or asked what it was like (e.g., what did it feel like) to have that experience. They might be approached to depict the phenomenon (for example "equivocalness" in Nicolaides' 2015 study). They might be asked what meaning the phenomenon has in their lives.

Qualitative research is utilized to understand how individuals experience the world. While there are many ways to deal with qualitative research, they will quite often be adaptable and centre around retaining rich meaning when interpreting information. Non-probability is a part of test choice that uses non-random ways of selecting a gathering of individuals to take part in research. Within non-probability sampling this study utilized Purposeful Sampling, also called purposive and particular sampling. Purposeful sampling is a sampling strategy that qualitative researchers use to select members who can give in-depth and point by point information about the phenomenon being scrutinized. It is profoundly emotional and determined by the qualitative researcher generating the qualifying measures every member should meet to be considered for the research study.

Purposeful sampling is a strategy broadly utilized in qualitative research for the distinguishing proof and choice of information-rich cases for the best utilization of restricted assets (Babbie, 2020). This involves identifying and selecting individuals or groups of individuals that are particularly educated about or experienced with a phenomenon of interest (Cresswell and Plano Clark, 2011). Purposive sampling has a long formative history and there are as many perspectives that it is basic and clear as there are about its intricacy. The justification behind purposive sampling is the better matching of the sample to the aims and objectives of the research, subsequently improving the rigour and trustworthiness of the information/data and results. Purposive sampling was used to recruit between 30 to 50 research participants. The researcher with the help of a key informant identified specific individuals who were infected with covid-19 or knew someone infected with covid-19. The sample size of 30 to 50 research participants was rationalized on the fact that, I did not want to expose myself to COVID-19 by conducting longitudinal ethnographic research on a bigger sample. The purposive sampling enables an equal representation of people

who are community members of Ntabeni community. Miles and Huberman (1992) cited in Omona (2013) argues that purposive sampling adds credibility when researchers intend to research issues that affect communities with a big population, and they want to ensure a reasonable representation of community members.

4.4.2 INCLUSION AND EXCLUSION CRITERIA OF PARTICIPANTS FOR THIS STUDY

When conducting research, it is important to have inclusion and exclusion criteria of participants for the study (Miles and Scott, 2017). For this research, different inclusion and exclusion criteria of participants were used to make this study more reliable and valid. For this study, the inclusion criteria of participants were that the informants had to be permanent residents of Ntabeni. The exclusion criteria were that those that did not reside at Ntabeni cannot participant in this study. Inclusion and exclusion criteria during data collection. Data collection excluded children and recruited research participants from 18 years and above because they were able to consent or not consent without seeking any form of guardianship. Data collection did not include the collection of participants' names. untraceable names (pseudonyms) were used to plot narratives in the data analysis chapter. The data collection schedule observed social distancing and times that were convenient for those who voluntarily consented to participate.

4.5 METHOD OF DATA COLLECTION AND INSTRUMENTS USED

For this study, data was collected through unstructured face-to-face interviews. The collected data was not tape recorded but I as the principal investigator took the responsibility to record them on the data collection instrument. Through unstructured/face-to-face/open-ended questions/interviews, anthropologists can collect detailed information (Bihu, 2020). Unstructured interviews do not utilize any set questions, instead, the interviewer poses open-ended questions in view of a particular research point and will attempt to allow the interview to flow like a natural discussion. The merit of unstructured/face-to-face/open-ended questions/interviews is that it allows anthropologist a conversational method of data collection, anthropologists can tap into the natural world of the researched, through which they benefit from recording epistemological knowledge which is the social construction of the reality of the subject or the studied population.

The interviewer alters their questions to suit the candidate particular experiences. Unstructured interviews are at times alluded to as 'discovery interviews' and are like a 'guided structured' than a structured interview. They are in some cases called informal interviews. The researchers prepared data collection instrument which consisted of questions that the interviews will be guided by. Full consent was acquired from the members before the investigation. Confidentiality was the rule of thumb in this research because the nature of collected data also included the recording of persisting medical conditions within this community. Data collection took more than three (3) months because I had to observe COVID-19 restrictions. This was from August 2021 to October 2021.

4.5.1 HOW IS THIS DATA COLLECTION METHOD RELEVANT TO THE PROBLEM STATEMENT AND THEORETICAL FRAMEWORK?

To collect data for this study, unstructured interviews were used. It is relevant for this study because unstructured interviews are more versatile and adaptable as questions can be changed depending on the respondents' reactions. Unstructured interviews produce qualitative data utilizing open questions. This permits the respondent to use their own words to socially construct their day-by-day experiences. This assists the researcher to immerse or develop a genuine feeling of how individual might interpret a circumstance. They additionally have increased validity since it offers the interviewer the chance to test for a more significant game plan, demand clarification and allow the interviewee to direct the orientation of the interview, etc. For this study, two theoretical frameworks were used, these are access theory and social constructivism. In order to fully embrace these theories, the use of unstructured interviews was the most valid and reliable way to get information that is true and not bias. Through the use of this data collection method the people of Ntabeni voices can be heard and understood.

4.5.2 THE ONTOLOGY AND EPISTEMOLOGY OF KNOWLEDGE FOR THE STUDY.

The research paradigm and methods used in this study contributed to the ontology and epistemology of knowledge for the study. Conducting interviews with the participants resulted in epistemological knowledge being generated. The information that was gathered is epistemological knowledge that is the reality of Ntabeni community when it comes to access to healthcare during COVID-19. It is not the ontology of healthcare or access to healthcare. It is not based on the ontology (policies or nature of healthcare).

4.5.3 DATA COLLECTION PLAN

For this study, a maximum of 30 participants were interviewed. A maximum of three participants were interviewed per day at Ntabeni in their homes and the interviews took a maximum of 30-45 minutes. The data collection period lasted for a month. The researcher went to the community members home to conduct the interviews. This was because the participant felt safe in their homes because of COVID-19. All COVID-19 protocol were strictly followed. Confidentiality was kept up with through interviewing each member in turn. An unstructured interview guide was utilized during the interviews and a sound recorder was not utilized to record the interviews. Most of the interviews were conducted in isizulu and this was because most participants were not comfortable with (did not know) English. The researchers additionally kept an envelope of "field notes" to supplement interviews. Field notes grant the researcher to keep up with and remark upon impressions, natural settings, rehearses, and nonverbal signs. Field notes can give a significant setting to the understanding of the huge number of information and can help the researcher with recollecting situational factors that may be significant during information examination. Such notes need not be formal.

4.6 DATA ANALYSIS, DATA HANDLING AND FILTERING

Throughout all the interviews the researcher took notes down. Some of these notes were direct answers from the participants and some where other observations observed during the interview. To filter all the information the researcher used codes and themes to group the findings. Doing qualitative research is about seeing another individual's point of view and seeing the world according to that individual's perspective. The most important part of data analysis and management is to be true to the participants. It is their voices that the researcher is trying to hear, so they can be interpreted and reported for others to read and gain from. Once all the research interviews have been transcribed and checked, it is time to begin coding. Field notes compiled during an interview can be a useful complementary source of information to facilitate this process, as the gap in time between an interview, transcribing, and coding can result in memory bias regarding nonverbal or environmental context issues that may affect interpretation of data.

Coding refers to the identification of topics, issues, similitudes, and differences that are uncovered through participants' narratives and interpreted by the researcher. This process allows the researcher to begin to comprehend the world as indicated by each member's viewpoint. Coding needs to be done by hand on a printed copy of the record, by making notes on the edge or by highlighting and naming areas of text.

4.7 ETHICAL CONSIDERATION

The concern of anthropologists to conduct research that is morally and ethically sound has grown in the past several decades. At first, when leading ethnographic field work, anthropologists were not especially stressed over moral troubles and the effect of their research on the people that they were examining. Today, anthropologists have an immeasurably better comprehension of the significance and unquestionable nature of moral hardships. All research, especially field work, influences people being referred to that are being contemplated. Properly, anthropologists should ensure that their work does not adversely affect others and that they do not benefit from one more social and cultural group without giving something back to the local area. Moral norms are indispensable for anthropologists because significant moral issues arise in their work. This arrangement of norms is planned to increase consciousness of the moral issues that anthropologists face, and to offer them helpful guidelines to help with settling these issues.

4.7.1 VOLUNTARY PARTICIPATION

Voluntary participation suggests that people responding to questions have made a free choice to be involved in data collection. They should not be compelled into participation in any way. They can stop the questions or change their viewpoint on being involved whenever they wish to do so. Interest should be deliberate in all research, and there should be no force or deception (this will be discussed in the subsections named "Informed Consent" and "Other, More Specific Ethical Issues"). For this study no one was forced to participate in the data collection (being the interviews). There were no incentives for people who will participate.

4.7.2 ANONYMITY AND CONFIDENTIALITY

Anonymity and confidentiality are a vital feature of research. Particularly in anthropology, where a significant part of the research is the result of conversations and interviews, anonymity is important. Anonymity, for example, using a different name for an individual helps to maintain privacy. Confidentiality implies that any identifying information is not made available to anyone but the individual coordinating the data collection (or potentially individuals in their team). The researcher indicated before the interview that no names would be mentioned in the last report.

4.7.3 INFORMED CONSENT

When conducting research, informed consent is very important. Informed consent means the person being asked questions has been fully informed about your study. You need to have high quality accessible information sheets, together with straightforward and user-friendly consent signing sheets. This will ensure that you not only deliver the information needed to provide informed consent, but also that you have a record of having done so. The primary purpose of informed consent is to enable the respondent to make an informed decision about whether they want to answer your questions. For this study, the researcher prepared English and isizulu consent forms that all participants had to read and sign if they agreed to participate in the research.

4.7.4 POTENTIAL FOR HARM

A fundamental moral commitment shared by anthropologists is to cause no damage or harm. Before any anthropological work is embraced - in communities with non-human primates or different animals, at archeological and paleoanthropological destinations - each researcher thoroughly considers the potential ways that the research may cause harm. Among the most veritable damages that anthropologists should attempt to avoid are mischief and pride, and to significant and material success, especially when research is led among vulnerable populations. Anthropologists should not simply keep away from causing immediate and quick damage, they should also weigh the expected outcomes and coincidental effects of their work. Researchers ought to know about the exact justification for involvement in a study to prevent unwanted private matters. The probability of openness to vicarious trauma as a result of the interviews should be evaluated. Interviewers ought to be appropriately booked to furnish the researcher with sufficient recuperation time and lessen the danger of emotional exhaustion, while permitting abundant time

for examination of the objective and emotional aspects of the research. It is additionally fundamental for the researcher to be acquainted with indications of extreme fatigue and be ready to take essential measures before too much harm is done. For this study, the researcher made sure that no emotional or socio-cultural harm was experienced by the participants. No participant was forced to be interviewed.

4.8 DATA COLLECTION EXPERIENCE DURING COVID-19

The COVID-19 presented unprecedented challenges not only to the health, social, financial, economic and education areas of South Africa. Assuming there is one significant truth about ethnography, it is that intimacy, and not distancing, is vital. Given this, researchers needed to readjust our research at a moment characterized by the effects of the novel coronavirus. This study was motivated by the crisis that aroused in the healthcare area because of the COVID-19 pandemic. Data collections during COVID-19 brought a lot of mixed emotions. I faced a lot of fears, stress and anxiety. Being in an impoverished community also brought about a lot of sorrow. The researcher had to be very responsible because the safety of the informants and herself was very important. Making sure that all COVID-19 protocol were followed was challenging. Collecting data during the pandemic was not easy at all. However, it was very informative and memorable. It forces the researcher to try new ways of collecting data. Because of the fear of contracting COVID-19, many participants were reluctant to participate in the study. I had to deal with a lot of participants cancelling their consent during the data collection process. Another challenge I faced was that I contracted COVID-19 and had to stop work for 2 weeks as I was being treated and recovering. This affected my data collection schedule. But when I recovered, I continued with my study.

After conducting research and interpreting the data collected, I can state that the issues that the research view as problematic are indeed problematic. The community of Ntabeni which is a rural and impoverish community struggles when it comes to access to health care facilities during covid-19 level 4-5. They face numerous barriers which are affordability, availability, accessibility, accommodation, acceptability and awareness.

4.9 VALIDITY, RELIABILITY, GENERALIZABILITY, CONFIRMABILITY, REFLEXIBILITY AND TRANSFERABILITY IN THE STUDY

Validity, reliability, and generalizability are very important when conducting research. Reliability in qualitative research refers to the stability of responses to multiple coders of datasets (Creswell and Poth, 2013). It can be enhanced by detailed field notes, by using recording devices and by transcribing the digital files. In this study reliability was obtained through making sure that all the informants were residents of Ntabeni only. Creswell and Poth (2013) consider "validation" in qualitative research as attempting to assess the "accuracy" of the outcomes, as best depicted by the researcher, the participants, and the reader. This shows that any report of research is a portrayal by the creator. They acknowledge that approval is used to underline a cycle, rather than confirmation made by broad time spent in the field, nitty gritty depiction, and a cozy connection between the researcher and the members. For this study, the researcher used purposive examining to ensure research validity and reliability. This came through the recruitment of research participants from Ntabeni who had challenges in accessing health care services during the studied lockdown levels. In anthropology, the collection of data from affected subjects/participants is called the recording of emic perspectives, which is the collection/recording of experiences. The researcher interviewed 30 participants who were not children in order to enhance validity. They further state that through qualitative research, it is easy to generalise information. However, this study used phenomenological enquiry which means that any generalisations made are only restricted to Ntabeni community and their experience with access to health care during COVID-19 lockdown level 5-4.

When conducting research, it is important that the data collect is trustworthy. To ensure confirmability an Audit Trail was used for this study. This is the most popular technique used to establish confirmability because it is incredibly useful when writing up the results chapter. An audit trail is when a qualitative researcher details the process of data collection, data analysis, and interpretation of the data. You record what topics were unique and interesting during the data collection, write down your thoughts about coding, provide a rationale for why you merged codes together, and explain what the themes mean. For this study this was done in the methodology and data and interpretation chapter.

Reflexivity, this is a technique that is useful in qualitative research, especially in phenomenological research. Reflexivity is an attitude that a qualitative researcher adopts when collecting and analyzing the data. For this study, the researcher observed how her own background and position influence the research process (i.e., selecting the topic, choosing the methodology, analyzing the data, interpreting the results, and presenting the conclusions). In order to achieve reflexivity, the researcher kept and maintain a reflexive journal. This where the researcher reflected on how the interviews were. The researcher also tried to obtain transferability. This was when the researcher talked about talking where the interviews occurred, and other aspects of data collection that help provide a richer and fuller understanding of the research setting. This information helps the reader construct the scene that surrounds the research study, from the daily lives of participants to the way that implicit biases may affect their responses. It is helpful to put what participants express to the researcher into the context of the surrounding social and cultural environments that the research study is framed around. This allows outside researchers and readers to make the transferability judgements themselves.

4.10 CONCLUSION OF CHAPTER

This chapter contains the research design utilized in the study, the targeted population, sampling procedure and methods of data collection, validity and reliability of the questionnaire which were utilized for information collection. It additionally contains the objectives under study and strategies for data analysis in addition to moral considerations witnessed.

CHAPTER FIVE

DATA ANALYSIS, PRESENTATION, AND INTERPRETATION

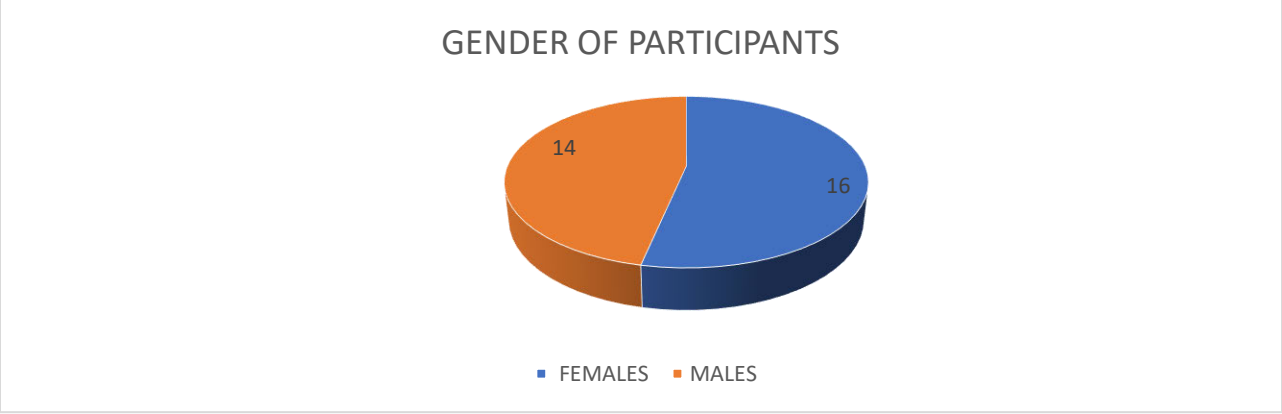
5.1 INTRODUCTION

This chapter will cover data analysis, presentation, and interpretation of findings based **o**n the information gathered from the informants through a qualitative study. It will focus on qualitative methods of data collection to understand background information and explore the challenges faced by the people of Ntabeni.

This section presents a portion of the points of view of Ntabeni members with respect to health service usage. These points of view are set up utilizing qualitative strategies drawn from in-depth interviews. Participants were additionally urged to recommend manners by which they could vanquish blocks that hold them back from getting to health services. This chapter begins by laying out the outlining the characteristics of sample and then presents the themes that were generated from the thematic analysis of the in-depth interviews.

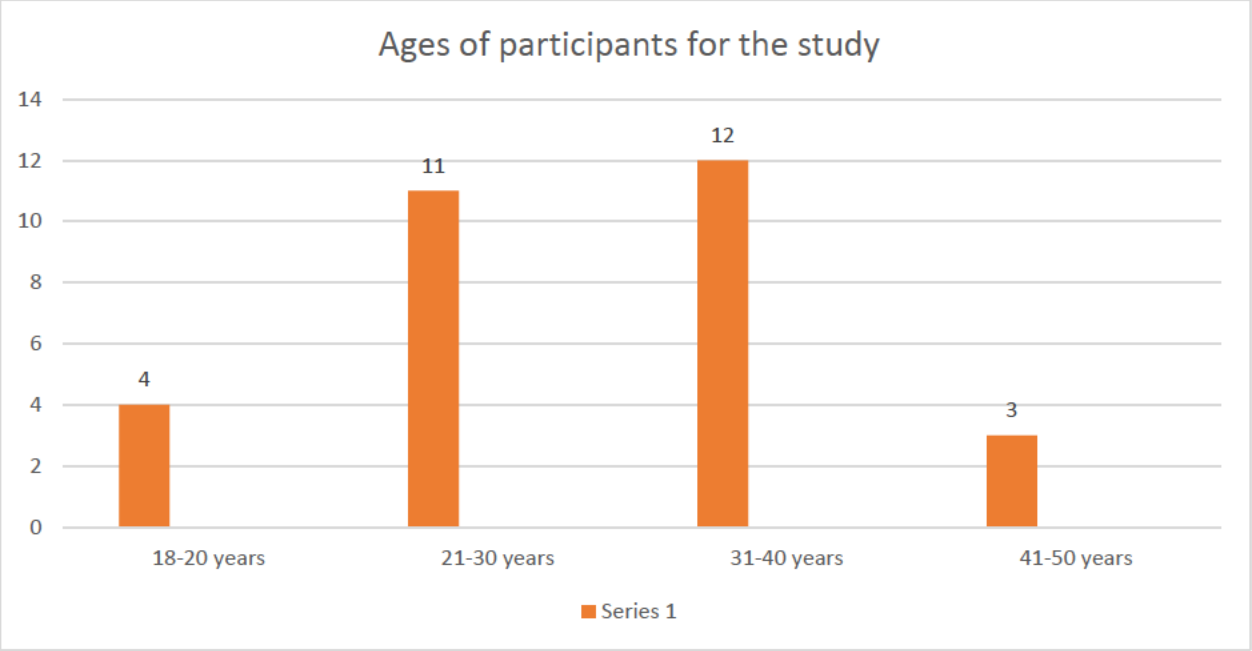
5.2 DEMOGRAPHICAL PROFILE OF THE SAMPLE

FIGURE 3: GENDER OF PARTICIPANTS



The above figure shows the gender of the participants interviewed. There were 14 males and 16 females. The total number of participants is 30.

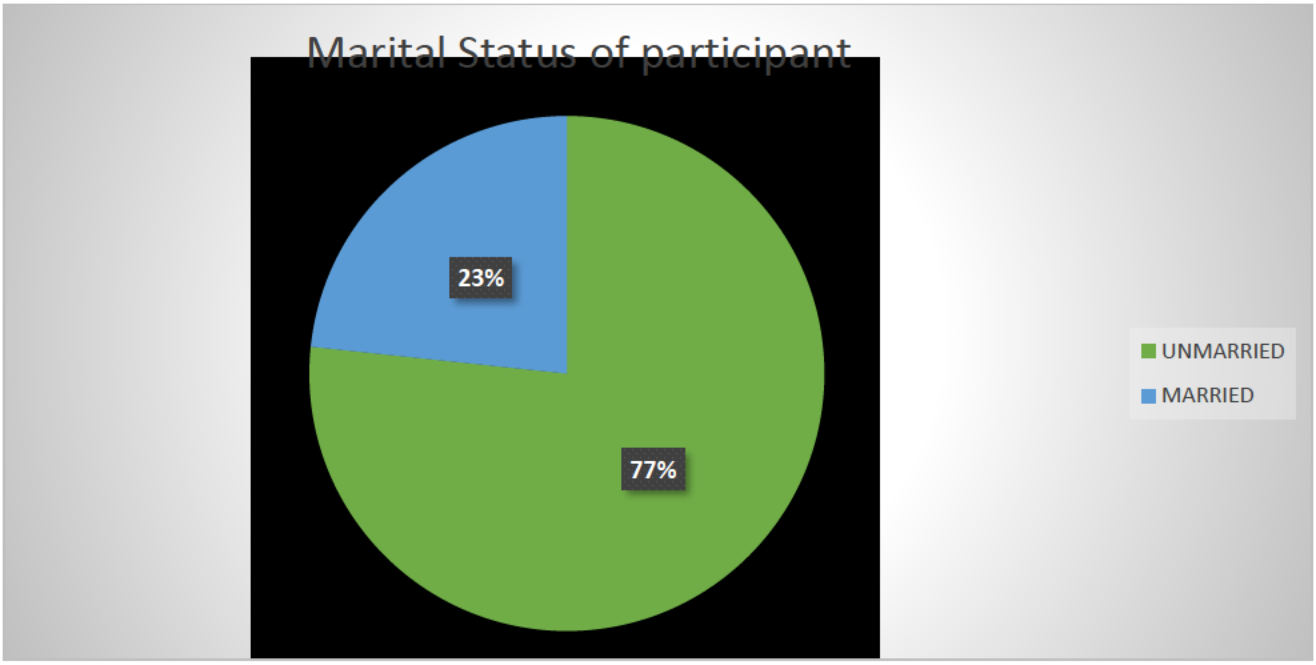
FIGURE 4: AGE OF PARTICIPANTS



Age of participants	
18 -20 Years	**04**
21-30 Years	**11**
31-40 Years	**12**
41-50 Years	**03**
Total	**30**

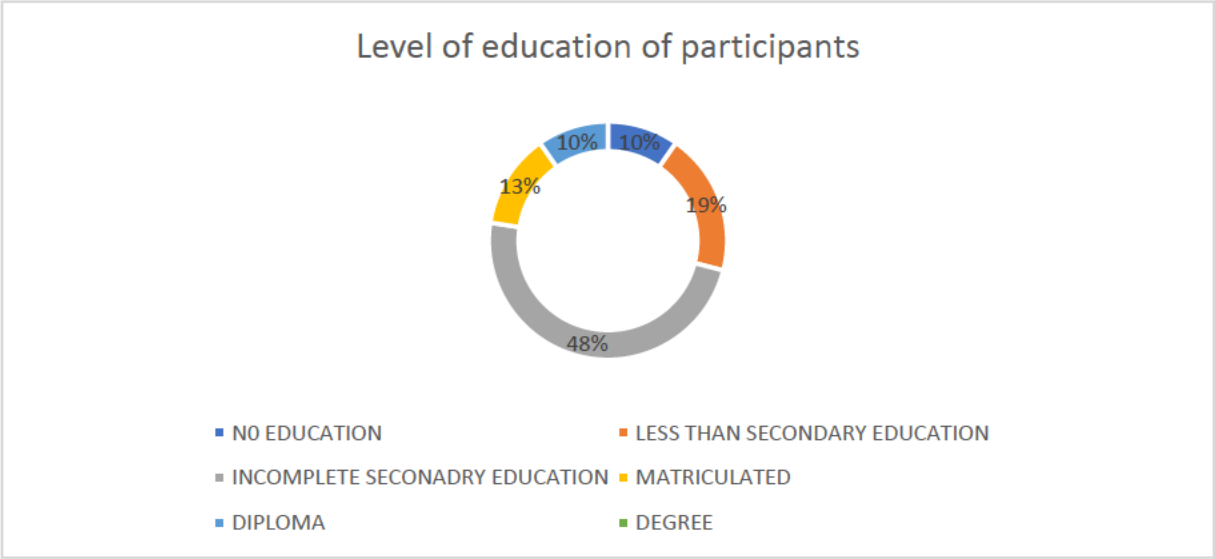
The table above shows the age of the participants of the study. Only individuals above 18 were interviewed. The study did not allow any children to participate as informants. The graph also shows that this community is highly populated with middle aged individuals.

FIGURE 5: MARITAL STATUS OF PARTICIPANT



The pie chart above illustrates the marital status of participants that were interviewed. Out of the 30 informants 7 are married and 23 are not married.

FIGURE 6: LEVEL OF EDUCATION OF PARTICIPANTS



The chart above shows the level of education amongst the 30 participants. Two participants have no education, six have less than secondary school, 15 only Completed secondary school, only 4

have a national senior certificate and only 3 acquired Diploma. None of the participants has a degree. This chart proves that the Ntabeni community lacks the drive for education and is prone or susceptible to quite a number of socio-economic vulnerabilities which they cannot resolve without being dependent on the service delivery provision that is made by government.

FIGURE 7: EMPLOYMENT AND UNEMPLOYMENT STATUS OF PARTICIPANTS

The chart below shows the employment and unemployment status of the participants interviewed. There were 11 employed participants and 19 unemployed participants. At Ntabeni community there is a high rate of unemployment, many rely on social grant. In relation to the study, the level of unemployment that is the experience of this population gives an indication that they are dependent on free services provided by government. The high rate of unemployment compromises this community from access to health care facilities as most people cannot afford paying for transportation to such facilities. This means that unemployment does exclude people from accessing services that are offered by government.

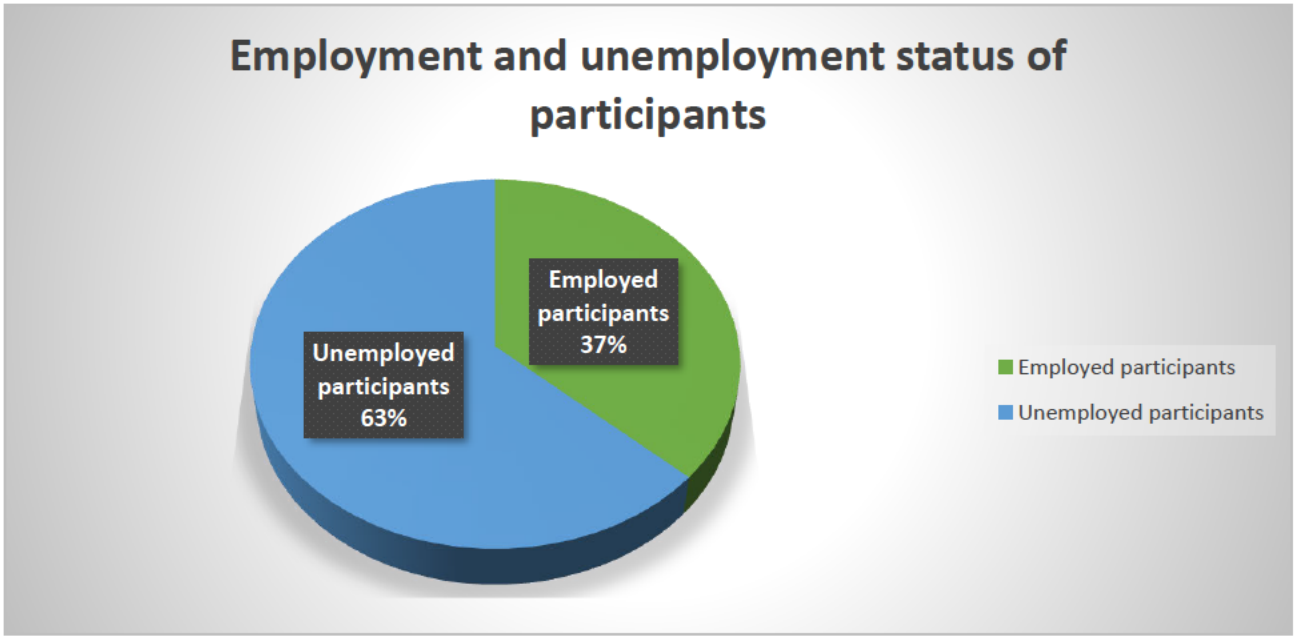
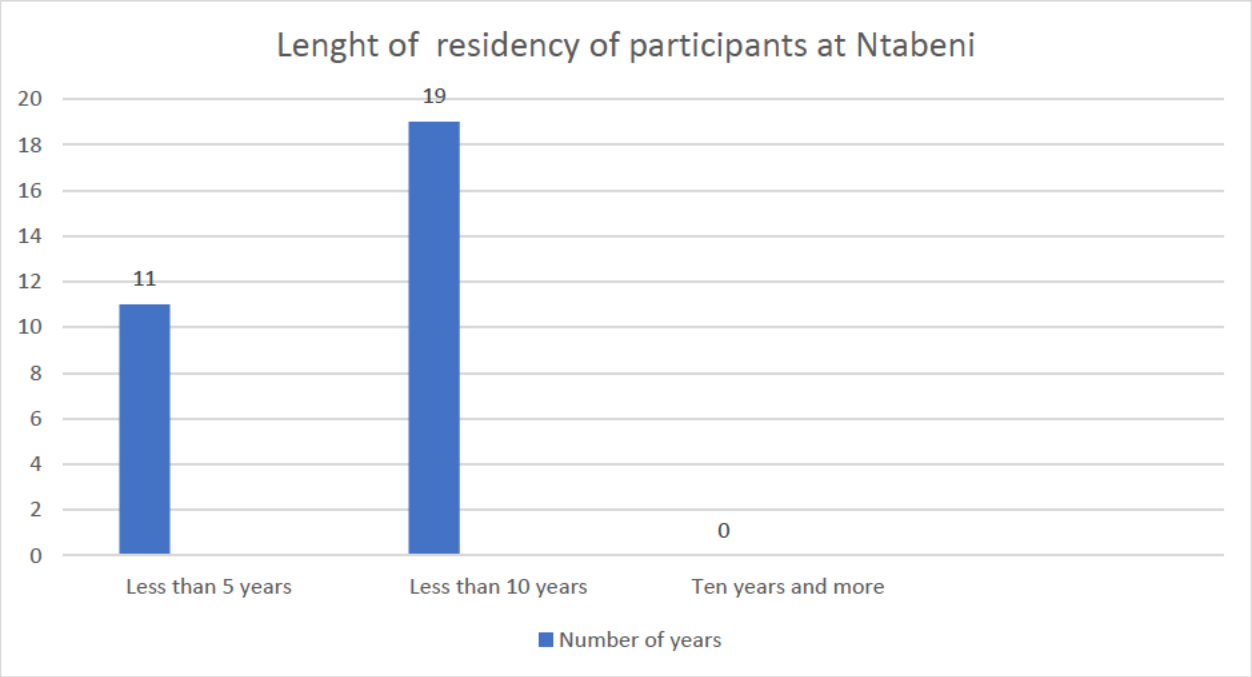


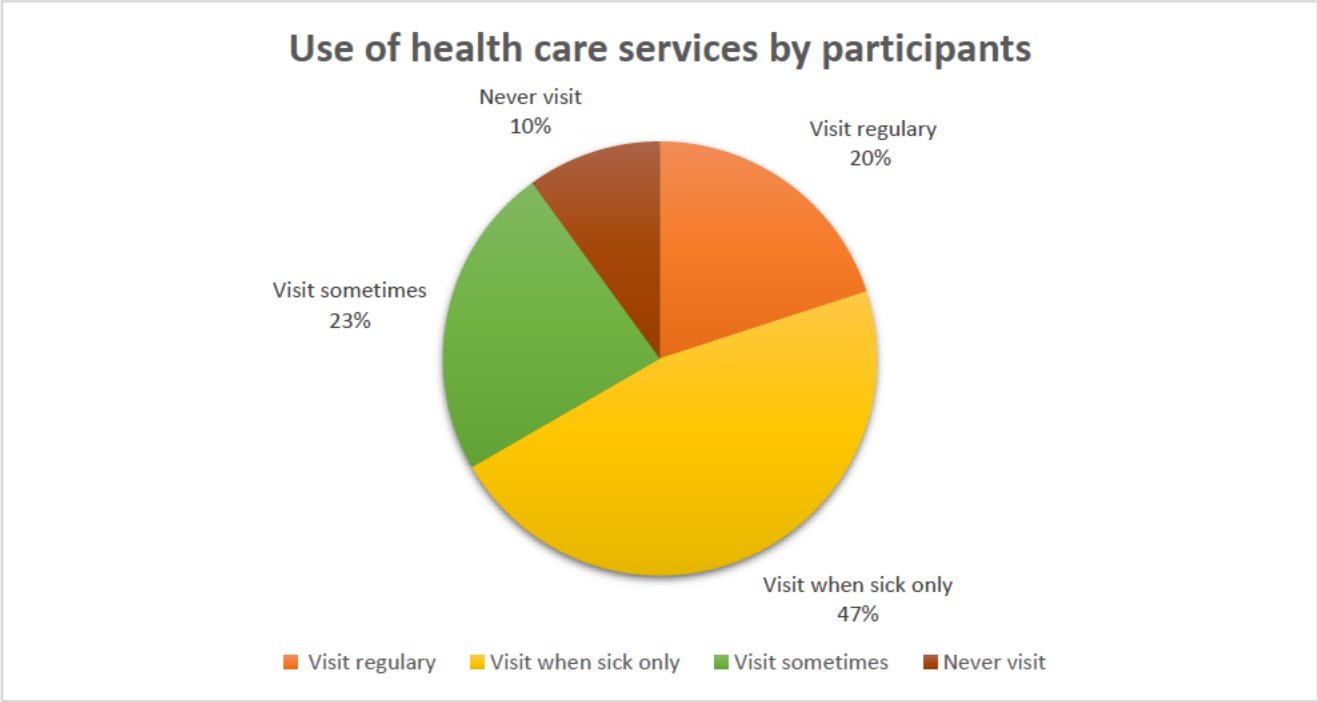
FIGURE 8: LENGTH OF RESIDENCY OF PARTICIPANTS AT NTABENI

The table below shows the length of residency of participants at Ntabeni. Ntabeni community is a rural settlement that has been formed by foreigners, illegal South African citizen and legal citizen that left their homes. This community has existed for about 14-15 years.



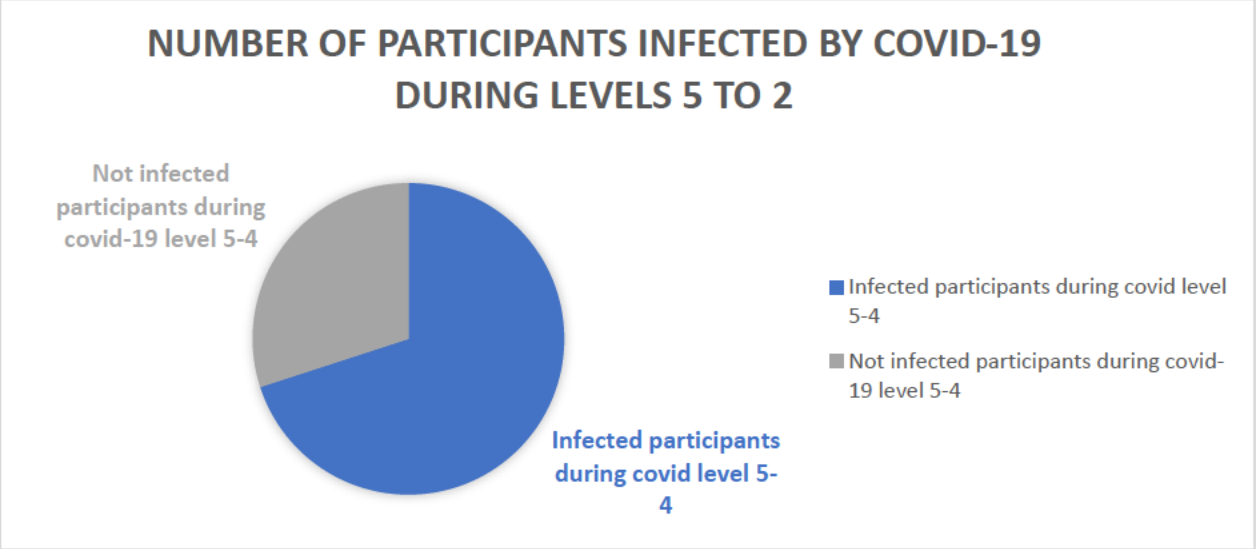
Length of residence of participants at Ntabeni	
Less than 5 years	11
Less than 10 years	19
10 years and more	0
Total	30

FIGURE 9: USE OF HEALTHCARE SERVICES BY PARTICIPANTS



The chart above shows the use of healthcare services by participants. The chart shows that the participants did not visit clinics or hospitals regularly. 47% only used healthcare services when sick and 10% never visited healthcare services. 20% of the participants stated that they visited healthcare services regularly even just for checks ups. 23% stated that they visited healthcare sometimes.

FIGURE 10: NUMBER OF PARTICIPANTS INFECTED BY COVID-19 DURING LOCKDOWN LEVELS 5 TO 2



Amongst the 30 participants 9 individuals stated that they did not get infected during COVID-19 lockdown level 5 to 2 and 21 got infected by COVID-19 during level 5-4. This shows that during the early stages of COVID-19 many people got infected.

FIGURE 11: DURING COVID-19 LEVEL 5-4 DID YOU FEEL THAT YOU HAD ADEQUATE ACCESS TO HEALTHCARE AT NTABENI?

The table below shows that amongst the 30 participants over 50% believed they did not have adequate access to healthcare as Ntabeni community.

During COVID-19 level 5-4 did you feel that you had adequate access to healthcare at Ntabeni?	
Yes	**11**
No	**21**
	30

During the COVID-19 pandemic level 5-4 there were still other persisting diseases. The Ntabeni community was still also faced with other chronic diseases. The table below shows other illness that were vast at this community.

Other persisting health issues/illnesses at Ntabeni community during the pandemic
HIV/AIDS
Tuberculosis
Sexually transmitted diseases
Mental illnesses

TABLE 2: MEANS OF SURVIVAL OF PARTICIPANTS DURING COVID-19 LEVEL 5-4

Different means of survival	**Number of individuals**
Child-support grant	**06**
Elderly grant	**03**
Pension	**00**
COVID-19 social relief grant (350)	**07**
Salary/Wages	**11**
Other	**03**

The table above shows the participants' means of survival. Only 11 participants are employed. The rest depend on government support grants. Seven participants stated that they now have some sort of income through the COVID-19 social relief grant and, although it was not enough, it was very helpful during the pandemic.

TABLE 3: OVERVIEW OF IDENTIFIED ACCESS BARRIERS TO HEALTHCARE DURING COVID-19 LEVELS 5-4 AT NTABENI

The table below shows a summary of all identified barriers to access to healthcare during COVID-19 levels 5-4 for Ntabeni community.

Overview of identified access barriers to healthcare during COVID-19 levels 5-4 at Ntabeni
Availability
Means of transport available
Geographic accessibility
Unqualified health workers, staff absenteeism, opening hours Information on health care services/providers
Waiting time Education
Motivation of staff
Drugs and other substances
Non-integration of health services
Lack of opportunity (exclusion from services)
Late or no referral
Affordability
Costs and prices of services, including informal payments
Private–public dual practices
Cash flow within society
Accessibility
Clinics are far
No local clinic with proper healthcare services
During COVID-19 level 5-4 participants with chronic diseases had no access to their medication

Acceptability
Complexity of billing system and inability for patients to get vaccine before it was provided by government
Community and cultural preferences
Stigma
Lack of health awareness
Accommodation
During COVID-19 chronic patience's felt less accommodated

5.3 THEMES GENERATED FOR DATA ANALYSIS

5.3.1 THEME ONE: AVAILABILITY

When looking at availability, one is studying the adequate supply and proper load of health workers, with the abilities and skill-mix to match the health needs of the populace. Analysis of the Ntabeni community experience of heath care during Coronavirus shows that people's experiences with availability at general health facilities were not good. This is because of prescription/drugs not being accessible, significant delays and 'badly designed opening times.

Thembi stated that she went to the clinic to go and get her medication for HIV and AIDS, but it was so packed at the clinic that she did not even get the help she was looking for after waiting the whole day. He came back without his medication.

Ntabeni does not have basic infrastructure and health care providing facilities. They rely on their neighboring communities which are Ashdown, Prestbury, Edendale and Napierville communal clinics and hospitals. Not having proper access to healthcare meant that during the COVID-19 pandemic Ntabeni residence had limited available healthcare resources. The pandemic resulted in clinic and hospital overcrowding, so much that some patients had to go back home without any

medical assistance. Some community members even stated that clinics and hospitals were so full that they decided not to even bother about going to collect their chronic medication. Some felt that they had to rely on home remedies whenever they experienced symptoms of COVID-19. Other informants stated that their hinderance to accessing healthcare was the lack of transportation fee and the registration fee of R40 at public hospitals. Although there were other hospitals and clinics in town or other sections of Pietermaritzburg, they did not have the money.

Thobile stated that she did not have enough money for transport which she needed to go to the hospital as she had to rush her child because her child had asthma.

5.3.2 THEME TWO: ACCESSIBILITY

For the Ntabeni community, access to healthcare during COVID-19 was extremely challenging. This is because of clinic and hospitals being far. Within Ntabeni there is no local clinic with proper healthcare services. This is because Ntabeni is an informal settlement that excluded from several service delivery, including access to health facilities and health care. Some informants revealed that during COVID-19 level 5-4 patients with chronic diseases had no access to their medication. This was because of lockdown and other contributing factors like fears of going out, lack of money, and overcrowding at healthcare facilities. For others, their access to health care was hindered by unpleasant staff mentality or poor interpersonal abilities just as complex billing systems at clinics and hospitals, absence of self-confidence and low confidence by patients from among poor people, which expanded the trouble of getting health services.

Dudu stated that she wanted to go to the clinic but the thought of how full it has discouraged her. For her the clinic are already far so going and having to come back without any assistance resulted in her not going and risking her life.

Limitations on the tasks that can be performed by different health staff, for example, approaches that favor the utilization of metropolitan based, medical clinic associated obstetricians to help deliver in circumstances where birthing assistants would be sufficient (Mavalankar and Rosenfield 2005). The late or non-referral to more expert consideration of patients who might report with a condition at lower-level health offices (Kiwanuka et al. 2008). Shame related with a sickness or condition, like tuberculosis (Storla et al. 2008). Absence of time or potential chance to sell

resources, in any event, when accessible, to guarantee the accessibility of money at the hour of looking for care (Khun and Manderson 2007).

5.3.3 THEME THREE: ACCEPTABILITY AND ACCOMMODATION

Acceptability and accommodation are also very important when it comes to access to health care at Ntabeni. Health labor force attributes and capacity (e.g., sex, language, culture, age, and so on) to treat all patients with dignity, provoke trust and advance interest for services is crucial. However, this is not fully fulfilled for the Ntabeni community.

Lindo stated that he does not like going to the clinic or hospital because they are told to go to their nearest clinic. They are marginalized by other neighboring community clinics. They must lie and say they stay in a specific address that is closer to which ever clinic they go to.

The above outcomes suggest that an inclination towards private health services exists, even among poor people. The analysis of the acceptability aspect of access could help with clarifying this uncovered preference for private health services. Different elements, other than availability and accommodation, may influence the decision of doctors consulted when sick or harmed. These variables might incorporate discriminations or bad experiences of going to public health facilities.

5.3.4 THEME FOUR: AFFORDABILITY

While affordability stays an issue in accessing health care, it is not really the primary hindrance to access. According to the participants at Ntabeni affordability also greatly shaped how they experienced healthcare services during COVID-19 and even before.

Nombuyiselo stated that she could not afford transportation money to go to the clinic. She did not even afford to buy the medicine from the pharmacies to prevent COVID-19 [vitamin C] and other medicines.

An illustration of this is that respondents considered health care to be 'excessively costly'. From the health clients' point of view, issues connected to reasonableness might reach out past client charges and co-installments to incorporate costs, for example, travel costs. It is, thus, sensible to expect that a few respondents might have addressed the inquiry considering travel costs, while others may not have. Most of the participants did not work and relied on grants for their needs. Participants felt that during lockdown level 5-4 people with medical aid and money to visit private

doctors were lucky and had more survival chances during the pandemic. Some even spoke about how the rich had access to the vaccine before the government provided the vaccine and this is because they could afford it. Another participant stated that sometimes when they go to the clinic or hospital, they do not get their medication as they are told its finished or did not arrive. They then must buy their medication from pharmacies which they sometimes do not buy because they do not that the money to.

Shaka stated that he was grateful for the social relief grant because he was able to use the money to buy medication instead of going to the clinics and waiting in the long ques.

This study reveals that unemployment excluded people from accessing services offered by government while it also recognizes that the provision of social grants enabled most people to have access to money which they invested in transport which afforded them access to health care facilities.

5.3.5 THEME FIVE: AWARENESS

As stated in the literature review, amongst the five as of access theory, awareness should also be added as a factor when studying access to healthcare. Awareness means that for people to access healthcare facilities they need to be aware of them. Then again, on the chance that individuals do not know about illnesses and healthcare choices, it holds them back from making a precautious move or from visiting their primary care physician and accessing care. Absence of awareness is because of the nonattendance, inaccessibility or error of data, which is some of the time made more diligently by cultural taboos, myths and fear, which can prevent individuals from making a deterrent move or seeing doctors.

Lethuxolo stated that she did not believe covid was real. When she caught COVID-19 she dismissed it to just normal flu. She did not go to check or tell anyone that she had all COVID-19 symptoms. This is because she feared that people were going to isolate her and that she was going to die.

Because of absence of awareness, individuals frequently come to healthcare offices when their illness has deteriorated or arrived at a late stage, bringing about lower chance of successful treatment. Absence of awareness likewise prompts shame. Absence of awareness is not just risky as far as demolishing health results; it can likewise be troublesome in the public eye and can influence personal satisfaction. During COVID-19 level 5-4 many people at Ntabeni got infected

because they were not made aware about the seriousness of the pandemic. Other people mostly in rural setting were not fully aware of ways to hinder the spread of COVID-19 during the early stages.

Thabo stated that he did not believe in Covid 19 as it is in the air, he stated that he believes that the government speared this disease because it wants to decrease the population in our country.

Nokwazi stated that she believed that the vaccine that is supposed to make u stronger and protect you from Covid 19 does not protect you from it but makes you even more venerable and that is why she did not want to take the vaccine

5.3.6 THEME SIX: QUALITY OF HEALTH CARE

When looking at the quality of health care, one is looking at the labor force capabilities, abilities, information and conduct, as evaluated by proficient standards and as seen by clients. Without adequate availability, accessibility to health workers cannot be ensured. If they are available and accessible, without acceptability, the health services probably will not be used, when the quality of the health labor force is lacking, improvement in health results will not be achieved or satisfactory.

Thapelo stated that he did not even bother to travel to the clinic because he was not going to get any help. Since a lot of people were sick the clinics ran out of flu/COVID-19 medication. He resorted into buying flu pack at a pharmacy when he went to collect his social relief grant.

Delivery of quality health care is a sacred responsibility in South Africa (Stuckler, Basu and Mckee, 2011). Government has subsequently introduced various changes and projects to further develop health care, proficiency, security and quality of delivery and access for all clients (Mogashoa and Pelser. 2014), and there have been significant changes in health strategy and regulation to guarantee consistence in conveying quality consideration (Moyakhe ,2014).

Susan stated that they as the community of Ntabeni do not have access to healthcare. She said that they rely on other communities' clinics however even there the quality of healthcare is so poor that sometimes she just prefers not going to the clinic. She said that she feels that the government has neglected her community healthcare services.

Zubane (2011) stated that notwithstanding various admirable goals having been set by government for improved quality of service delivery in healthcare settings, reports by media and networks in 2009 uncovered those services in general health institutions were failing to fulfill essential guidelines of care and patients' expectations (National Department of Health 2012). This has caused people in general to lose trust in the healthcare system. Koelble and Siddle (2014) depict the healthcare system in South Africa as demolished and in genuine need of fix. Many issues in the South African healthcare system can be followed back to the politically sanctioned racial segregation period (1948-1993) in which the healthcare system was exceptionally divided, with biased impact, between four unique racial groups (Black, Coloured, Indian and white) (Baker 2010:79). This led to decay in health service delivery due to absence of assets, and helpless communities were particularly impacted (Chassin and Loeb, 2013). There is overwhelming evidence that the nature of medical care in South Africa has been subverted by various challenges that influence medical care quality negatively. According to the people of Ntabeni the nature of medical care services in Ntabeni is of bad quality. The sources feel that they do not look for genuine medical care therapy. They acknowledge that this could be resolved by improvement in quality care meaning fewer errors, reduced delays in care delivery, improvement in efficiency, increased market share and lower cost. Decline in quality medical services has caused the public in general to lose trust in the medical care systems in South Africa.

5.3.7 THEME SEVEN: ETHNOMEDICINE

Ethnomedicine is a study of traditional medication considering bioactive mixtures in plants and creatures and rehearsed by different ethnic groups, particularly those with little access to western medicine, such as native people groups. The word ethnomedicine is occasionally utilized as a synonym for traditional medication. These ethnomedical plants have proved to be indigenous, accessible, cheap and do not have side effects. Data revealed that Ntabeni community is a multicultural community and relay largely on these plants to cure most health issues. The analysis of data further revealed that, other than it being indigenous, poor people opt for it because it is cheap and does not require transportation fees in order to access it. A deeper insight of data analysis revealed that most local traditional healers in the community cured some of the participants when they were infected with COVID-19 and other disease such as TB, diarrhea, etc. Some participants stated that because of poor access to healthcare they just relied on ethno-medicines. They did not

go to the clinic or hospital. The utilization of medicinal plants as a principal part of the traditional African healthcare system is maybe the most established and generally differed of every remedial system. The traditional healers endorse medicinal plants and are the most accessible and reasonable health asset accessible to the local community of Ntabeni, and now and again the main enduring treatment. A great many people in Ntabeni like to utilize traditional medication/therapeutic plants rather than Western medication since they accept that traditional medication is more productive, accessible and reasonable. In any case, despite these turns of events, traditional medication has been disregarded and its significance underplayed by native communities.

Sipho stated that he showed all the signs of Covid-19 but because he does not truly believe in the modern technology, he believes more in the traditional medicine he decided to help himself by steaming with umhlonyane.

For some of the participants, they relied on *umhlonyane* during the pandemic. Umhlonyane, which is also called lengana is used for the most part by black traditional healers and is additionally utilized in numerous African families to treat illnesses like asthma and respiratory diseases. Umhlonyane also purifies the Spirit, releases bacteria and toxins affecting the immune system, relieves sinuses congestion and headaches, clears the skin, expands blood vessels and circulation which boosts a healthy blood flow. One may steam with *iMpepho* or Fever tea. Steaming (ukufutha or ukungquma) is also another method that was used by the participants as their traditional way of fighting COVID-19.

5.4 SYNTHESIS OF FINDINGS

During this lockdown level 5-4, clinics, facilities, health offices, drug stores and other fundamental services stayed open. Nonetheless, patients' access to healthcare may have been exceptionally impacted by the geological distribution of health facilities, tight restrictions on movements of people across subnational boundaries, suspension of public vehicle, and patients' dread of COVID-19 disease. COVID-19 has infected large number of individuals while causing a great many deaths worldwide. Research findings revealed that during the global COVID-19 lockdown, the community of Ntabeni experienced boundaries to accessing healthcare and difficulties clinging to prescription. The data shows that the Ntabeni people did not have appropriate access to healthcare

during Coronavirus lockdown levels 5-4 just because they were poor and could not access to health care services. There are six recognized factors that made hinderance to legitimate access to healthcare during Coronavirus level 5-4 at Ntabeni. These boundaries are affordability, accommodation, awareness, availability, acceptability and accessibility. Data collected show that these elements are the primary obstructions for the Ntabeni community. Due to these obstructions the quality of healthcare services was compromised and further revealed that poor communities are not guaranteed access to health care and facilities. Research participants expressed that the quality of healthcare service and access to healthcare services that they experienced during Coronavirus level 5-4 was of incredibly helpless standards. A few individuals depended on traditional healthcare techniques considering the helpless healthcare services that they experienced during Coronavirus level 5-4.

5.5 CHAPTER CONCLUSION

For Ntabeni community, access, affordability, acceptability, accommodation, attitudinal issues, destitution, insufficiently prepared healthcare experts, and actual inaccessibility are significant obstructions to healthcare services. Because of these factors Ntabeni community (participants) have experienced poor access to healthcare during COVID-19 level 5-4 and this has exacerbated the gap between the poor and the affluent. It further gives a clear interpretation that one's geography does include or exclude him or her from accessing health services. Traditional medicinal also known as ethnomedicine proved to be accessible at the time of need. This then validate those traditional plants continue to be the hope of poor people while rich people could afford health care and facilities at the time of their need.

CHAPTER SIX

STUDY SUMMARY, RECOMMENDATIONS AND CONCLUSION

6.1 INTRODUCTION

The researcher endeavored to produce knowledge on the experiences of Ntabeni rural community during COVID-19 levels 5-4. The study suggests that poverty and unemployment have been a major socio-economic condition that have excluded people living at Ntabeni from accessing health care facilities and health care. And this was most evident during the rapid rise of COVID-19 as many community members faced multiple barriers to access to healthcare facilities. Research findings confirmed that rural communities are confronted by many difficulties, one of which is health issues and compromised access to health care offices. Without access to health services, sufficient prescription, and appropriate service delivery, chronic illnesses will keep on being a danger to the health of individuals in rural areas such as Ntabeni

6.2 STUDY SUMMARY

This study was conducted to study the experience of Ntabeni community when it comes to access to healthcare during COVID-19 level 5-4. The findings show that Ntabeni had multiple barriers towards access to healthcare during COVID-19 level 5-4. These barriers were affordability, accommodation, awareness, availability, acceptability and accessibility. Accessibility was the major issue for the Ntabeni community because they have no healthcare facilities. Cost adds to the challenges of using health services among the Ntabeni people group, this being the second significant limitation that kept them from accessing health care during Coronavirus lockdown level 5-4. Although participants affirmed that they did not pay for health services, they did, nonetheless, notice how they were impacted by extra expenses in accessing health care. This is lamentable, because a large portion of them revealed that they were employed and did not have the money for such crises, making it important to get money from their neighbors, which put them in danger. The cash-based medical treatment affects the health usage of facilities that provide access to healthcare. Notwithstanding the South African government gaining critical headway towards giving free essential health care to all citizens, the money needed to accessing health services remains a major

concern. Transport cost, food and refreshments are a portion of the extra expenses revealed by respondents while accessing health services.

Traditional healers and the usage of ethnomedicine such as *umhlonyane* was recorded as an alternative of health relief for some of the community members of Ntabeni. During COVID-19 level 5-4 some individuals relied on traditional healers to cure them from COVID-19. While traditional healers have been predominant in providing medicine for the physically ill and injured, their contribution to health care during covid-19 cannot be dismissed. Health care providers are at the focal point of the accomplishment of health service delivery in South Africa, and they play a significant role in the usage of health care services. A few members have affirmed that they feel awkward or acknowledged in some health care offices and healthcare suppliers. A few members detailed that the disposition of health laborers at the health care offices is not suitable, and they are not accommodative of their necessities.

In relation to accessibility of health care facilities, research informants reported that they spend more time waiting to receive treatment than travelling to clinic. The long waiting period at large rural hinder access to proper services delivery, forcing time costs on patients, hindering proper use and causing patient disappointment. In this study, the respondents detailed that during Coronavirus level 5-4 they went through almost 1-3 hours at the health facilities and felt that this was exceptionally debilitating, on the grounds that they have other significant responsibilities, such as family and work. Despite the topographical area of the health office, long holding up hours obstruct or hinder use of health services. This is because many people were sick due to COVID-19 which resulted in the overcrowding of healthcare facilities that the participants used.

6.3 IMPLICATION FOR EXISTING THEORIES

The COVID-19 pandemic caused a rapid and significant chaos is healthcare facilities. Penchansky and Thomas conceptualized the idea of access to health care as comprising five dimensions, known as the Five A's of access: affordability, availability, accessibility, accommodation, and acceptability. Considering these dimensions of access allowed health care systems to dissect barriers to access to better identify ways to overcome them. This study agrees with Penchansky

and Thomas Access theory. The five A, s of access listed in the Access theory are the causes of barrier to access to health care during covid-19 level 4-5 in Ntabeni community. However, for this community another A was discovered which is Awareness. For Ntabeni community another hinderance to access to healthcare for the was not being aware of the information and dangers of covid-19 during level 4-5. This study also agrees to the ideologies of the social constructivism theory. For this study to be possible and for the researcher to get in-depth information the participants had to share their realities about their experience of access to health care facilities during covid-19. It through social constructivism theory that the participant of Ntabeni community where the center of knowledge production.

6.4 RESEARCH LIMITATIONS

This study is not without limitations. It was limited to the experience of Ntabeni people only during COVID-19 level 5-4. Only members of Ntabeni were allowed to participate in this study.

6.5. STUDY RECOMMENDATION

1. I recommend that awareness is necessary to access, that it ought to turn into a long-lasting piece of the Access Theory figured out by Penchansky and Thomas and be applied at whatever point utilizing the theory to create, carry out, or assess medical care services and access.
2. Health literacy interventions should be a priority in rural communities, with community and traditional leaders placing more emphasis on health and the barriers they face in accessing health services.
3. The department of health in Pietermaritzburg should consider availing a mobile clinic provision that will cater for the Ntabeni Community in order to maximize opportunities of access to health care and facilities. If this is thought of destitute individuals or individuals who are jobless would not feel prevented from getting to medical care and offices at the hour of their need. This decentralized assistance will likewise diminish the time spent while wanting to receive medical care services. Future research is needed where anthropology researchers will look at factors that are inhibiting community members from accessing

universities and contributing to a high rate of unemployment. Other studies could also look at the impact of the Msunduzi Integrated Development Planning which is supposed to be positively impacting the lives of Ntabeni community in relation to their socio-economic needs.

6.6. RECOMMENDATIONS FROM THE RESPONDENTS

1. The department of health should prioritize health and access to health care and facilities for the Ntabeni Community which is afflicted by poverty, unemployment and many health issues which are threatening the survival right of all human beings in the world.
2. Government should remove user fees at public hospitals as this would maximize access to health care and facilities for indigent/poor people.
3. The provision of a wellness/mobile clinic should be expedited as they will also accommodate those that cannot travel for their medical needs. This will improve the affordability dimension of health service access.
4. Medical treatment should be delivered every month and on time. Healthcare should be the same everywhere not only in urban areas.
5. More awareness on health issues is needed as most people would be educated about the different diseases and the importance of regular checkup.

Discoveries from this study show that policy makers could use this study to further develop access to medical services over the long run. While the study presumed that income/money was the primary determinant of access to medical care services, it has additionally shown that access to medical care in Africa is a necessary rather than a luxury, consequently, calling for strategy and policy interventions that explicitly ensure access to medical services for the entire population.

6.7 CONCLUSION

The study discovered that the community of Ntabeni faces challenges in accessing healthcare. The researcher additionally learned that the way of life of the people of Ntabeni puts their health in danger as they take part in reckless conducts such as smoking, substance misuse and fighting, which makes them more inclined to illness, mishaps and wounds. Ntabeni people are confronted with different obstacles in accessing health services, for example, distance to health centers, transport, cost, long waiting hours and lines, pessimistic health care suppliers, absence of medical insurance and privacy. The discoveries in the study propose that assessing successful ways of lessening these boundaries is an under-explored region. However, one where the arrangement suggestions are possibly significant. It recommends that in planning interventions, the networks ought to be completely engaged with request to guarantee that the subsequent arrangement is socially adequate. Nonetheless, interventions should not just focus on the hindrance's the Ntabeni people group face yet additionally focus on the aberrant factors that influence healthcare, like neediness, joblessness, education and low financial status. These occasionally being the fundamental factors that add to the hindrances in accessing health services among rural communities in South Africa.

The study of hindrances to accessing healthcare in South Africa was worth investigating in the time of COVID-19. This was effectively recorded by giving an account of the viewpoints and encounters of individuals who look for healthcare services at public health offices. The study adds to significant discussions about the deficiencies of healthcare experts in the country, the predetermined number of examinations reporting health looking for practices of men and the financial difficulties confronting rural regions, which all influence the health of the populace. It was clear in the study that hindrances, for example, lack of education, joblessness and geological area are critical to their restricted admittance to health services. Different hindrances that were found incorporate the apparent absence of privacy of healthcare suppliers as detailed by the members, a gendered viewpoint of the health administration and the misrepresented degree of neediness which by and large are significant obstructions to healthcare access.

REFERENCES

1. Adejumo O. & Archibong U, 2013, 'Affirmative action in South Africa: Are we creating new casualties?', *Journal of Psychological Issues in Organizational Culture* 3, 14–27.
2. Alase, A., 2017. The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education and Literacy Studies*, *5*(2), pp.9-19.
3. Alves J., Peralta S. & Perelman J, 2013, 'Efficiency and equity consequences of decentralization in health: An economic perspective', *Revista Portuguesa de Saúde Pública* 31, 74–83.]
4. Babbie, E.R., 2020. *The practice of social research*. Cengage learning.
5. Baker P, 2010, 'From apartheid to neoliberalism: Health equity in post-apartheid South Africa', *International Journal of Health Services* 40, 79–95. [PubMed] [Google Scholar]
6. Barron P. & Padarath A, 2017, *Twenty years of the South African Health Review*, South African Health Review 2017, Health Systems Trust, Durban. [Google Scholar]
7. Bliss, L.A., 2016. Phenomenological research: Inquiry to understand the meanings of people's experiences. *International Journal of Adult Vocational Education and Technology (IJAVET)*, *7*(3), pp.14-26.
8. Burger R. & Jafta R, 2010, *Affirmative action in South Africa: An empirical assessment of the impact on labour market outcomes Crise Working Paper No. 76*, Crise working paper, Stellenbosch University, Stellenboch. [Google Scholar]
9. Carney M, 2009, 'Public health nurses' perception of medicalleadership in Ireland: Narrative descriptions', *Journal of Nursing Management* 17, 435–445. 10.1111/j.1365-2834.2009.01015.x [PubMed] [CrossRef] [Google Scholar]
10. Carrithers, Michael; Candea, Matei; Sykes, Karen; Holbraad, Martin; Venkatesan, Soumhya (2010). "Ontology Is Just Another Word for Culture: Motion Tabled at the 2008 Meeting of the Group for Debates in Anthropological Theory, University of Manchester". *Critique of Anthropology*. **30** (2): 152–200. doi:10.1177/0308275X09364070. ISSN 0308-275X.

11. Chassin M.R. & Loeb J.M, 2013, 'High-reliability health care: Getting there from here', *The Milbank Quarterly* 91, 459–490. 10.1111/1468-0009.12023 [PMC free article] [PubMed] [CrossRef] [Google Scholar]
12. CohenMiller, A. S. and P. Elizabeth Pate. "A Model for Developing Interdisciplinary Research Theoretical Frameworks." *The Qualitative Researcher* 24 (2019): 1211-1226.
13. Coovadia H., Jewkes R., Barron P., Sanders D. & Mcintyre D, 2009, 'The health and health system of South Africa: Historical roots of current public health challenges', *Lancet* 374, 817–834. 10.1016/S0140-6736(09)60951-X [PubMed] [CrossRef] [Google Scholar]
14. Cullinan K, 2006, *Health services in South Africa: A basic introduction. Health-e News Service* 1–38, viewed n.d., from https://www.researchgate.net/publication/266408254_Health_services_in_South_Africa_A_Basic_Introduction
15. Dramowski A. & Whitelaw A, 2017, 'A framework for preventing healthcare-associated infection in neonates and children in South Africa', *South African Medical Journal* 107, 192–195. 10.7196/SAMJ.2017.v107i3.12035 [PubMed] [CrossRef] [Google Scholar]
16. Dunjwa M, 2016, *Public health facilities audit results: Facilitiesof Health Standards Compliance (OHSC) briefing*, Parliamentary Monitoring group, Pretoria, South Africa. [Google Scholar]
17. ECONEX , 2010, *Accreditation of healthcare providers*, April 2010 edn., Pretoria, South Africa, viewed 01 February 2016, from https://econex.co.za/wp-content/uploads/2015/04/econex_health-reform-note_2.pdf [Google Scholar]
18. ECONEX , 2013, *The South African private healthcare area: Role and contribution to the economy*, November 2013 edn., Pretoria, South Africa, viewed 01 February 2016, from https://econex.co.za/wp-content/uploads/2015/03/econex_researchnote_32.pdf [Google Scholar]
19. Fonn S., Ray S. & Blaauw D, 2011, 'Innovation to improve health care provision and health systems in sub-Saharan Africa – Promoting agency in mid-level workers and district managers', *Global Public Health* 6, 657–668. 10.1080/17441692.2010.489905 [PubMed] [CrossRef] [Google Scholar]
20. Franks P.E, 2014, *Dealing with the 'soft' issues that undermine service delivery at all levels*, University of Stellenbosch, Stellenboch. [Google Scholar]

21. Frodeman, Robert. *The Oxford Handbook of Interdisciplinarity*. New York: Oxford University Press, 2010.
22. Hendricks S.J.H., Buch E., Seekoe E., Bossert T. & Roberts M, 2014, 'Decentralisation in South Africa: Options for District Health Authorities in South Africa', *South African Health Review* 4, 59–71. [Google Scholar]
23. Heywood M, 2014, *The broken thread: Primary health care, social justice and the dignity of the health worker*, 2014 edn., Wits Political Studies Department, Pretoria. [Google Scholar]
24. Kahn K, 2011, 'Population health in South Africa: Dynamics over the past two decades', *Journal of Public Health Policy* 32, S30–S36. 10.1057/jphp.2011.27 [PubMed] [CrossRef] [Google Scholar]
25. Kama Z.S, 2017, 'An evaluation of access to health care: Gugulethu Community Health Clinic', Master of Technology, Faculty of Business Cape Peninsula University of Technology, Cape Town. [Google Scholar]
26. Kamndaya M., Thomas L., Vearey J., Sartorius B. & Kazembe L, 2014, 'Material deprivation affects high sexual risk behavior among young people in urban slums, South Africa', *Journal of Urban Health* 91, 581–591. 10.1007/s11524-013-9856-1 [PMC free article] [PubMed] [CrossRef] [Google Scholar]
27. Kilonzo E.M. & Ikamari L, 2015, 'Impact of affirmative action on quality of service delivery inthe public service area of Kenya: A comparative case study of the ministry of state', *Journal of Education and Practice* 6, 113–125. [Google Scholar]
28. Koelble T.A. & Siddle A, 2014, 'Institutional complexity and unanticipated consequences: The failure of decentralization in South Africa', *Democratization* 21, 1117–1133. 10.1080/13510347.2013.784270 [CrossRef] [Google Scholar]
29. Kohn, Eduardo (21 October 2015). "Anthropology of Ontologies". *Annual Review of Anthropology*. **44** (1): 311–327. doi:10.1146/annurev-anthro-102214-014127. ISSN 0084-6570.
30. Kollapen J.J., Carnelly M., Jaichand V. & Lawrence M.I, 2017, *Issue Paper 33, Project 141, Medico-Legal Claims*, 20 May 2017 edn., South African Law Reform Commission, Cape Town, South Africa. [Google Scholar]

31. Kon Z.R. & Lackan N, 2008, 'Ethnic disparities in access to care in post-Apartheid South Africa', *American Journal of Public Health* 98, 2272–2277. 10.2105/AJPH.2007.127829 [PMC free article] [PubMed] [CrossRef] [Google Scholar]
32. Kukreja B.J., Dodwad V. & Kukreja P, 2012, 'The law and medical negligence – An overview', *International Journal of Public Health and Dentistry* 3, 11–19. [Google Scholar]
33. Lateef F, 2011, 'Patient expectations and the paradigm shift of care in emergency medicine', *Journal of Emergerncy Trauma Shock* 4, 163–167. 10.4103/0974-2700.82199 [PMC free article] [PubMed] [CrossRef] [Google Scholar]
34. Lourens G, 2012, 'The national core standards and evidence-based nursing', *Professional Nurse Today* 16, 3–4. [Google Scholar]
35. Maharaj B, 2004, *Immigration to post-apartheid South Africa*, Global migration perspectives, Global Commission on International Migration, KwaZulu-Natal, South Africa. [Google Scholar]
36. Malherbe J, 2012, 'Counting the cost: The consequences of increased medical malpractice litigation in South Africa', Publication no. 10.7196/SAMJ.6457, *South African Medical Journal* 103, 83–84. 10.7196/SAMJ.6457 [PubMed] [CrossRef] [Google Scholar]
37. Managa A, 2012, *Unfulfilled promises and their consequences: A reflection on local government performance and the critical issue of poor service delivery in South Africa*, Policy Brief: Africa Institute of South Africa, Pretoria. [Google Scholar]
38. Manyisa Z.M. & Van Aswegen E.J, 2017, 'Factors affecting working conditions in public hospitals: A literature review', *International Journal of Africa Nursing Sciences* 6, 28–38. 10.1016/j.ijans.2017.02.002 [CrossRef] [Google Scholar]
39. Mayosi B.M., Lawn J.E., Van Niekerk A., Bradshaw D., Abdool Karim S.S. & Coovadia H.M, 2012, 'Health in South Africa: Changes and challenges since 2009', *Lancet* 380, 2029–2043. 10.1016/S0140-6736(12)61814-5 [PubMed] [CrossRef] [Google Scholar]
40. Mcintyre D. & Klugman B, 2003, 'The human face of decentralisation and integration of health services: Experience from South Africa', *Reproductive Health Matters* 11, 108–119. 10.1016/S0968-8080(03)02166-9 [PubMed] [CrossRef] [Google Scholar]
41. Mogashoa M.G. & Pelser G.P, 2014, 'An analysis of the implementation of the national core standards in public hospitals', *African Insight* 44, 142–147. [Google Scholar]

42. Mokoele M.S, 2012, 'The impact of the undocumented immigrants on the provision of housing, job opportunities and health facilities in Limpopo Province: A case study of Polokwane Municipality', Master's Degree, University of Limpopo. [Google Scholar]
43. Mokoena M.J, 2017, 'Perceptions of professional nurses on the impact of shortage of resources for quality patient care in a public hospital: Limpopo Province', Master of Arts, University of South Africa. [Google Scholar]
44. Moyakhe N.P, 2014, 'Quality healthcare: An attainable goal for all South Aricans', *South African Journal of Black Leadership* 7, 80–83. 10.7196/sajbl.355 [CrossRef] [Google Scholar]
45. Naidoo S, 2012, 'The South African national health insurance: A revolution in health-care delivery!', *Journal of Public Health (Oxford, England)* 34, 149–150. 10.1093/pubmed/fds008 [PubMed] [CrossRef] [Google Scholar]
46. National Department of Health, 2011, *National core standards for health establishments in South Africa: 'Towards quality care for patients'*, Departhment of Health, Republic of South Africa, Tshwane, South Africa. [Google Scholar]
47. National Department of Health, 2012, *The national health care facilities baseline audit. National Summary Report, Health e-News*, in Visser R., Bhana R. & Monticelli F. (eds.), National Department of Health, Pretoria, South Africa. [Google Scholar]
48. National Department of Health, 2013, *Regulating the quality of health services: Benchmarking of approaches, institutions and systems*, Towards the establishment of an facilitiesof health Standards, May 2013 edn., Republic of South Africa, Pretoria. [Google Scholar]
49. National Department of Health , 2014, *Department of Health Strategic Plan 2014/15–2018/19*, Health e-News, Pretoria, viewed 31 March 2017, from https://www.health-e.org.za/2014/09/25/report-department-health-strategic-plan-201415-20189/ [Google Scholar]
50. National Department of Health, 2016, *Statistics South Africa. Mid-year population estimates*, Pretoria, viewed 08 May 2017, from https://www.statssa.gov.za/publications/P0302/P03022016.pdf [Google Scholar]
51. Ned L., Cloete L. & Mji G, 2017, 'The experiences and challenges faced by rehabilitation community service therapists within the South African primary healthcare health

system', *African Journal of Disability* 6, 311. [PMC free article] [PubMed] [Google Scholar]

52. Nevhutalu H.K, 2016, 'Patients' rights in South Africa's public health system: Moral-critical perspectives', PhD Degree in Philosophy, University of Stellenbosch. [Google Scholar]
53. Ngomane T.S, 2010, 'The socio-economic impact of migration in South Africa: A case study of illegal Zimbamweans in Polokwane Municipality in the Limpopo Province', Master's Degree, University of Limpopo. [Google Scholar]
54. Oladipo J.A, 2014, 'Utilization of health care services in rural and urban areas: A determinant factor in planning and managing health care delivery systems', *African Health Sciences* 14, 322–333. 10.4314/has.v14i2.6 [PMC free article] [PubMed] [CrossRef] [Google Scholar]
55. Pillay R, 2010, 'The skills gap in hospital management: A comparative analysis of hospital managers in the public and private areas in South Africa', *Health Services Management Research: An Official Journal of the Association of University Programs in Health Administration/HSMC, AUPHA* 23, 30–36. [PubMed] [Google Scholar]
56. Pillay-Van Wyk V., Msemburi W., Laubscher R., Dorrington R.E., Groenewald P., Glass T. et al., 2016, 'Mortality trends and differentials in South Africa from 1997 to 2012: Second National Burden of Disease Study', *The Lancet Global Health* 4, e642–e653. 10.1016/S2214-109X(16)30113-9 [PubMed] [CrossRef] [Google Scholar]
57. Pretorius R. & Klopper H.C, 2012, 'Positive practice environments in critical care units in South Africa', *International Nursing Review* 59, 66–72. 10.1111/j.1466-7657.2011.00923.x [CrossRef] [Google Scholar]
58. Regchand S, 2015, 'The Pietermaritzburg High Court had ordered the Escourt Hospital to hand over medical records to attorney', *The Mercury*, South Africa, 8 April, p. 2. [Google Scholar]
59. Regmi K., Naidoo J., Pilkington P.A. & Greer A, 2010, 'Decentralization and district health services in Nepal: Understanding the views of service users and service providers', *Journal of Public Health* 32, 406–417. 10.1093/pubmed/fdp116 [PubMed] [CrossRef] [Google Scholar]

60. Republic of South Africa , 1996, *Constitution of the Republic of South Africa*, Government Gazette, 2014 edn., Pretoria, South Africa, viewed n.d., from https://www.gov.za/documents/constitution/constitution-republic-south-africa-1996-1 [Google Scholar]
61. Siddle A.M, (2011), 'Decentralisation in South African Local Government: A critical evaluation', Degree of Doctor of Phylosophy, Doctoral thesis, University of Cape Town. [Google Scholar]
62. Sithole S. & Mathonsi N, (2015), 'Local governance service delivery issues during Apartheid and post-Apartheid South Africa', in Ijeoma E. (chief ed.), *Africa's Public Service Delivery and Perfomance Review* 3, 5–30. [Google Scholar]
63. South African Medical Association , (2015), *Submission to Minister of Health, National Department of Health Comments in respect of White Paper for National Health Insurance for South Africa: Towards universal coverage*, Pretoria, viewed 15 December 2015, from https://www.mm3admin.co.za/documents/docmanager/f447b607-3c8f-4eb7-8da4-11bca747079f/00105160.pdf [Google Scholar]
64. Stuckler D., Basu S. & Mckee M, (2011), 'Health care capacity and allocations among South Africa's provinces: Infrastructure-inequality traps after the end of Apartheid', *American Journal of Public Health* 101, 165–172. 10.2105/AJPH.2009.184895 [PMC free article] [PubMed] [CrossRef] [Google Scholar]
65. Sunday Tribune, (2015), *Family of Miss Blanche Brown (35) blame the hospital for her death*, 08 March, 2015, Charmel Payet, KwaZulu-Natal, South Africa, pp. 1–12. [Google Scholar]
66. Surender R, (2014), *The drivers of universal health care in South Africa: The role of ideas, institutions and actors*, UNRISD project on towards universal social security in emerging economies: Process, institutions and actors, UNRISD, Geneva. [Google Scholar]
67. Tana V.V, (2013), 'Experiences of chronic patients about long waiting time at a community health care center in the Western Cape', Master of Nursing Sciences in the Faculty of Health, University of Stellenbosch. [Google Scholar]
68. The Centre for Development and Enterprise (CDE), 2011, *Reforming healthcare in South Africa: What role for the private area?* South Africa. [Google Scholar]

69. Timeslive , (2018), *Eight alarm bells at South African state hospitals*, South Africa, viewed n.d., from https://www.timeslive.co.za/news/south-africa/2018-06-14-eight-alarm-bells-at-south-african-state-hospitals [Google Scholar]
70. Tonsaker T., Bartlett G. & Atrpkov C, 2014, 'Health information on the Internet. Gold mine or minefield?', *Canadian Family Physician* 60, 407–408. [PMC free article] [PubMed] [Google Scholar]
71. Toyana M. & Auriacmbe C.J, 2013, 'Considerations for the implementation of the National Health Insurance: Health worker shortages', *Administratio Publica* 22, 62–219. [Google Scholar]
72. Turok I, 2012, *Urbanisation and development in South Africa: Economic imperatives, spatial distortions and strategic responses*, Human Settlements Group, International Institute for Environment and Development. [Google Scholar]
73. Twala T, 2014, 'The causes and socio-political impact of the service delivery protests on the South African citizenry: A real public discourse', *Journal of Social Science* 39, 159–167. [Google Scholar]
74. Van Rensburg H.C.J, 2014, 'South Africa's protracted struggle for equal distribution and equitable access – Still not there', *Human Resources for Health* 12, 1–27. 10.1186/1478-4491-12-26 [PMC free article] [PubMed] [CrossRef] [Google Scholar]
75. Veld M. & Van De Voorde K, 2014, 'How to take care of nurses in your organization: Two types of exchange relationships compared', *Journal of Advanced Nursing* 70, 855–865. 10.1111/jan.12247 [PubMed] [CrossRef] [Google Scholar]
76. Voget U, 2017, 'Professional nurses' lived experiences of moral distress at a district hospital', Thesis presented in partial fulfilment of the requirements for the degree of Master of Nursing Science in the Faculty of Medicine and Health Sciences, Stellenbosch University. [Google Scholar]
77. Whittaker S., Green-Thompson R.W., Mccusker I. & Nyembezi B, 2000, 'Status of a health care quality review programme in South Africa', *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care/Isqua* 12, 247–250. [PubMed] [Google Scholar]
78. Whittaker S., Shaw C., Spieker N. & Linegar A, 2011, *Quality standards for healthcare establishment in South Africa*, SAHR, Pretoria, South Africa. [Google Scholar]

79. Winchester M.S. & King B, 2018, 'Decentralization, healthcare access, and inequality in Mpumalanga, South Africa', *Health & Place* 51, 200–207. 10.1016/j.healthplace.2018.02.009 [PubMed] [CrossRef] [Google Scholar]
80. Young M, 2016, 'Private vs. public healthcare in South Africa', Honors thesis, Western Michigan University. [Google Scholar]
81. Žikić, B., 2007. Qualitative field research in anthropology: An overview of basic research methodology. *Етноантрополошки проблеми*, *2*(2), pp.123-135
82. Zubane P, 2011, *Alternative service delivery models for the South African public service for the year 2020*.

REFERENCES: PRIMARY RESOURCES

1. AHRQ (Agency for Healthcare Research and Quality). 2009 National Healthcare Quality and Disparities Reports. Rockville, MD: AHRQ; 2010. [June 13, 2017]. https://archive .ahrq.gov/research/findings/nhqrdr/nhqrdr09/qrdr09.html.
2. AHRQ. 2016 National Healthcare Quality and Disparities Reports. Rockville, MD: AHRQ; 2017. [June 13, 2017]. https://www.ahrq.gov/sites/default/files /wysiwyg/research/findings/nhqrdr/nhqdr16/2016qdr.pdf.
3. Armelagos, G. and Barnes, K. (1999). The Evolution of Disease and the Rise of Allergy: Epidemiology Transitions. Medical Anthropology. 18:187-213.
4. Biehl, J. and Petryna, A. (Eds.). (2013). When people come first: Critical Studies in Global Health. Princeton University Press.
5. Bihu, R. (2020). Using unstructured interviews in educational and social science research: the process, opportunity and difficult. GSJ: Volume 8, Issue 10.
6. Booysen, F. (2003 and 2010). Urban-rural inequalities in health care delivery in South Africa. Development Southern Africa, 20:5, 659-673,
7. Brown, C. and Ravallion, M. (2020, 10 August). Poverty, Inequality, and COVID-19 in the US. VoxEU.org. Available at: https://voxeu.org/article/poverty-inequality-and-COVID-19.

8. Burger, R. and Christian, C. (2018). Access to Health Care in Post-Apartheid South Africa: Availability, Affordability, Acceptability. Health Economics, Policy and Law, 15(1), 43-55. Available at https://DOI.org/10.1017/S1744133118000300.
9. Burger, R. and Ngwenya, M. (2020). Health: The [OUP] Handbook of the South African Economy. Unpublished manuscript. 28 Burger, R., Christian, C., English, R., Maughan-Brown, B., and Rossouw, L. (2020). Navigating COVID in the Post Lockdown Period: Shifting Risk Perceptions and Compliance with Preventative Measures. Income Dynamics Study (NIDS)-Coronavirus Rapid Mobile Survey (CRAM) Working Paper. Available at https://cramsurvey.org/wp-content/uploads/2020/09/4.
10. -Burger-R.-Christian-C.-English-R.-MaughanBrown-B.-_-Rossouw-L.-2020-Navigating-COVID-in-the-post-lockdown-period-Shifting-risk-perceptionsand-compliance-with-preventative-measures.pdf.
11. Buthelezi, A. S. L. (2019). Access to health facilities. A case study of Thubelihle informal settlements KwaMashu. Submitted in partial fulfillment of the requirements of the requirements for sustainable development and cities (geog330)
12. Chowdhury, S. and Koike, M. (2009). Use of plants in healthcare: A traditional ethno-medicinal practice in rural areas of southeastern Bangladesh. International Journal of Biodiversity Science, Ecosystem Services & Management 5(1)
13. Constitution of the Republic of South Africa. (No. 108 of 1996). Statutes of the Republic of South Africa – Constitutional Law 38: 1241–1331, http://www.info.gov.za/documents/constitution/1996/a108-96.pdf,
14. Donabedian, A., 1972. Models for organizing the delivery of personal health services and criteria for evaluating them. *The Milbank Memorial Fund Quarterly*, *50*(4), pp.103-154.
15. Farmer, P., Kim, J., Kleinman, A. and Basilico, M. (Eds.). (2013). Reimagining Global Health: an introduction. University of California Press.
16. García, S., Parejo, A., Personal, E., Guerrero, J.I., Biscarri, F. and León, C., 2021. A retrospective analysis of the impact of the COVID-19 restrictions on energy consumption at a disaggregated level. *Applied Energy*, *287*, p.116547.
17. Goundar, S. (2012). Chapter 3 - Research Methodology and Research Method Chapter. ResearchGate publishers.

18. Grut, L., Gubela, M.J.I., Braathen, S. H. and Ingstad, B. (2012). Accessing community health service: challenges faced by poor people with disabilities in a rural community in South Africa.
19. Harris, B., Goudge, J., Ataguba, J. E., Diane McIntyre, D., Nxumalo, N., Siyabonga Jikwana, S. and Matthew Chersich, M. (2011). Inequities in access to health care in South Africa. Journal of Public Health Policy, 2011, Vol. 32, Supplement 1: Public health, health area reforms, and policy implementation in South Africa: Studies and perspectives on the 24th anniversary of the Centre for Health Policy (2011), pp. S102- S123 Published by: Palgrave Macmillan Journals
20. Harris, B., Goudge, J., Ataguba, J. E., McIntyre, D., Nxumalo, N., Jikwana, S., and Chersich, M. (2011). Inequalities in access to health care in South Africa. Journal of Public Health Policy, Vol.32 Supplement 1: Public health, health area reforms and policy implementation in South Africa: Studies and perspective on the 24th anniversary of the Centre for Health Policy. url: https://www.jstor.org./stable/20868835. Published by: Palgrave Macmillan Journals
21. Ishtiaq M, Maqbool M, Ajaib M, Ahmed M, Hussain I, Khanam H, et al. (2021) Ethnomedicinal and folklore inventory of wild plants used by rural communities of valley Samahni, District Bhimber Azad Jammu and Kashmir, Pakistan. PLoS ONE 16(1): e0243151. https://doi.org/10.1371/journal.pone.0243151
22. Jensen, C. and McKerrow, N. H. (2021). Child Health services during a COVID-19 outbreak in KwaZulu-Natal Province, South Africa. South African Medical Journal 2021:111(2):
23. Ji, R. and Cheng, Y. (2021). Global Health Research and Policy. https://doi.org/10.1186/s41256-021-00233-z
24. Kumar, M.; Radha; Devi, H.; Prakash, S.; Rathore, S.; Thakur, M.; Puri, S.; Pundir, A.; Bangar, S.P.; Changan, S.; et al. Ethnomedicinal Plants Used in the Health Care System: Survey of the Mid Hills of Solan District, Himachal Pradesh, India. Plants 2021, 10, 1842. https:// doi.org/10.3390/plants10091842
25. Lieberman-Cribbin, W., Tuminello, S., Flores, R. M., and Taioli, E. (2020). Disparities in COVID-19 Testing and Positivity in New York. American Journal of Preventive Medicine, 59(3), 326-332

26. Malakoane, B., Heunis, J.C., Chikobvu, P., Kigozi, N.G and Kruger, W.H. (2020). Public Health system challenges in the Free State, South Africa: a situation appraisal to inform health system strengthening. BMC Health Services Research. 20:58
27. Maphumulo, W.T. & Bhengu, B.R., 2019, 'Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review', Curationis 42(1), a1901. https://doi.org/ 10.4102/curationis. v42i1.1901
28. Mbunge, E. (2020). Effects of COVID-19 in South African health system and society: An explanatory study. Diabetes & Metabolic Syndrome: MedicalResearch & Reviews 14 (2020) 1809e1814
29. McLaren, Z., Ardington, C. and Leibbrandt, M., 2013. *Distance as a barrier to health care access in South Africa*.
30. Miles, D.A. and Scott, L. (2017). Workshop: Confessions of a Dissertation Chair Part 1: The Six Mistakes Doctoral Students Make with the Dissertation. Presented at the 5th Annual 2017 Black Doctoral Network Conference in Atlanta, GA on October 26-29, 2017.
31. Mohajan, H. (2018). Qualitative Research Methodology in Social Science and Related Subjects. Journal of Economic Development, Environment and People, Vol-7, Issue 01,2018, pp.23-48
32. Mooney, G. and Mc Intyre, Di. (2007). The Economics of Equity. Published in the United States of America by Cambridge University Press, New York
33. Morris-Paxton AA, Reid S, Ewing R-MG. Primary healthcare services in the rural Eastern Cape, South Africa: Evaluating a service-support project. Afr J Prm Health Care Fam Med. 2020
34. Morris-Paxton, A., Reid, S. Ewing, A. (2020). Primary healthcare services in the rural Eastern Cape, South Africa: Evaluating a service-support project.
35. Nasiripour, A. A., Mahmond, G. and Raeissi, P. (2011). A survey on Exploring the dimessions of Access to Medical Services. Article in World Applied Sciences Journal
36. National Institute for Communicable Diseases (2020a). COVID-19 Testing Summary: South Africa Week 23 2020. Johannesburg, South Africa: NICD. Available at https://www.nicd.ac.za/wpcontent/uploads/2020/06/NICD-COVID-19-Testing-Summary_-Week-23-2020-005.pdf

37. Neely, A. B. and Ponshunmugan, A. (2019). A qualitative approach to examining health care access in rural South Africa. Elsevier, https://doi.org/10.1016/j.socscimed.2019.04.025
38. Nevhutalu, K. H. (2016). Patients' rights in South Africa's public health system: Moral-critical perspectives. Dissertation submitted for the PhD degree in Philosophy at the University of Stellenbosch.
39. Ogunkola, I. O., Adebisib, Y. A. Imoa, U. F, Odeya, G. O., Esua, E. and Lucero-Prison, D. (2021). Impact of COVID-19 pandemic on antenatal healthcare services in Sub-Saharan Africa. Public Health in Practice (2) (2021). Elsevier publishers. 11-345672819-11121314715
40. Okeng Ebi, E.A. (2016). Enforcing the Right of Access to Healthcare Services in South Africa. Submitted in accordance with the requirements for the degree of Master of Law at the University of South Africa.
41. Okereke, M., Ukor, N., Adebisi, Y. A. and Ogunkola, I.O. (2020). Impact of COVID-19 on access to healthcare in low-and in-middle-income countries: Current evidence and future recommendations. International Journal of Health Planning Management. 1-5. Wileyonlinelibrary.com/journal/hpm
42. Omona, J. (2013). Sampling in Qualitative Research: Improving the Quality of Research Outcomes in Higher Education. Makereke Journal of Higher Education ISSN:1816-6822;4(2) 169-`185 DOI: http://dx.doi.org/10.4314/majohe.v4i24
43. Panter-Brick, C. and Eggerman, M. (2017). The field of medical anthropology in Social Science and Medicine. Journal homepage: www.elsevier.com/locate/socscimed.
44. Parikh, P., Bisaga, I., Loggia, C, Georgiadou, M. C. and Ojo-Aromokudu, J. (2020). Barriers and opportunities for participatory environmental upgrading: Case study of Havelock informal settlement, Durban. http://dx.doi.org/10.1016/j.cacint.2020.100041 2590-2520. Elsevier publishers
45. Pillay, Y., Pienaar, S., Barron, P and Zondi, T. (2021). Impact of COVID-19 on routine primary healthcare services in South Africa. S Afr Med J 2021;111(8):714-719. https://doi.org/10.7196/SAMJ.2021.v111i8.15786

46. Rakotoarivelo, N. H., Rakotoarivony, F., Ramarosandratana, A. V., Jeannoda, V. H. Kuhlman, A. R., Randriansolo, A. and Bussmann, R, W. (2015). Medicinal plants used to treat the most frequent diseases encountered in Ambalabe rural community, Eastern Madagascar. Journal of Ethnobiology and Ethnomedicine (2015) 11:68 DOI 10.1186/s13002-015-0050-2

47. Rubin-Miller, L., Alban, C., and Artiga, S. (2020, 16 September). COVID-19 Racial Disparities in Testing, Infection, Hospitalization, and Death: Analysis of Epic Patient Data. Kaiser Family Foundation. Available at https://www.kff.org/report-section/COVID-19-racial-disparities-in-testing-infection-hospitalizationand-death-analysis-of-epic-patient-data-methods.

48. Sapkota, P. P. (2020). An Anthropological Study of COVID-19: Effects on Socio-cultural Life of the People. Dhaulagiri Journal of Sociology and Anthropology Vol. 14, 2020, PP. 37-45

49. Sieder, M.J., Kraemer, J.D., Meyer, M.J. Harling, G., Mngomezulu, T., Gabela, G., Dlamini, S., Gareta, D. Majozi, N., Ngwenya, N., Seeley, J., Wong, E., Iwuji, C., Shahmanesh, M., Hanekom, W. and Herbst, K. (2020). Access to primary healthcare during lockdown measures for COVID-19 in rural South Africa a: an interrupted time series analysis. BMJ Open 2020;10: e043763. doi:10.1136/ bmjopen-2020-043763

50. Siedner, M.J, Kraemer, J.D., Meyer, M, J., Harling, G., Mngomezulu, N., Ngwenya, N. Seeley, J. Wong, E., Iwuji, C., Shahmanesh, M., Hanekom, W. and Herbst, K. (2020). Access to primary healthcare during lockdown measures for COVID-19 in rural South Africa: an interrupted time series analysis. BMJ Open 2020;10: e043763/bmjopen-2020-043763

51. Smit, W. (2020). Opinion: Tackling COVID-19 in Informal Settlements in Cape Town. Thomson Reuters Foundation News. Available at https://news.trust.org/item/20200708104926-3gwm4.

52. Staunton, C., Swanepoel, C. and Labuschaigne, M. (2020). Between a rock and a hard place: COVID-19 and South Africa's Response. Journal of Law and the Biosciences, 1-12 DOI:10.1093/jlb/Isaa052

53. Summers, G.F., 1986. Rural community development. *Annual Review of Sociology*, *12*(1), pp.347-371.
54. Syed ST, Gerber BS, Sharp LK. Traveling towards disease: Transportation barriers to health care access. Journal of Community Health. 2013;38(5):976–993. [PMC free article] [PubMed]
55. Thomas, T., Laher, A.E., Mahomed, A., Stacey, S., Motara, F. and Mer, M. (2020). Challenges around COVID-19 at a tertiary-level healthcare facilities in South Africa and strategies implemented for improvement. S Afr Med J. 2020; 110(10):964-967.https://doi.org/10.7196/SAMJ.2020.v110i10.15143
56. Vergunst, R. (2018). From global-to-local: rural mental health in South Africa. Global Health Action 2018, Vol.11,1413916 https://doi.org/10.1080/16549716.2017.1413916. Taylor and Francis Group.
57. Vitacare, R.., (2020), Lockdown News. World Health News.
58. Weimann, A. and Oni, T. (2019). A Systematized Review of the Health Impact of Urban Informal Settlements and Implications for Upgrading Interventions in South Africa, a Rapidly Urbanising Middle-Income Country. Int. J. Environ. Res. Public Health 2019, 16, 3608; doi:10.3390/ijerph16193608
59. World Health Organization (2010, 2014, 2020). Increasing access to health care in rural areas through improved access: Global policy recommendations. Geneva: World Health Organization.
60. World Health Organization. Health in the Green Economy: Health Co-Benefits of Climate Change Mitigation—Housing Area; World Health Organization: Geneva, Switzerland, 2011.
61. Zank S, Hanazaki N (2017) The coexistence of traditional medicine and biomedicine: A study with local health experts in two Brazilian regions. PLoS ONE 12(4): e0174731. https://doi.org/10.1371/journal.pone.0174731
62. Zohrabi, M. (2013). Mixed Method Research: Instruments, validity, reliability and reporting findings. Theory and Practice in Language Studies, 3 (2), 254-262

INFORMED CONSENT FORM (ENGLISH)

Dear Participant

I am Hloniphile Ndlovu, student number 217063176, a registered Master of Social Science candidate at the University of KwaZulu-Natal at Howard College Campus. The title of my research is Access to health care facilities during Covid-19: Probing experiences of Ntabeni a rural community in Pietermaritzburg, KZN. This research purpose is to investigate the issue of access to healthcare during Covid-19: Probing the experiences of the destitute population in Ntabeni during Covid-19. The findings of this study will provide insight, explanations, and reasoning towards access to healthcare challenges experienced by the Ntabeni community. It will also provide solution on the challenges faced by Ntabeni community. The study will also show the inequality that still present today between different races and traditions.

You are being approached to partake in a research study. Before you choose to take an interest in this examination, it is significant that you comprehend why the exploration is being done and what it will include. If it is not too much trouble, read the accompanying data cautiously. If it is not too much trouble, inquire as to whether there is whatever is not clear or on the off chance that you need more data.

Please note that:

- The information that you provide will be used for scholarly research or academic purposes only.
- Your participation is entirely voluntary. You have a choice whether to participate or not in this research. You will not be penalized for taking such of any action between the two.
- Your views in this interview will be presented anonymously. Neither your name nor identity will be disclosed in any form in the study.
- Because of Covid19 which is prohibiting human contact and the promotion of social distancing which is what anthropologist like the most when conducting their research. All COVID 19 curbing rules, protocols and regulations will be observed.
- The interview will take approximately 30minutes to 45 minutes per session.
- You are encouraged to ask questions or raise concerns at any time about the nature of the study or the methods I am using. Please contact me at any time at the e-mail address or telephone number listed above.
- Our discussion will be audio taped to help me accurately capture your insights in your own words. The tapes will only be heard by me for the purpose of this study. If you feel uncomfortable with the recorder, you may ask that it be turned off at any time.

- You also have the right to withdraw from the study at any time. In the event you choose to withdraw from the study all information you provide (including tapes) will be destroyed and omitted from the final paper.
- All recorded data (if consented) will be always kept safe. No one will have access to them besides my supervisors.
- If you agree to participate, please sign the declaration attached to this statement (a separate sheet will be provided for signatures)

I can be contacted at School of Social Sciences, University of KwaZulu-Natal Howard College campus, Durban. Email address: 217063176@stu.ukzn.ac.za. Cell phone number: 0624205205.

My supervisor is Dr. Balungile Zondi, who is located at the School of Social Sciences, Pietermaritzburg campus. Email address: zondiL4@ukzn. ac.za. Cellphone number: [redacted]

The humanities and Social Sciences Research Ethics Committee Contact details are as follows: HSSREC Research Office, Telephone 0312608350/4557/3587, email: hssrec@ukzn.ac.za

By signing this consent form, I certify that I _____ agree to

(Print full name here)

the terms of this agreement.

_____ _____

(Signature) (Date)

IFOMU LOKUVUMA ELINOLWAZI (ISIZULU)

Mbambiqhaza othandekayo

NginguHloniphile Ndlovu, umfundi onenombolo 217063176, obhalisele iziqu zeMaster of Social Science e-University of KwaZulu-Natal e-Howard College Campus. Isihloko socwaningo lwami sithi Ukufinyelela ezikhungweni zokunakekelwa kwezempilo ngesikhathi sikaCovid-19: Ukuhlangenwe nakho kokuhlola uNtabeni umphakathi wasemakhaya eMgungundlovu, eKZN. Lenhloso yocwaningo ukuphenya inkinga yokuthola usizo lwezempilo ngesikhathi seCovid-19: Ukuhlola okwenzeka kubantu abaswele Ntabeni ngesikhathi seCovid-19. Okutholakele kulolucwaningo kuzohlinzeka ukuqonda, izincazelo, kanye nezizathu maqondana nokuthola izinselelo zokunakekelwa kwezempilo okutholwe umphakathi wase-Ntabeni. Izophinde inikeze isisombululo ngezinselelo umphakathi wasNtabeni obhekene nazo. Ucwaningo luzokhombisa nokungalingani okukhona nanamuhla phakathi kwezinhlanga namasiko ahlukene.

Ucelwa ukuba uhlanganyele ocwaningweni locwaningo. Ngaphambi kokukhetha ukuba nentshisekelo kulokhu kuhlolwa, kubalulekile ukuthi uqonde ukuthi kungani kwenziwa ukuhlola nokuthi kuzofakani. Uma kungenankinga enkulu, funda idatha ehambisana nayo ngokuqapha. Uma kungeyona inkinga eningi, buza ukuthi ngabe kukhona yini okungacaci noma ukuthi udinga idatha engaphezulu.

Sicela wazi ukuthi:

- Imininingwane oyinikezayo izosetshenziselwa ucwaningo lwezifundiswa noma izinjongo zezifundo kuphela.
- Ukubamba kwakho iqhaza kungokuzithandela ngokuphelele. Unokukhetha ukuthi ubambe iqhaza noma cha kulolu cwaningo. Ngeke ujeziswe ngokuthatha noma isiphi isenzo phakathi kwalaba bobabili.
- Imibono yakho kule ngxoxo izokwethulwa ngokungaziwa. Igama lakho noma ubuwena ngeke kudalulwe nganoma yiluphi uhlobo ocwaningweni.
- Ngenxa ye-Covid19 evimbela ukuxhumana kwabantu kanye nokwenyusa ukuqhelelana kwezenhlalo nokuyilokho isazi semvelo esithanda kakhulu lapho senza ucwaningo lwaso. Yonke imithetho ye-COVID 19 yokunqanda, imigomo neziqondiso kuzobhekwa.

- Inhlolokhono izothatha cishe imizuzu engama-30 kuya kwemizuzu engama-45 ngeseshini ngayinye.
- Uyakhuthazwa ukuthi ubuze imibuzo noma uphakamise ukukhathazeka nganoma yisiphi isikhathi mayelana nohlobo locwaningo noma izindlela engizisebenzisayo. Sicela ungithinte nganoma yisiphi isikhathi kukheli le-imeyili noma inombolo yocingo ebhalwe ngenhla.
- Ingxoxo yethu izorekhodwa ngokulalelwayo ukungisiza ngibambe ngokunembile ukuqonda kwakho ngamazwi akho. Amateyipu azozwakala kimi kuphela ngenhloso yalolu cwaningo. Uma uzizwa ungakhululekile ngesirekhoda, ungacela ukuthi icishwe noma kunini.
- Unelungelo futhi lokuhoxa ocwaningweni nganoma yisiphi isikhathi. Uma kwenzeka ukhetha ukuhoxa ocwaningweni yonke imininingwane oyinikezayo (kufaka phakathi amateyipu) izokonakala futhi ishiywe ephepheni lokugcina.
- Yonke imininingwane eqoshiwe (uma ivunyelwe) izogcinwa iphephile. Akekho ozoba nokufinyelela kuzo ngaphandle kwabaqondisi bami.
- Uma uvuma ukubamba iqhaza sicela usayine isimemezelo esifakwe kulesi sitatimende (kuzonikezwa ishidi elehlukile lamasiginesha)

Ngingathintwa eSchool of Social Sciences, e-University of KwaZulu-Natal Howard College campus, eThekwini. Ikheli le-imeyili: 217063176@stu.ukzn.ac.za. Inombolo kamakhalekhukhwini: [redacted]. Umphathi wami nguDkt Balungile Zondi, otholakala eSchool of Social Sciences, eMgungundlovu campus. Ikheli le-imeyili: zondiL4 @ ukzn. ac.za. Inombolo kamakhalekhukhwini: 0716065062.

Ikomidi le-Humanities and Social Sciences Research Ethics Ikheli lokuxhumana limi ngokulandelayo: HSSREC Research Office, Telephone 0312608350/4557/3587, email: hssrec@ukzn.ac.za

Ngokusayina leli fomu lokuvuma, ngiyaqinisekisa ukuthi _____ ngiyavuma imibandela yalesi sivumelwano. (Phrinta igama eligcwele lapha)

_____ _____

(Isiginesha) (Usuku)

ENGLISH DATA COLLECTION INSTRUMENT

Access to health care facilities during Covid-19: Probing experiences of Ntabeni a rural community in Pietermaritzburg, KZN.

Part A: Inclusion or rather exclusion (consent seeking) questions:

1. Are a Ntabeni community member/residence?

Yes	
No	

2. Are you above 18 years?

Yes	
No	

3. What is your specific age? _____

4. Are you holistically fit to participate in this research?

Yes	
No	

5. Have you infected by COVID-19 during level 5 to 2?

Yes	
No	

Part B: Research specific questions

1. How long have you lived in the Ntabeni community?
2. Did you recently moved, or your ancestors also lived in this community?
3. What is your understanding of access to health facilities and health care?

4. What experiences of access to health facilities and care did the community at large celebrated or complained about during?
5. What are persisting health issues affecting most people of Ntabeni Community? please do not mention people's names.
6. Would you say these experiences of access to health facilities and health care are historical issues, if yes, why……?
7. Who was in terms of age mostly complained by not being able to access health facilities and health care during COVID-19?
8. Did the community experienced a lot of fatalities as a result of not being able to access health facilities and health care during COVID-19?
9. What are the factors that permitted or restricted access to health care facilities during the COVID-19?
10. How did community respond to restricted access to health care facilities in the community?
11. Where did community access health facilities and health care, did they travel other nearby communities or opted for ethnomedicine?
12. What solutions could be raised in order improve health care access?

ISIZULU DATA COLLECTION INSTRUMENT.

Insimbi Yokuqoqa Idatha

Ukutholakala kwezikhungo zokunakekelwa kwezempilo ngesikhathi sika COVID-19: Ukuhlangenwe nakho okuhlola iNtabeni umphakathi wasemakhaya eMgungundlovu, eKZN.

Incenye A: Kufakwa nobe kunalokho kukhishwa imibuto (kufuna imvume):

1. Ngabe uyilunga / uhlala endaweni yasNtabeni?

Yebo	
Cha	

2. Ngabe ungaphezu kweminyaka eyi-18?

Yebo	
Cha	

3. Iyini iminyaka yakho yobudala? _____

Yebo	
Cha	

4. Ingabe ukulungele ngokuphelele ukubamba iqhaza kulolu cwaningo?

Yebo	
Cha	

5. Ngabe uthelelekе nge-COVID-19 ngeleveli 5 kuya ku-2?

Yebo	
Cha	

Incenye B: Cwaninga imibuto letsite

1. Uhlale isikhathi esingakanani emphakathini wasNtabeni?
2. Usanda kuthutha, noma okhokho bakho nabo bahlala kulo mphakathi?
3. Yini ukuqonda kwakho ngokufinyelela ezikhungweni zezempilo nokunakekelwa kwezempilo?
4. Yikuphi okuhlangenwe nakho kokufinyelela ezikhungweni zezempilo nokunakekelwa umphakathi wonkana owugubhe noma wakhononda ngakho ngesikhathi?
5. Yiziphi izindaba zezempilo eziqhubekayo ezithinta abantu abaningi bomphakathi wasNtabeni? ngicela ungasho amagama abantu.
6. Ungasho ukuthi lokhu okuhlangenwe nakho kokufinyelela ezikhungweni zezempilo nokunakekelwa kwezempilo kuyizindaba zomlando, uma kunjalo, kungani ……?
7. Ngubani ngobudala obekhalazwa ngokungakwazi ukufinyelela ezikhungweni zezempilo nokunakekelwa kwezempilo ngesikhathi seCOVID-19?
8. Ngabe umphakathi wehlelwe yingozi enkulu ngenxa yokungakwazi ukufinyelela ezikhungweni zezempilo kanye nokunakekelwa kwezempilo ngesikhathi seCOVID-19?
9. Yiziphi izinto ezivunyelwe noma ezivimbela ukufinyelela ezikhungweni zokunakekelwa kwezempilo ngesikhathi seCOVID-19?
10. Umphakathi uphendule kanjani ekuvinjelweni kokufinyelela ezikhungweni zokunakekelwa kwezempilo emphakathini?
11. Ngabe umphakathi wazifinyelela kuphi izikhungo zezempilo nokunakekelwa kwezempilo, ngabe bahambela eminye imiphakathi eseduze noma bakhetha i-ethnomedicine?
12. Yiziphi izixazululo ezingaphakanyiswa ukuze kuthuthukiswe ukufinyeleleka kwezempilo?

GATEKEEPERS LETTER AND ETHICAL CLEARANCE

The Msunduzi Municipality

CITY OF CHOICE
PIETERMARITZBURG
MSUNDUZI

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Enq: Nonhlanhla Tel: 033 392 2541 E-mail: nonhlanhla.mkhize@msunduzi.gov.za

20 July 2021

University of KwaZulu-Natal
School of Social Sciences

Dear Student

Please find herewith our letter of support for your proposed research study "ACCESS TO HEALTH CARE FACILITIES DURING COVID-19: PROBUNG EXPERIENCES OF NTABENI A RURAL COMMUNITY IN PIETERMARITZBURG".

This proposed study will be to investigate the issues of access to health care during covid-19: probing the experiences of the destitute population in eNtabeni during covid-19. The findings of this study will provide insight, explanations, and reasoning towards access to healthcare challenges experienced by the eNtabeni community. It will also provide solution on the challenges faced by eNtabeni community. The interviews will give a clear picture of the situation in rural areas.

As the Ward Councillor of Ward 01(Mpumuza Location): Councillor JJ Ngubo of Msunduzi Municipality I support the stated benefits of the study and as a Municipality we promote transparency.

For any assistance don't hesitate to contact my office on 079 6060 103.

Yours Sincerely

[redacted]

CLLR J. NGUBO
WARD 01 COUNCILLOR
MSUNDUZI MUNICIPALITY

FOR USE BY COUNCILLORS

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

31 July 2021

Miss Hloniphile Talent Ndlovu (217063176)
School Of Social Sciences
Howard College

Dear Miss Ndlovu,

Protocol reference number: HSSREC/00003083/2021
Project title: Access to health care facilities during Covid-19 lockdown levels (5-2): Probing the experiences of people in Ntabeni, a rural community in Pietermaritzburg, KZN
Degree: Masters

Approval Notification – Expedited Application

This letter serves to notify you that your application received on 08 July 2021 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. 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.

This approval is valid until 31 July 2022.
To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

All research conducted during the COVID-19 period must adhere to the national and UKZN guidelines.

HSSREC is registered with the South African National Research Ethics Council (REC-040414-040).

Yours sincerely,

[redacted]

Professor Dipane Hlalele (Chair)

/dd