Provision of healthcare services: Perspectives and experiences of the elderly in the case study of Umkomaas.

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A dissertation submitted in partial fulfilment of the academic requirement for the award of Masters in Population Studies under the School of Built Environment and Development Studies, University of KwaZulu-Natal.

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2020

COLLEGE OF HUMANITTIES.

Declaration- Plagiarism.

I, Sindiswa Menzi Zamaswazi Gininda declare that:

1. Provision of healthcare services: Perspective and experiences of the elderly in the case study of Umkomaas is my own work that has never been submitted for any degree or examination at any university or any other higher learning institutions.

2. This thesis is being submitted for the degree of Master in Population Studies under the school of Built Environment and Development Studies, University of KwaZulu-Natal, Durban, South Africa.

3. All citation and references used in this dissertation have been acknowledged.

Sindiswa Gininda   Date

Signed…………….   ………………..

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Dedication

The completion of this dissertation is dedicated to my Lord God Almighty. There are no enough words to describe how thankful I am for giving me strength to complete my work. Thank you for being my pillar of strength and staying truthful in your word.

I also like to dedicate this work to my family (my parents) Nokuthula Jeza and Zakhele Gininda and my late grandmother Makhosazane Gininda. I thank my family for believing in me, for the strong support and for the continuous encouragement, they are truly a blessing from God.

Abstract

The number of elderly has increased in South Africa, however, ageing is usually accompanied by poorer health. There are health concerns as a person ages, which necessitate regular check-ups. There is a dearth in research that places focus on the health of the elderly. This study aims to fill this gap by attempting to shed insights into the provision of healthcare services for both elderly men and women. For this study, data was obtained from face-to-face, in-depth interviews conducted with elderly women and men from Umkomaas, Ilfracombe. In total, 20 interviews were held with 15 women and 5 men. The elderly have different experiences when seeking healthcare and accessing healthcare services at the clinic. The findings of the study indicate that the elderly encounter challenges when seeking healthcare and accessing healthcare services at the clinic. In addition, the findings of the study also revealed that in some cases the elderly seek healthcare and access healthcare services at the hospital. Despite the challenges they encounter, there are enabling factors that encourages them to continue seeking healthcare and accessing healthcare services at the clinic. The study suggests the need to prioritise healthcare for the elderly especially the ones in rural and semi-rural areas. The elderly from the rural and semi-rural areas are usually neglected when it comes to the provision of healthcare services. The study recommends that more efforts need to be directed to addressing the issue of high patient numbers. More skilled nurses need to be employed at clinics, this will go a long way in overcoming some of the problems at health facilities. The government should focus on enhancing the quality of healthcare through reforms that promote healthy ageing, health facilities that are ageing friendly, with qualified workers, adequate medicines, this can result in satisfaction for the elderly.

List of acronyms

ABMHSU	Andersen Behavioural Model of Health Service Use.
AIDS	Acquired Immune Deficiency Syndrome.
HIV	Human immunodeficiency virus.
PLP	People living in poverty.
SES	Socio economic status.
WHO	World Health Organization.

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Chapter 1

Introduction

1.1 Background to the Study

The United Nations defines the elderly as any person who is 60 years old and above (Falaha et al., 2016). This definition is also applicable in the South African context (Marx, 2016). The term elderly significantly varies depending on the social context. Projections suggest that the number of the population aged 60 years and over will increase to 1.2 billion in 2025 and 2 billion in 2050 (Shrivastava et al., 2013). By 2025, it is said that about 75% of this ageing population will be residing in the developing countries, which already has an overburdened health-care system (Shrivastava et al., 2013). The estimations show that nearly 63% of the population aged 60 and above currently live in developing nations, and this percentage is said to increase to about 73% over the coming 25 years (Velkoff and Kowal, 2006).

Regardless of the fact that the elderly population comprises a small proportion of the population in sub-Saharan African countries, the number of elderly continues to grow. It was projected that there were 34 million individuals in the year of 2005 that were aged 60 and over in sub-Saharan Africa, and it is projected that this number will grow above 67 million by 2030. By the year of 2030, more than 30% of Europeans are projected to be 60 years old and over (Velkoff and Kowal, 2006). In Latin America, Asia and Caribbean, the proportion aged 60 and over are likely to double in less than 25 years. According to Velkoff and Kowal (2006), sub-Saharan Africa stands in a different position to other regions of the world with the proportion of 60 years old and over predicted to grow only slightly, from 4.7% in the year of 2005 to 5.5% in the year of 2030 (Velkoff and Kowal, 2006).

In Sub-Saharan Africa, population aging is not consistent (Velkoff and Kowal, 2006). The size of the elderly individuals in many sub-Saharan African countries is approximately equivalent to certain developed nations, for instance, the elderly in Nigeria is roughly the same in size as those in Canada and South Korea (Velkoff and Kowal, 2006). Suzman and Beard (2011) argues that even though more developed nations have the oldest population profiles, the vast majority of these older persons and the most rapidly aging population are found in the developing countries. They further argue that the estimates between 2010 and 2050 show that the number of elderly in developing nations will grow more than 250%. As a person enters older ages, they put a strain on national infrastructures, especially health systems of a country (Suzman and Beard, 2011). Growth of the elderly individuals around the

world is a problem that has caused a transformation in global demographics. As the population ages, there is a continuous need for valid and comparable data when it comes to the health and well-being of the elderly. There is also a need to build an evidence base that can be utilised in creating policies and monitoring their effect (UNDP, 2002).

In South Africa, the health system has been receiving so much attention and this is due to the fact that it has been influenced strongly by the political systems of the country on the basis of racial separation (Pillay, 1993). Although South Africa is classified as a middle-income country when looking at its economy, its health results are worse than those in several lower income countries (Coovadia et al., 2009). In South Africa, the elderly are not seen as a priority (Charlton, 1998). This is problematic because the elderly are normally the main consumers of health-care resources. One of the basic human rights that is enshrined in the Constitution of South Africa is access to healthcare. According to Statistics South Africa (2013), the South African constitution promotes access to healthcare facilities for all. Services for healthcare are available both in the public and private health sectors and the South African democratic government guarantees equal access to healthcare services and to an improved welfare in societies (Statistics South Africa, 2013).

According to Beard et al. (2012), the term ageing was previously associated with developed nations, but later it has become a global concern and it is said to be accelerating rapidly in the developing nations. Dutt (1998) states that it has been observed that as life expectancy increases in the developing nations, the elderly population also increases. Ageing is considered as a natural process, which introduces a distinctive challenge for all components of the society (Shrivastava et al., 2013). According to He et al. (2016), aging is a major concern when it comes to costs for healthcare systems, especially in settings where there are not enough institutional, financial, and human resource capacity to meet the basic needs of the elderly and also, in the absence of social safety nets.

Developed countries may differ from the developing countries in readiness or resources available to offer healthcare for the elderly people (He et al., 2016). According to Dutt (1998), the main focus that is seen in the developing nations is on maternal and child health, the healthcare for the elderly population is said to be neglected. The healthcare workers that are the first point of contact with the elderly individuals in the developing countries are not equipped and trained enough to care for them (Dutt, 1998). It has been shown by different scholars that very few secondary and tertiary care institutions have separated services for the

elderly population which is problematic (Dutt, 1998). Proper coordination of healthcare services for the elderly is seen as crucial.

According to Dutt (1998), the change that is observed in the demographic profile of developing countries needs to be recognised and the healthcare systems requires improvements. The world is aging at an unusual rate. It is believed that the population aging will soon become the most significant demographic dynamic influencing families and communities throughout the world in the following decades.

1.2 Overviewing the health situation of the elderly

According to United Nations (2017), the population aged 60 years and over were 962 million around the world in 2017, and the number of these individuals is expected to reach 2080 million by 2050. Lutala et al. (2010) states that the elderly in the African countries were estimated to be 38 million. United Nations (2017) claims that in 2017, there were 67.8 million persons aged 60 years and above in Africa. This population is projected to reach 225 million by the year of 2050. The number of elderly individuals is expected to increase faster in the continent of Africa over the coming decades. The elderly population is expected to triple between 2017 and 2050, from 69 to 226 million (United Nations, 2017).

According to Lehohla (2014), for the developed nations, population ageing was mainly due to the increasing life expectancy and decreasing fertility. Nonetheless, the conditions and experiences of ageing in sub-Saharan Africa and more particularly South Africa which is the epicentre of the Human immunodeficiency Virus (HIV) epidemic has been driven by higher mortality (Lehohla, 2014). In some countries in Africa such as South Africa, Malawi, Zimbabwe and Zambia that is experiencing a devastating HIV and Acquired Immune Deficiency Syndrome (AIDS) epidemic, the average life expectancy at birth in these countries is not more than 45 years, while the elderly individuals continues to grow (Kinsella and He, 2009). Access to healthcare and fair distribution of healthcare services are the important requirements for attaining good health within a population. The consequences of population ageing socially, economically, and politically have been seen as an important factor that has been taken into consideration when it comes to all planning aspects of policies and programmes (Phaswana-Mafuva et al., 2012). The purpose of this research is to explore the perceptions and experiences of the elderly population when it comes to the provision of healthcare services for them.

Effects of globalization, interconnecting many different countries have numerous impacts on the health and wellbeing of the elderly (Lee et al., 2002). Unlike developed countries, the less developed countries do not have a comprehensive policy and health agenda. According to Moe et al. (2012), as serious interest of the international agencies places it focus on the control of diseases and primary healthcare activities, government needs to take sole responsibilities when it comes to healthcare of the elderly. However, the programmes of the elderly have numerous challenges in resource and technical efficiency (Moe et al., 2012). The socio-economic and gender development issues that relates to the health of elderly people are less addressed in both political and public agendas in the developing nations of the world (Moe et al., 2012). Moreover, it has been observed that there are many unequal facilities in basic health, the medical care and the social support for those elderly individuals residing in the rural areas of many countries (Moe et al., 2012).

South Africa is said to be one of the countries with a disproportionately large elderly population (Phakathi, 2011). The elderly population in 2011 was estimated to be 7.7% in South Africa (Statistics South Africa, 2011). According to Statistics South Africa (2017), the latest mid-year population estimates produced by Statistics South Africa indicate that the proportions of the elderly (60 years and older) in South Africa is increasing, reaching 8,1% in 2017. The estimates show that, there are 4.6 million persons over 60 years of age in South Africa (Statistics South Africa, 2017). The continuous growth of the elderly population in South Africa does not only indicate the demographic and health transition of a country, but it also points to the new social, financial and health demands South Africa is bound to face (Statistics South Africa, 2017).

Among the four different population groups in South Africa namely African, White, Indian and Coloured, the pattern of ageing differs in these population groups (Dolo, 2010). Phaswana-Mafuya et al. (2013) states that South Africa has the continent's highest percentage of elderly, 6.7% of the population of this country in 2005 was estimated to be 60 years and older. The rapid increase of the elderly population around the world has presented new problems to countries but these problems are observed more in developing countries that are not in a position to adequate address the ageing population (Dolo, 2010). The continuous growth of the elderly population, together with the exigencies of growing old, places a great

pressure on the governments to respond and provide for this populations' needs. As a result of this, the United Nations Madrid International Plan of Action on Ageing and the 2003 African Union Policy Framework and Plan of Action on Ageing were developed to convince government to take account the implications of ageing (Phaswana-Mafuya et al., 2013).

1.3 Motivation for the study

Population ageing has long-term and serious implications for all aspect of human life. It has been observed that the growing number of the elderly has given rise to increasing demands on the public healthcare system and social services (Phaswana-Mafuya et al., 2012). According to Dolo (2010), ageing is characterised by high levels of poverty, disability, unemployment and inadequate education. Ageing gives rise to the probability that older individuals will be troubled with chronic diseases permanently that will weaken their abilities. When their abilities are weakened they usually become dependent on their families and other members of the society in order to care for them and support them in their own homes (Dolo, 2010).

Nkrumah (2015) argues that good health for individuals in different countries around the world is important especially for human development and it is important when it comes to the improvement of economies. The delivery of healthcare has been viewed as one of the services deliveries that usually demand high consumer involvement in the process of consumption (Nkrumah, 2015). The entire procedure of delivering healthcare services involves the clients, therefore the satisfaction of clients is very crucial. Poor or bad service delivery can cause harm to the client and it can lead to one losing their lives (Nkrumah, 2015). According to Liu and Wong (1997), the number of elderly has been increasing gradually for the past decades. Nevertheless, longevity usually gives rise to poorer health. This means that a growing demand for the provision of healthcare services for the elderly population rises.

This suggest that an assessment of whether or not the client is satisfied with the provision of healthcare is important because this will enable for improvements in the quality of health system in countries. The dearth in research that places it focus on the health of the elderly is due to the assumption that the health of these elderly is highly related to the process of ageing. Furthermore, another reason could be that many studies usually avoids researching about the health of the elderly population, instead they focus on children and youth.

1.4 Aim of the study

The overall aim of this study is to explore healthcare provision for the elderly in a semi-rural area.

The specific objectives are:

- To explore health seeking behaviour of elderly.
- To ascertain attitudes of the elderly towards healthcare provision.
- To determine the challenges faced by the elderly in accessing the health services.

In line with the objectives of the study, the key research questions are:

- What are the experiences of the elderly in accessing health services?
- How do the elderly perceive healthcare provision in their community?
- What are the challenges faced by the elderly in accessing health services in Umkomaas?

This study draws on qualitative data from in-depth interviews with the elderly aged 60 years. To better understand healthcare provision, interviews were held with 20 elderly men and elderly women residing in Umkomaas. The findings were drawn from the one-on-one interviews in order to gain insights into the perspectives and experiences of the elderly on the provision of healthcare services.

1.5 Theoretical framework for the study

According to Babitsch at al. (2012), healthcare utilisation can be seen as the point where patients needs in health systems meet the professional system. It is important to note that healthcare utilisation is also supply-induced and therefore strongly dependent on the structures of the healthcare system. Moreover, numerous study findings have indicated differences in healthcare use based on the patient's social characteristics (Babitsch et al., 2012). For example, several studies have shown that women often seek and use healthcare services than men (Bertakis et al., 2000; Hansen and Høye, 2015). In addition to many studies explaining the patterns of utilisation in different healthcare settings, some scholars have come up with explanatory frameworks identifying predictors of healthcare use (Ricketts and Goldsmith, 2005). This model was developed in the 1968 by the American medical sociologist Ronald M. Andersen who is a health services researcher (Babitsch et al., 2012).

This study will make use of the Andersen Behavioural Model of Health Service Use (ABMHSU) because this model explores prevalent health disparities, it also seeks to explore the perceived challenges when seeking healthcare and utilisation of healthcare services among a particular group of people. The model was developed to evaluate and understand person's use of health services and it considers the factors that encourage or hinder use of health services (Jahangir et al., 2012). The adoption of the ABMHSU in this study enables the researcher to explore certain factors that enables or impedes access and use of healthcare services among the elderly in Umkomaas.

Andersen's Behavioural Model of Health Service Use is a leading model when it comes to explaining contextual factors related to healthcare utilisation. According to Glanz et al. (2008), the utilisation of health services is not simply due to health conditions, but it is a final outcome after creating health needs based on socio-economic factors. This becomes the basis of theories when it comes to health needs and is crucial when determining aspects of utilisation of health services. This model has been very useful because it provides an understanding of health-related situations in different countries with respect to the utilisation of health services among the population in order to help the government with identifying the factors that discourage people from accessing and using health services to improve the public health policy of the country (Graham et al., 2017). Both the health and medical field uses the Andersen theoretical models to explain services utilisation (Mendenhall, 2012; Lindamer et al., 2012; Diehr et al., 1999). The model is known to explain that service utilisation is determined by predisposing, enabling, and need factors and is mostly used as a theoretical model that analyses predictors of health services utilisation. This model is said to be suitable when exploratory research is required because of the lack of previous studies on both outpatient and inpatient health services utilisation (Barrett and Young, 2012).

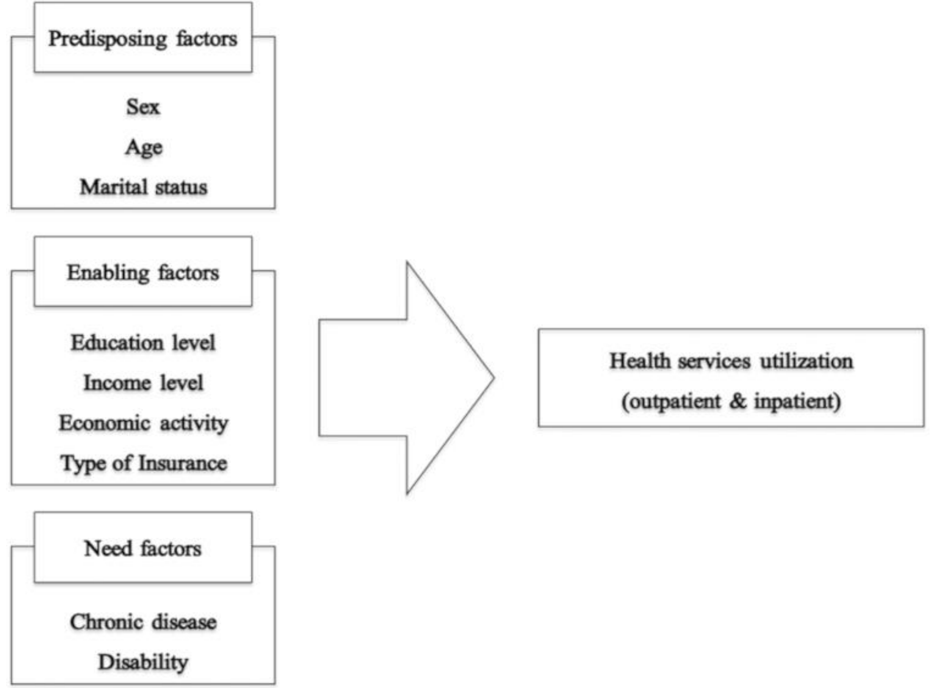
According to the model, patterns of healthcare utilisation can be described by the collective influence of personal and environmental factors, needs (both objective and perceived), and enabling resources. Traditionally, predisposing characteristics include demographic factors of an individual such as age, gender that contribute to either biological underpinnings of needs for healthcare services. There are also aspects of social structures that contribute to health services need because of group membership or identity in the community surroundings, also the available resources in the physical environment that lead a person to be able to make

healthy life choices (Sutter, 2017). Features of social structure include occupation, race or ethnicity, education and culture. Lastly, health beliefs are attitudes, and knowledge a person has about health services, which influence need perceptions of healthcare services (Andersen, 1995).

Sutter (2017) states that enabling resources are those that include factors that are personal, familial and community, these factors must exist in order for people to utilise healthcare services. Such enabling factors include the availability of healthcare facilities, income, health insurance, and a regular source of care (Anderson, 1995). The expanded enabling vulnerable domain also looks into both the availability and utilisation of public benefits and social services, competing needs, use or availability of information sources and community crime rates (Gelberg et al., 2000). When looking at the need domain that is where the focus is placed on both the perceived need (e.g. self-perceptions) and objective appraisals (e.g. evaluated needs). Perceived need is known to be helpful in explaining care-seeking behaviour and medical regimen adherence, while objective appraisals are more crucial with respect to the amount and type of treatment the patient requires after seeing a healthcare provider (Andersen, 1995).

Since this study deals with utilisation, access, challenges to health services, the researcher believes that the chosen theory is suitable because the model assists in gaining more insights into the conditions and factors that influence the elderly to utilize health services. This model is also appropriate for this study because it allows the researcher to seek more explanations with regards to health disparities of the elderly and the challenges they encounter when accessing and utilising healthcare services.

Figure 1.1 Andersen's Behavioural Model of Health Service Use



Source: Kim and Lee (2016)

1.6 Organisation of dissertation.

Chapter one provides a background and rationale for the study as well as the aims of the study and ends with an outline of the theoretical framework Chapter two provides an overview of the literature review by looking at the factors impacting the use of health services by the elderly. Chapter three discusses the research methodology and starts by reviewing the location of the study and discussing in detail the methods used for data collection and analysis. The ethical considerations and limitations of the study are also outlined. Chapter four summarises the main findings obtained from the interviews on the elderly's perspectives and their experiences when it comes to the provision of health services. Chapter five presents a discussion of findings and looks at the implications of the findings of the study and it also provides recommendations.

Chapter 2

Literature Review

2.1 Introduction

The elderly have always been susceptible to illnesses and diseases for many years, as this population continues to increase, the number of chronic illnesses also continues to grow and this places pressure on healthcare system (Gomez-Olive at al., 2010). This section will be focusing on reviews of previous studies that are applicable to this research. The overall aim of the study is to explore healthcare provision from the perspective of the elderly. This review begins by discussing the health status of the elderly and reason for seeking healthcare and then it discusses the challenges they encounter when accessing healthcare services.

2.2 Ill-health among the elderly

The elderly suffer from different age-related health problems. These are inclusive of hypertension, diabetes, arthritis, cataracts, depression, stroke and dementia. As a result, elderly experience numerous forms of ill health which necessitate regular check-ups and treatments. As a person ages, physical, sensory and cognitive impairments become more common and they normally develop different health complications such as frailty, not being able to control their urine and they have a higher risk of falling (Araujo de Carvalho et al., 2017). These health complications cannot be placed in separate disease categories. According to Woo (2017), the elderly living with frailty are seen to be at risk of marked changes in both physical health and mental health after slight events which challenge their health, normally leading to falling, disability, being hospitalised, institutionalization and mortality. Frailty is known to represent one of the geriatric syndromes, increasing with age. Managing these syndromes is becoming increasingly vital (Woo, 2017).

The World Health Organisation (WHO) further claims that, there is now more evidence from many different countries that conditions before birth and conditions found in early childhood impact health in adult life (WHO, 2005). For example, low birth weight is now known to be related with increased rates of high blood pressure, stroke, heart disease and diabetes (Mudege and Ezeh, 2009). It has been argued that although diabetes affect individuals irrespective of their socio-economic status, individuals from poor areas are affected more compared to those in wealthier settings (Peláez and Vega, 2006). According to Mudege and Ezeh (2009), the poor are more exposed for numerous reasons, such as decreased access to health services because of their lack of affordability.

The danger of having various non-communicable health illnesses increase with a person's age and if these illnesses are not taken into consideration through robust care coordination, they can result in polypharmacy, hospitalisation and death (Araujo de Carvalho et al., 2017). Offering care for the elderly individuals that has multiple health complications is complex. It is common for many healthcare workers to be involved with an individual's care especially in countries where there is a wide range of medical specialists. However, various existing healthcare systems tend to manage health challenges in a way that is not connected and fragmented and there is an absence of coordination across care providers, settings and in the timing of the care that is supposed to be provided (Araujo de Carvalho et al., 2017).

According to Nicholas and Hall (2011) more than any other population group, it has been shown that the elderly are the ones that underuse necessary preventive health services, which are known to improve their quality of care. The term underuse in this context represents care that is not adequate or suitable in type, location, intensity or timeliness to meet the medical needs of the patients (Orszag, 2008). On the other hand, Araujo de Carvalho et al. (2017) state that the elderly individuals usually find it challenging to utilise health services even when they are available for them to use. In developing countries, the elderly population utilise healthcare services less frequently than the young population in spite of suffering poor health as compared to the younger counterparts.

2.3 Reasons for seeking healthcare

Literature on health seeking behaviours for individuals and the determinants of health service use particularly in the context of developing nations have grown. According to Patle and Khakse (2015), the concept of health-seeking behaviour is described as any activity that is undertaken by people who see themselves as having health issues or as being sick with the aim of getting appropriate medication. The way individuals conceptualise the cause of their health issues and their understanding of symptoms plays a vital role when it comes to seeking healthcare. People who see themselves as being ill show different behavioural changes such as, staying away from their usual activities or lying in bed or visiting the health practitioner.

Wang et al. (2013) argues that in almost all countries, the average life expectancy is higher for women than men however, this differs historically and geographically. Biological factors and behaviours offer a limited explanation towards health, however, it is assumed that men and women have different approaches and perspectives with regards to consulting a

healthcare professional. This may be a significant contributor to the gender gap that is observed in mortality (Wang et al., 2013).

According to Hunt et al. (2011), due to women consulting more frequently with their general practitioners compared to men, it widely assumed that their consultation is more about all symptoms and conditions. This assumption is supported by many qualitative studies reporting a widespread unwillingness of men to consult health care practitioners (Hunt et al., 2011).

According to Gerritsen and Devillé (2009), research on patterns of healthcare use suggests that women utilise medical services more than men. There are various reasons for women's greater service utilisation such as the status of their health, health knowledge, willingness to report health issues they encounter, acceptance of seeking help and complying with treatment (Gerritsen and Devillé, 2009).

According to Redondo-Sendino et al. (2006), women live longer than men, but, report greater morbidity and disability and they are more likely to utilise health-care services. However, the greater use of health services by women is not a continual finding but depends on the type of services. Redondo-Sendino et al. (2006) argues that although studies show that women are more likely to contact general practitioners than men, there is no difference when it comes to admissions in hospitals or, alternatively, men are more likely to be admitted in hospitals more regularly that women. The utilisation of healthcare services by both men and women differs, depending on the health problem for which care is needed at that particular time. There are different reasons behind the greater usage of healthcare services by women. Women's need for healthcare services is often seen as due to their worse state of health than men (Redondo-Sendino et al., 2006).

According to Patle and Khakse (2015), there are a number of reasons for the delay in healthcare seeking including ageing, low economic status and negative attitudes of healthcare workers. There are many different factors that impact the usage of healthcare service among the elderly, adults and adolescents (Jim, 2010). A study conducted in Nigeria by Jim (2010) to determine the main factors influencing health-seeking behaviour found that the nature of illness, quality of services, attitude of staff members, the waiting time, service availability, accessibility in terms of travelled distance and educational level affected utilisation patterns of the elderly.

According to Bhat and Kumar (2017), the health seeking behaviour of a person is influenced by some factors such as illiteracy, family composition, misconceptions, social isolation and dependency and income. These factors can give rise to suffering and disability for the elderly. According to Musoke et al. (2014), the factors determining health behaviour may be socio-economic, physical, political or cultural. Usage of healthcare system can depend on a number of factors including educational levels, economic factors, and cultural beliefs together with practices. Other factors that can be included are environmental conditions, socio-demographic factors, gender concerns, awareness about health facilities and the healthcare system itself (Musoke et al., 2014).

2.4 Challenges to healthcare

This section, challenges to healthcare, covers both challenges in healthcare provision and access to healthcare. According to Almeida (2002), the factors that affect patient satisfaction can be grouped into different categories. The first category is the socio-emotional aspects; these are the main determinants of patient satisfaction and refer to patient's perception of provider's communication and interpersonal skills (for instance, caring and empathy). The second category is the physical or the technical features of the service encounter, for instance, the waiting time for the appointment, accessing the services, technical quality of care, the costs and length of the visit (Almeida, 2002).

2.4.1 Transportation

Levesque et al. (2013) argue that access is significant in evaluating how healthcare systems performs around the world. However, access to healthcare services continues to remain a complex notion with different definitions (Levesque et al., 2013). When looking at healthcare system, the focus is placed on the utilisation of healthcare services, and can be defined as the opportunity for individuals to utilise quality services in relation to their needs at that particular time. According to Mclntyre and Ataguba (2016), access relates to the opportunity to get and appropriately utilise quality health services. Access places its focus on the "degree of fit" or what is known as compatibility between the health systems for persons who need to utilise these services. Two dimensions of access are highlighted namely the availability, which looks at physical access and the affordability dimension of access, which looks at financial access. The availability dimension of access looks at whether suitable health services are available in the right place and at the right time to meet the requirements of the population. The affordability dimension of access looks into the "degree of fit" between the

full costs of utilising healthcare services and the person’s ability-to-pay in the context of the household budget and other demands on that same budget (Mclntyre and Ataguba, 2016).

According to WHO (2015), in the context of ageing, availability means taking into account the extent to which health facilities, goods and services meet the particular health necessities of the elderly. The accessibility of health facilities, goods and services includes four sub-dimensions namely: physical accessibility, non-discrimination, accessibility of information and economic accessibility or affordability. These are all significant to the elderly who may face aged-based rationing of services, limitations in physical abilities that make access not easy, financial insecurities due to their age, challenges in information ranging from literacy to the ability to utilise web-based material, a form with which they may not be familiar or have access to. According to Nzama (2001), accessibility is being able to reach different destinations or places that give opportunities for a desired activity. For the purpose of this study, the focus is on transportation and its role in healthcare service access.

According to Aday and Andersen (1947), access is determined by the qualities of a population at large (looking at the family income, insurance coverage and attitudes towards the medical care offered) and the delivery of health system (looking at how the health resources are distributed). On the other hand, the definition of access is said to be entering into the healthcare system and the usage of available healthcare resources (Aloro, 2017). Some other scholars see access as the characteristics of different factors that affect both the entry and usage of the healthcare system (Aloro, 2017).

Consuming social services is very costly, for instance utilisation of healthcare services are usually influenced by the costs of having to move from the place of residence to where the services are allocated. According to Nzama (2001), the South African Department of Transport acknowledges the positive role that the transportation system plays in influencing access to services such as healthcare. Transportation is one of the basic but essential services for ongoing healthcare and access to medication, especially for those with chronic illnesses.

Chronic disease care necessitates regular clinician visits, access to medication, and changes to treatment plans. There may be delays in clinical interventions due to transportation problems. The delays in care may give rise to the lack of proper medical treatment, exacerbation of chronic illnesses or unmet healthcare needs, which can build up and worsen health outcomes (Syed et al., 2013). The elderly residing in rural areas may encounter particular challenges

with transportation due to care services often being concentrated in large cities which are far from their places of residence and communities (Araujo de Carvalho et al., 2017). According to Wallace et al. (2005), patients that encounter transportation challenges carry a greater burden of illnesses than others which may, in other aspect, reflect the relationship between poverty and the availability of transport. Consequently, understanding the relationship between challenges of transportation and health may be vital to addressing health in the most vulnerable people who live in poverty.

According to Neri and Kroll (2003), elderly persons who have limitations related to activities of daily living are likely to require more healthcare services compared to individuals without such limitations, because of the underlying medical conditions that cause them. However, limitations in mobility might increase the necessity for medical care while hampering an individual's ability to access such care. Araujo de Carvalho et al. (2017) argue that failure of health services to take into consideration the limitations in physical capacity that are common in the elderly individuals can be considered as another challenge when it comes to accessing healthcare services. There may be not adequate accessible toilets; there may be long queues in the healthcare facilities, physical challenges to access and communication challenges resulting from lack of information for those with difficulties in hearing or sight. Any challenge to the full range of required medical care could be anticipated to have negative outcomes on the health and functioning level of elderly individuals, and could also give rise to increase downstream costs for healthcare (Taylor Jr and Hoenig, 2006).

2.4.2 Cost and distance

According to Araujo de Carvalho et al. (2017), the considerable challenge to use of healthcare services appears to be costs when visiting the health-care and transportation difficulties. It has been observed that more than 60% of the elderly in the developing countries did not access the healthcare due to the costs of the visit and the lack of transport or not being able to pay for transportation (Araujo de Carvalho et al., 2017). Transportation is usually identified as a key challenge to accessing healthcare (Kim et al., 2007; Syed et al., 2013). Different studies have showed transportation challenges affecting access of healthcare in as little as 3% or as much as 67% of the population sampled (Giambruno et al., 1997; Branch and Nemeth, 1985).

The purpose of the study that was conducted in Malawi was to investigate and explain factors that affect access to health facilities for general medical and surgical care, with main focus

being placed on transport, finances and travel time. The study showed that the cost of and access to transport is a significant challenge when accessing healthcare by rural communities in Malawi. According to Eide et al. (2015), delayed presentations of illness are seen in medical practices in low income settings due to transportation costs and time taken to reach health facilities. Individuals residing in the rural parts of Malawi encounter challenges such as long distance between the community and the nearest health facility, be it at a district hospital or central hospital or any health centre. According to Geoffroy et al. (2014), only half of Malawians live within 5 kilometers from a health facility, this is a walkable distance for a healthy individual, though not necessarily for a person seeking healthcare. Munthali et al. (2014) observed that the distance from the community to the health facility has an influence on the health seeking behaviour for individuals in Malawi and this has resulted in a gap in the accessibility of public health services.

According to Lungu et al. (2000), poverty and financial difficulties influence decisions on where and when an individual seeks healthcare. The study showed that almost half of the respondents had financial difficulties, this had an influence when it came to their access to healthcare for surgical conditions. District hospitals support health centres with ambulance services to transport sick individuals from the health centre to the district hospital and to the tertiary central hospitals if necessary. This hospital ambulance transport provided usually gives priority to maternity patients, particularly urgent obstetric complications. There is no available government public transportation in most rural areas, this could be due to poor infrastructure or public transport supported by the government not being available. This has given rise to privately owned sources of transport which are extremely costly.

A study conducted in Uganda among elderly aged 60 years and over found that they faced many challenges when it comes to accessing healthcare services (Annet, 2013). The thematic analysis of the responses from the interview obtained from the elderly participants showed that long distance to health facilities was mainly reported by the elderly in the rural areas (Annet, 2013). This shows that distance from where an elderly resides to health facilities is still a challenge, as some of the participants indicated that they walk for over five kilometres to access a healthcare facility. By the time that these elderly individuals reach the healthcare facility they are exhausted because their bodies are weak and painful (Annet, 2013).

In addition, the study found that other challenges such as aloofness and rudeness of healthcare workers, shortages of medicines and lack of money, prevented the elderly both in

the rural and urban areas of all the regions of Uganda from having access to healthcare (Annet, 2013). But, challenges such as lack of medicine were featured more prominently in the urban areas of Uganda while those challenges that had to do with long distances to healthcare facilities were more prevalent in the rural areas of Uganda (Annet, 2013).

2.4.3 Staff Shortage in health facilities

According to Buchan and Aiken (2008), the world has come into a critical period when it comes to human resources for health. The shortage of health personnel that are qualified including the nurses is said to be one of the major challenges to achieving health system effectiveness. Mahlathi and Jabu (2015) stated that health service provision is mainly dependent on the sufficiency of the health personnel in terms of numbers and the quality of skills they have. In many developing countries, primary healthcare services have been hindered by extreme shortages and inequitable distribution of the healthcare workforce (Nkomazana, 2017). Throughout the world there is a critical shortage of health professionals namely nurses, doctors, and the midwives (Buchan and Aiken, 2008). The shortfalls are greatest in sub-Saharan Africa (WHO, 2006). There are various and complex causes for the shortage in the healthcare workforce. These include underproduction, lack of appropriate skills, uneven distribution of the workforce and the migration of healthcare workers (Nkomazana, 2017). Migration of skilled healthcare workers in the midst of numerous unmet healthcare needs puts Africa at the centre of the global healthcare workforce crisis, evidence is shown in 36 sub-Saharan African countries having shortages of healthcare workers (Nkomazana, 2017). WHO also emphasised that these shortages mostly coexist in countries with a great number of unemployed health professionals, private labour markets that are imperfect, lack of public funds, political interference and bureaucratic red tape produce this contradiction of shortages in the midst of underutilized talent (WHO, 2006).

WHO (2006) states that the shortage crisis has the possibility to increase in the future and the demand for the provider of services will increase rapidly in all the countries, both poor and rich. The countries that are rich face a future of low fertility and a great number of elderly persons, which will give rise to the shift in chronic and degenerative diseases with high care demands (Buchan and Aiken, 2008). Advancements in technology and the growth of income will necessitate a more specialised workforce and the needs for basic care because of a decline in capacity or willingness of families to take care of their elderly (Buchan and Aiken,

2008). According to WHO (2006), a lack of training of workers in the poor regions causes the outflow of healthcare workers to developed regions.

According to Buchan and Aiken (2008), in most health systems, nurses are known to be the main professional component of the front line staff, the contribution of these nurses is recognised as being important in meeting development goals and delivering effective and safe care. At the country-level, nurse staffing shortage is described and measured in relation to that country's own historical staffing levels, it is also measured in relation to resources and estimations of demand for health services (Buchan and Aiken, 2008). According to Buchan (2006), the term shortage in this context is defined as a gap that exists between the reality of the current availability of nurses and the aspirations for higher or better level of provision.

According to Buchan and Aiken (2008), driven by continuous growth of the elderly, the demand for healthcare and demand for nurses is growing rapidly, while the supply of available nurses has fallen in some developing and developed countries. Evidence of the effect of relatively low staffing levels when it comes to healthcare delivery and consequences has been observed (Buchan and Aiken, 2008). Some of the factors that lead to nursing shortages include existing gender-based discrimination in many countries and cultures, with nursing usually being known as 'woman's work', and violence against healthcare workers in some countries with nurses frequently bearing the brunt due to the fact that they are at the forefront of direct delivery of healthcare (Buchan and Aiken, 2008).

A study that was conducted in Uganda revealed that the elderly mentioned shortage or absence of the healthcare workers at the health facilities as a challenge (Annet, 2013). The elderly participants revealed that the absence of the healthcare workers as a demoralizing factor when it comes to accessing government health facilities, particularly for those that are from the rural areas.

2.4.4 Lack of Geriatric Services

According to Hartgerink et al. (2015), health experts are continuously dealing with elderly patients that are suffering from multiple chronic illnesses. This creates problems for complex coordination of tasks that are performed when delivering care (Kodner and Kyriacou, 2000). The greater use of health services places the elderly patients at serious risk of getting fragmented or poor quality care (Leichsenring, 2004). Once the elderly patients are admitted to the hospital, the risks for poor outcomes increases. These outcomes could be readmission,

the length of stay being increased, functional decline, complications caused by medical treatment or examinations, and placement in nursing homes (Forster et al., 2003).

The quality of life for the patients is negatively impacted when the organisation and delivery of care in hospital is fragmented, not coordinated and duplicated (Boyd et al., 2005; Reuben, 2000; Kodner, 2006). Due to a considerable number of the elderly patients suffering from different issues in multiple life areas, protecting their quality of life does not only concern their physical health but it also involves both their psychological and social well-being (Rowe and Kahn, 1997). The elderly patients that are at risk have needs that are complicated and needs that are on-going, they encounter difficulties on a daily basis. This implies that they need services provided for them sequentially or simultaneously by many providers (Kodner and Spreeuwenberg, 2002). Providing healthcare, social services and related services at the required time and place to such elderly patients is very important. There is a need to urgently address the current geriatric health service dilemma in South Africa and for this, information on a successful service delivery model is required (Charlton, 1998).

According to Ferreira and Charlton (1996), the findings obtained from a qualitative study that was conducted among the elderly residents of Mitchell's Plain in the Cape Peninsula showed a high level of dissatisfaction with the quality of healthcare they receive at the primary level. The main complaints raised were disorganised appointment systems, long waiting times, staff not being interested in elderly's healthcare problems and transportation issues in visiting the health facilities (Charlton, 1998). In addition, it was observed in a study conducted in three farming towns in the Western Cape that 181 elderly residents were not satisfied with public health services (Ferreira et al., 1998). Although 73% of the elderly reported that they were facing financial issues, a quarter of elderly residents mentioned that they chose to see private doctors and to pay the doctor R50-R60 for the consultation rather than utilising a government facility where pensioners are permitted free access to healthcare (Charlton, 1998).

According to Joubert and Bradshaw (2006), the elderly population in South Africa showed dissatisfaction when it came to the quality of health care provided for them at the primary level, including disorganised appointment systems, long waiting times, staff not being interested in elderly's healthcare problems. The elderly residing in both urban and rural areas indicated that the quality of health care services they received at the primary level was of major concern including insufficient and unavailability of medication, unavailability of medical equipment, lack of confidentiality and respect (Joubert and Bradshaw, 2006). More

than half of the elderly people in Kenya reported that they buy their medication over the counter (Waweru et al., 2003). Many elderly people access their medication over the counter and this highlights the inefficiency of health care services in meeting the needs of the elderly population in the third world countries. These encountered challenges faced by the elderly are exacerbated due to the scarcity of trained healthcare workers in the care and treatment of the elderly people (Maharaj, 2012).

2.4.5 Attitude of the healthcare workers

The concept of ageism was first invented by Butler in the year of 1969. He defined ageism as a discrimination based on age which is reflected in the prejudice of a particular age group toward other age groups (Butler, 1969). In 1975, Butler redefined ageism as a systematic stereotype or discrimination against individuals because of them being old. Ageism can be directed to younger age groups, however, in most cases, theoretical and empirical research on ageism has focused on the old age groups (Iversen et al., 2009). According to Iversen et al. (2009), the term ageism can be defined as negative and positive stereotypes and discrimination against or to the benefit of ageing individuals due to their chronological age. Palmore (1999) claims that the term ageism usually leads particular individuals to see elderly as unproductive, depressing and often sick, and to believe that cognitive impairment is a natural result of ageing. This ageism is continued due to the portrayal of elderly as frail, ill, poor and dependent, and suffering mental deterioration (Vincent et al., 2017).

According to Doherty et al. (2011), research shows that there are several factors that have impact on the attitudes of the healthcare worker towards the elderly persons, for instance factors such as, age, gender, educational level, exposure to healthy older individuals, the area of practice and professional socialisation. On a global scale, the elderly population care services have challenges in attracting and retaining staff (Humphries et al., 2008; Buchan and Seccombe, 2006). The care provided by healthcare workers to the elderly has been getting a lot of attention from various researchers. A study conducted in the Republic of Ireland by Doherty (2011) to explore attitudes of healthcare workers towards the elderly found that they held positives attitudes towards the elderly.

According to Welford (2014), the elderly require nurses that are fully equipped to deal with their needs. The attitudes, beliefs and values of the health professionals towards the elderly have an effect on how they see and approach those in their care, which negatively impacts the quality of care that the elderly experience. High levels of knowledge from healthcare workers

is associated with the positive attitude they have towards the elderly. The negative attitudes of healthcare workers towards the elderly usually arises due to having to provide constant care for the elderly and handling their impairments and their difficulties (Welford, 2014). One of the studies conducted made a comparison between the attitudes of nurses towards the elderly among the Chinese and American populations and the results showed similar levels of positive attitudes among both samples (Arani et al., 2017). This study revealed that married nurses are more likely to have a positive attitude towards the elderly compared to those that are single. The explanation behind this may be their higher level of commitment because of their life experiences.

Liu et al. (2013) reported on a systematic study where both the nurse's and student nurse's attitudes towards the elderly became less positive from 2000. They further stated that doctors usually have positive attitudes towards the older persons compared to nurses, and suggest that this is a result of the greater investment in education for medical students (Lui et al., 2013). When one works with the elderly they need specific competencies. These competencies are described as listening, being able to negotiate, allowing opportunities and choice, and allowing for decision-making (McCormack, 2001). Interpersonal skills and commitment to the job can have a positive impact on the quality of life of the elderly.

According to Welford (2014), nurses working with older individuals should hold flexible and innovative attitudes to care and they need to be committed to understand an individual. One the other hand, Mellor et al. (2007), states that inadequate knowledge of the ageing process may not necessarily affect the attitudes that nurses have towards the elderly but poor knowledge of geriatric care may cause nurses to be unable to modify care in a correct manner, potentially placing the elderly patients at risk. According to Arani and Aazami (2017), some studies revealed that staff members who took the gerontology education sessions showed more positive attitudes towards the elderly. Research conducted in the city of Ilam found that nurses that took courses on caring for the elderly had a more positive attitude towards them, thus proving the important role that education plays (Arani et al., 2017). According to Bruus et al. (2012), being able to interact with a doctor or a nurse stands out as a significant element of medical care satisfaction. It is very common that during a consultation, the elderly does not only seek care but also comfort. They expect their health professionals to pay attention to them and speak to them freely.

The ageist attitudes that are seen in many different societies and among the health professionals is one of the significant factors that discourages the elderly from trying to find care or results in their disengagement from health services. According to Araujo de Carvalho et al. (2017), the continuous presence of these challenges implies that, in addition to enhancing the coordination of care, integrated health-care services have to be tailored to the exact needs of the elderly population, their services should be offered to them without discrimination, close to where individuals reside and within an infrastructure that is friendly to the elderly population.

2.4.6 Waiting-times

In South Africa and worldwide, healthcare services are known to be negatively impacted by long waiting times (Mokgoko, 2014). Long waiting times are seen as a main contributor to dissatisfaction among patients accessing healthcare facilities and present problems for healthcare providers and managers (Eilers, 2004; Zhecheng et al., 2012). There is a strong relationship between waiting time at the health facility and patient satisfaction (Sastry et al., 2015). Waiting time is said to be an issue that is equal to lack of access to healthcare services in South Africa and worldwide. Waiting time can be viewed as a vital component of accessing healthcare services (Mokgoko, 2014).

According to Egbujie et al. (2018), the South African National Policy on Management of Patients Waiting Time in Out Patient Departments defines patient waiting time as the amount of time spent by the patient waiting for services in a health facility. This health facility could be a hospital, outpatient clinic, primary healthcare clinic. Furthermore, patient waiting time could be seen as the amount of time a patient spends from entry into a facility to exit. According to Thompson et al. (1996), two different dimensions of waiting times exist: the actual (which is measured) and perceived (which is subjective) waiting times, it is said without proof that patients wait longer than expected.

The lengthy clinic visits sometimes cause patients to skip appointments and move from clinic to clinic, searching for the one with a shorter waiting time (Masango-Makgobela et al., 2013). One of the six priority areas identified by South African National Department of Health is reducing the waiting time for patients in public health facilities (Egbujie et al., 2018). According to Mokgoko (2014), patients are waiting longer than they are expected and this waiting results in them being angry, frustrated and anxiety. The patients usually feel this way because they lack information about the whereabouts of the doctors, this gives rise to conflict

between users (patients) and the healthcare workers. Not all public hospitals and clinics have the mechanisms for giving out the information about doctor's activities that may have an effect on the waiting time (Mokgoko, 2014). According to Mokgoko (2014), there are different causes of long waiting times at public hospitals and clinics, these usually involve clerks, doctors and pharmacists a fair share of lack of satisfaction is focused at nurses.

The patients report long waiting time as an issue and this is articulated by the reports from the media on how patients continuously complain about having to wait before receiving any medical attention (Mokgoko, 2014). The long waiting times were mainly for appointments that are prearranged. These damaging reports about the different healthcare facilities could prevent both nursing and other health professions of that country from attracting new staff (Mokgoko, 2014). In these report, the patients were showing dissatisfaction about the long waiting times at numerous departments for instance, departments such as admissions, casualty, polyclinic and pharmacy. Barlow (2002) asserts that in spite of the technological and organisational developments in healthcare, and numerous changes that are determined by management and government within the National Health Service hospitals, health seekers still encounters great levels of waiting.

A study conducted by Propper, Shearer and Croxson indicated that long waiting times for National Health Services hospital services have been associated with major political challenges in the United Kingdom for many decades (Mokgoko, 2014). One of the main goals of the United Kingdom government health policy reform during the early 1990s was to reduce waiting times for patients. According to Mokgoko (2014), there are strategies that are recommended to lessen waiting times including the strengthening of help desks, introducing a strategy of fast queues for those that have special needs, implementation of effective system that deals with degrees of urgency and training of queue marshals. It has been observed that one of the major reasons for patient dissatisfaction was the long waiting period.

Mokgoko (2014) notes an operational study conducted by different scholars at one regional hospitals' pharmacy and in Gauteng Province established that the actual waiting time for the patients was longer than expected. Some of the major complaints were about the long waiting time to get files at admissions, seeing the doctor and getting medication (Mokgoko, 2014). According to Saidi (2007), patients from particular hospitals in the South African country are usually sent back to community health centres which causes them a great deal of frustration.

Masae and Suwandechochai (2011) state that the growth in numbers of patients results in long waiting time at the outpatients departments in Thailand.

It has been observed that the waiting time leads to patients becoming dissatisfied and some leaving without receiving any health services. Masango-Makgobela et al. (2013) states that in most public health facilities across South Africa, clinic visits are lengthy. This usually lead patients to skip appointments and move from one particular clinic to the next in search of one with a shorter waiting time. Araujo de Carvalho et al. (2017) claims that long waiting times and queues in the healthcare facilities can be seen as an issue for the elderly with physical disabilities, limited mobility or urinary incontinence. Hunter et al. (2017) argues that reducing waiting time for the patients in health facilities has therefore been recognised by the South African National Department of Health as one of six priority areas. Different scholars have shown that there is an inverse relationship between waiting time and satisfaction of the patients in most healthcare facilities (Michael et al., 2013; Pandit et al., 2016).

2.4.7 Treatment and care for the elderly

The health status of a person is determined by numerous factors. According to Arani et al. (2017), the elderly often visit healthcare providers regularly. Elderly needs for medical care are usually considerable. Thorpe et al. (2011) states that about 80% of the elderly necessitate constant care for at least one chronic illness, 50% have many chronic illnesses, and 60% are managing prescription medications that are three or more. Even if chronic illnesses are not present, the elderly need to have access to medical care for acute conditions as they arise, and also for substantial preventive care services suggested by evidence-based guidelines for instance, yearly annual influenza vaccination, hypertension screening, hypercholesterolemia, and all kinds of cancers (Thorpe et al., 2011). Accessing different health services is therefore significant in order for one to prevent new illnesses and for maintaining the health and well-being of the elderly.

According to Vrdoljak and Borovac (2015), the elderly patient has more comorbidities, they usually suffer from many illness conditions (multiple morbidities), they normally use more than a few medication and also they have physiologically deteriorated organ function because of ageing which is the natural process. According to Boss and Seegmiller (1981), the changes with age have significant practical implications for the clinical management of elderly patients. These observed changes with age have significant implications when it comes to clinical management of elderly patients.

According to Karki et al. (2015), chronic health issues are more common in elderly individuals, for that reason, it is necessary to expand the training of health professionals to deal with elderly care. Previous studies have shown that different elements could be taken into account in order to make the process of treatment easy for the elderly (Karki et al., 2015). Furthermore, improvements in medical technologies and serious changes in the lifestyle of individuals have also been factors contributing to older people living longer (Karki et al., 2015). It is important for healthcare workers to provide information adequate information about their treatments, for instance explaining in detail the care protocol. Those individuals who are informed and consulted about their health and treatment perform better in terms of healing than those that are not informed and consulted.

2.4.8 Quality of services

The quality of healthcare services is said to be the difference between the perspectives of the patient when it the services offered by specific health centres and what they expect from the health centre offering such services (Nkrumah, 2015). According to Nkrumah (2015), it is very important for the healthcare providers to constantly note and measure customer service expectations and perceptions. It has been shown by different scholars that the quality of service delivery results in greater patient satisfaction. The healthcare services are interesting by nature, this is due to the fact that there are services that most people do not want but require at some point in time (Nkrumah, 2015). According to Nkrumah (2015), in developing countries, consumers are increasingly becoming aware of their right to good service delivery as far as their health is concerned.

According to Bruus et al. (2012), different studies show that the patient-centred approach does not only increase the elderly individual's level of satisfaction but it also promotes their recovery. The patient-centred approach aims to take into consideration the patient's needs and degree of autonomy, but at the same time get them to participate in decision-making, in keeping with their preferences and values. An experience of the patient cannot be viewed in isolation from their concerns about the quality of healthcare. It is important to understand how the elderly perceive quality of care in order to develop measures to increase the use of healthcare services and the quality of care (Peltzer and Phaswana-Mafuya, 2012).

Another well-known determinant of satisfaction is said to be the commitment of the healthcare workers, their availability and humanity (Atherly et al., 2004). Receiving kindness and compassion from healthcare workers is also seen as a guarantee of healthcare quality

(Atherly et al., 2004). One of the challenges faced by France in improving the care quality for the frail elderly individuals is the coordination among healthcare workers but also among health, social and medico-social sectors (Atherly et al., 2004).

2.4.9 Poverty and health

According to Herdman et al. (2016), poverty can be seen as the state of multidimensional deprivation where the basic needs cannot be met, this is intimately linked with disease. The relationship between the two is complex and functions in two directions, in the most serious, it yields a vicious cycle of deprivation causing diseases, and increasing the costs of illness leading to further impoverishment (Wagstaff, 2002). Alleviation of poverty and improving global health have become the main focus of public health initiatives and development both nationally and internationally (Dhillon et al., 2012).

Awiti (2014) claims that there are different actions a person can take when feeling ill or injured such as seeking healthcare from a healthcare facility or consulting a traditional healer or self-care. In many countries of sub-Saharan Africa, traditional medicine is used more often because it is an affordable and available source of healthcare to a large population group (National Research Council and Committee on Population, 2006).

The action an individual takes is affected by household characteristics, numerous healthcare provider characteristics (mainly price of getting care and quality of care), societal and geographical factors. The main individual characteristic is being able to afford the healthcare that is required at that specific time (Awiti, 2014). Different literature have looked into the effect that income has on the demand for healthcare by investigating the effect of income when it comes to health seeking behaviour, also by investigating the effect of income on health expenditures or by looking at the effect that poverty has on healthcare demand. The studies in the literature that explored the effect of poverty on healthcare demand have been done mainly at the aggregate level (this is a level that is higher than the household level) (Farag et al., 2012; Peters et al., 2008).

According to Peters et al. (2008), individuals residing in developing countries usually have less access to health services compared to those in developed countries. Deprivations that result in ill health are usually associated with developing countries and the poor in these developing countries are mainly at risk. Different scholars have showed that the relationship between poverty and healthcare access is seen as part of a larger cycle, where poverty results

in ill health and ill health perpetuates poverty (Peters et al., 2008). Poverty can also be viewed as the absence of freedom to lead the life an individual has reason to value, with people empowered to lead healthy lives seen as both a means to overcome poverty and an end in itself (Peters et al., 2008).

Poverty is one of the major concerns when dealing with the elderly residing in developing countries. According to WHO (2005), the prolonged existence of poverty can make individuals vulnerable to illnesses such as diabetes in their older ages as a result of a poor diet. Gasparini et al. (2010) argues that impoverished individuals usually suffer from precarious sanitary conditions. This is usually due to their poor living conditions, lack of proper sanitation giving rise to diseases and the spread of them.

Poverty often limits access to healthcare by preventing the elderly from seeking care for financial reasons. Socio-economic status (SES) is very crucial in trying to understand the changes when it comes to the health of the elderly. According to Smith (2007), SES indicates the quality of health, mainly the elderly persons living in developing countries where the population is increasingly aging and requiring an increase in economic resources in order to respond to the needs of the elderly. People with lower SES encounter high mortality rates and they are likely to suffer from various health conditions (Smith, 2007). Doctor visits are conditioned by socio-economic status, and in some cases show connections with income, with rich individuals considering and treating their illnesses more seriously than those individuals with low socio-economic status.

In South Africa, poverty and inequality are rife and exacerbate the challenges associated with health (Ataguba et al., 2011). Poorer individuals encounter many predisposing factors that are seen as social determinants of ill-health. Poorer people also cannot afford to access health care when they are ill. In addition, the response and coping mechanisms are different between the poor individuals and the non-poor (Ataguba et al., 2011).

According to Gasparini et al. (2010), in the first world nations the combination of strong social systems, capital markets that is well-developed and small households, lead to higher living standards for the elderly. These conditions are not replicated in many third world nations where pension grant systems are weak. In developing countries the elderly usually live in large extended households where their budget is shared with a large number of children residing with them.

The role of the elderly has changed in some countries, for instance, there are some households where younger members are absent due to death from AIDS. In this instance, the role of the elderly person shifts and, instead of entering a period of resting and retirement, the elderly person continues to be the head of the household or the main caregiver and a breadwinner for the entire household (Phaswana-Mafuya et al., 2012). In most cases the elderly need to use the money from their social pension to take care of their health needs because the continuous increase of the elderly results in a number of repercussions. These repercussions can be the increased incidence and prevalence of chronic and non-communicable illnesses (Phaswana-Mafuya et al., 2012). In addition, a social pension for the elderly is meant to take care of their needs and sustain their livelihoods. In addition, it has become noticeable that the needs of the elderly are disregarded, this is seen in cases where they have to rescue their poor families. According to Smith and Goldman (2007), the level of income can influence epidemiological conditions, also the choices of work, housing, education, social support, diet and medical care.

Malmgren et al. (1996) report on a community survey conducted among older adult residents living in Seattle. The instrument for the survey included both mental and physical health, and functional state. It was also inclusive of measures to assess resident's ability to access healthcare and factors that affects healthcare usage. The findings of the study indicated that lack of money or private health insurance was the most frequently encountered challenge when it comes to accessing healthcare. Some participants stated that some doctors refused to accept Medicaid/ Medicare payment, they were denied healthcare or turned away because of not being able to pay (Malmgren et al., 1996).

According to Loignon et al. (2015), few studies have indicated that people living in poverty (PLP) have been avoiding or have stopped to utilise health services because of the perception they have of healthcare workers. Their perception is that healthcare workers ignore them, they are rude, judgemental and controlling. PLP strongly assume that their poverty influences the quality of care they receive and that they are mistreated, marginalised and discriminated against due to their financial difficulties (Loignon et al., 2015). PLP usually report that they only utilise health services that are free or low-cost and they state that there are healthcare needs that are not met because of transportation costs and medication costs. Few studies show the challenges encountered by PLP in the healthcare system. These challenges include healthcare workers having a misconception about their disadvantaged patient's situation, this

results in their negative attitude and stigma towards them (Bloch et al., 2011; Price et al., 1988; Monnickendam et al., 2007). There are very few studies exploring the perspectives of PLP who are affected by the non-responsiveness of the healthcare workers when looking into the context of poverty (Loignon et al., 2015).

2.5 Summary

This chapter has provided a summary of the main findings from the existing literature. The literature review suggests that the healthcare for the elderly globally, including developed and developing nations, continues to be an area of concern. There are factors impacting use of health services and factors that are inhibiting the use of healthcare facilities. The elderly are at higher risk for disease and disability, therefore understanding their health-seeking behaviour is crucial (Falaha et al., 2016). This chapter demonstrated that the health of the elderly is vital, and it showed the challenges that are encountered by the elderly around the world and in South Africa when it comes to accessing healthcare service.

Chapter 3

Research methodology

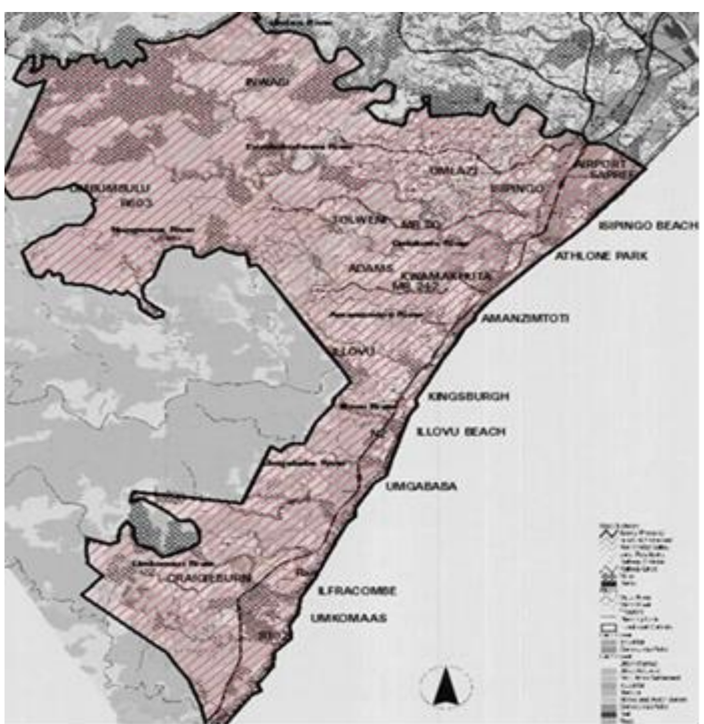
3.1 Introduction

The elderly are those individuals from the age of 60 years and above and in South Africa the majority of these individuals often reside in the rural and the semi-rural areas. There has been neglect in these areas in terms of healthcare service delivery. Conducting research in a semi-rural area will shed insights on the provision of healthcare services for the elderly. The study draws on qualitative data obtained by conducting in-depth interviews among the elderly in order to understand their perspectives and experiences. This chapter starts by providing an overview of the study setting. It then outlines the process for data collection and procedures for sampling used for the study. Thereafter, an explanation of the techniques used to analyse data is presented. Lastly, this chapter outlines the ethical considerations and the limitations of the study.

3.2 Study setting

Umkomaas is a small town on the south coast of the province of KwaZulu-Natal that was developed around the construction of a harbour to export sugar that was built in 1861 at the mouth of the uMkhomazi River, also known as the Mkhomazi or Umkomaas. Umkomaas consists of a number of rural and semi-rural villages as well as commercial and subsistence farming areas. With the development of the city of Durban's harbour, and the construction of the coastal railway line to another harbour town, Port Shepstone, the Umkomaas harbour was no longer used. Despite the absence of a harbour, the small town continued to grow, as well as the surrounding farming activities. The initial study site was the town of Umkomaas, but due to the inability to secure sufficient participants, it was then conducted in Ilfracombe, which is an area that falls under Umkomaas.

Figure 3.1 Location of Umkomaas, Ilfracombe



Source: EThekwini Municipality (2014)

Ilfracombe is a semi-rural area because it lies at the interface between the core urban and the rural setting. The study area remains poorly resourced and developed, it is inhabited by many African families. The area has no healthcare facilities, the nearby clinics are the Danganya clinic and the one in Umkomaas town. Both these clinics open during weekdays from 8am to 16pm. Most of the people in Ilfracombe use the clinic in Danganya because it is closer than the one in Umkomaas town and it is walking distance for many. The clinic is found between Ilfracombe and Umgababa and it is part of a catchment area consisting of more than 85 000 inhabitants, mainly Zulu-speaking African people and it primarily caters to the healthcare needs of the very poor. Access to Ilfracombe is by a tar road or a railway line, making travel in the area difficult. For serious health problems, the people in the area are referred to specialised hospitals in Scottburgh and Isipingo, or the UMshiyeni Hospital. Accessing healthcare in these hospitals is expensive due to the high transportation costs.

Figure 3.2: Houses in the area of Umkomaas, Ilfracombe

Figure 3.3: Umkomaas clinic and Danganya clinic

3.3 Research approach

To address the study objectives, a qualitative approach was used to enable people to provide in-depth information about the issues under investigation. The qualitative approach for this study is relevant because it examines human behaviour in a social, political and cultural context. In addition, it provides an understanding of social phenomena drawing on the experiences of all the study participants (Isaacs, 2014). This is vital as the aim of this study is to shed insights into the provision of healthcare services for the elderly by looking at their perspectives and experiences in Umkomaas, Ilfracombe. The qualitative approach enables the researcher to obtain an in-depth understanding of how humans behave, their experiences, attitudes, intentions and motivations, based on observation and interpretation in order to find out how people feel and think (Isaacs, 2014). In this study, the qualitative research approach provided the researcher with rich descriptive data which is in the form of words rather than numbers.

The advantages of using the qualitative approach for this study is that it allows the participants to be actively involved in the process of the research, thus empowering them. This research approach holistically attempts to understand the human experiences in specific settings, and sought to understand different individual's voices and meanings. The focus of the study was to obtain the experiences and perspectives of the elderly population regarding the provision of healthcare services. The qualitative approach is appropriate as it obtains detailed descriptions about individuals' experiences.

While the qualitative approach is appropriate for this study, it has its limitations. Some critics of the qualitative research approach argue that the results of the study cannot be generalized or applied to other contexts due to the small sample size (Lam, 2015). With qualitative data, interpretation and analysis of data may become difficult and complicated due to the smaller sample size and wealth of data, giving rise to issues of generalizability to the whole population (Richards and Richards, 1994). Qualitative research focuses on depth, meaning that the researcher is likely to spend more time in the field collecting data.

The focus of this study was on understanding the perspectives and experiences of the elderly when it comes to the provision of healthcare services for them. This study used qualitative

research method in order to understand the elderly's perspectives and experiences. Qualitative research method is appropriate for this study because it offers the best approach in acquiring such knowledge and meanings. This type of method enables an individual's experience to be examined in detail, this is why the researcher employed interviews for this study.

The researcher decided to conduct interviews because they are powerful in bringing out narrative data that enables the researcher to investigate individual's perspectives in depth. According to Alshenqeeti (2014), the advantage of conducting interviews is that they report detailed views of the informants and they allow interviewees to express how they feel and think. For this study, the interviews enabled the researcher to press for complete and clear answers by probing into any emerging topics. Conducting interviews fulfil the aim of the study which is to hear the perspectives and experience of the elderly when it comes to the provision of healthcare services for them. However, the critiques of interviews is that they are time-consuming with regard to both collecting and analysing data because they need to be transcribed, translated and coded (Alshenqeeti, 2014).

3.4 Sampling strategy

The sampling method used for this study was non-probability, snowball sampling which sought to shed insights into the provision of healthcare services for the elderly. Snowball sampling entails a participant providing the researcher with the name of people who might also be suitable candidates for inclusion in the study (Noy, 2008). The snowball sampling procedure is said to be the most widely used method of sampling when conducting qualitative research in many disciplines across the social sciences (Noy, 2008). The reason for choosing snowball sampling is because not all the households in the area of Umkomaas, Ilfracombe have elderly, making it difficult to identify potential participants. This method enables people to be referred who may meet the inclusion criteria (60+ years).

Since the researcher once resided in the area, this made access to the community to be easy. The local councillor had to be consulted in order to give permission to conduct the study in the area. The local councillor has authority over the area, therefore it was important for the researcher to get his permission. A gatekeepers' letter from the local councillor granted the researcher permission to conduct interviews in the area of Umkomaas, Ilfracombe. This letter was submitted to the Human and Social Sciences Research Ethics Committee of the

University of KwaZulu-Natal. Once permission was granted, participants were recruited and interviews were conducted.

A sample size of 20 elderly people was decided upon, with 10 of each gender being identified as being required to ensure that any bias in their experiences were not encountered. However, due to difficulties in locating elderly men, 15 women and 5 men aged 60 and above were included in the study.

3.5 Data collection methods

An interview guide was the most appropriate tool to provide insights or allow people to share their perspectives and experiences to obtain the objectives of the study. Interviews are regarded as a suitable qualitative research method to investigate participants' perspectives on a specific issue (Boyce and Neale, 2006). For this study, 20 in-depth face to face interviews were conducted among men and women aged 60 years and over. In order to be eligible for the interview, elderly women and men had to have sought and accessed healthcare in their lifetime at the public clinic. They also had to be residing in Umkomaas, Ilfracombe in which the study was conducted. Semi-structured interviews that were conducted consisted of a sequence of questions that all the interviewees were asked to answer. The reason for conducting semi-structured interviews was because it enabled the researcher to find similarities and differences in answers given to the same questions. In addition, these interviews are appropriate for this study because they produce detailed data sets that is rich, this offers an accurate assessment of the characteristics of persons and phenomena (Fallon, 2008).

The semi-structured interviews involved a series of open-ended questions to enable the interviewer and interviewee to discuss various related issues. These interviews enabled the researcher to obtain related information about the study due to the freedom to probe in order to get the participant to elaborate on their original response. Furthermore, it offered flexibility and enabled the interviewees to answer the questions freely, and to voice perspectives and experiences. During the interviews, a voice recorder was used and notes were taken down to substantiate or supplement the recorded data. The voice recorder were only used after receiving consent from the participant. The questions were divided into two sections, the first part dealt with the socio-demographic background characteristics and the second part focused on access to and provision of healthcare services to the elderly (Appendix 1).

The interviews were held at the home of the elderly. This enabled the participants to be comfortable in their own homes. Each interview lasted approximately 30 minutes. All the interviews were held in isiZulu, the local language. The researcher started by introducing herself, then asked if there is anyone in the household who is from the age of 60 and above, if yes, then the researcher outlined the purpose of the study, its rationale and significance. Thereafter the researcher sought permission to interview them, if they agreed then the information sheet together with the informed consent form was issued to them.

The informed consent form provided a platform for potential participant to freely agree to take part in the research with understanding fully the activities and risks attached to being part of the study. The researcher went over the informed consent form with the participant if there was a need to do so. The researcher also asked the participants to give their consent to use a voice recorder during the interviews. The participants were given assurance that their information will be strictly confidential, only the researcher and the supervisor will have access to it for academic purposes. The voice recordings from the interviews will only be accessed by the researcher and the academic supervisor at the School of Built Environment and Development Studies at the University of KwaZulu-Natal.

3.6 Data analysis

According to Maguire and Delahunt (2017), data analysis is central to credible qualitative research, as it organises and arranges information manually. For this research, data was analysed using thematic analysis, which is a process that involves identifying patterns and themes within qualitative data (Maguire and Delahunt, 2017). Thematic analysis helped the researcher to clarify the purpose of the interviews and the concepts explored. According to Robrecht (1995), in thematic analysis, well-grounded arguments are built by selecting suitable themes. This is usually done by reading literature that is related to the study and by repeatedly reading the transcripts obtained from interviews. Thematic analysis is appropriate for this study because it helps to categorise important issues reported during the interviews.

The recorded data was transcribed verbatim and translated from isiZulu to English. Transcriptions were important as they were useful in analysing data and the findings of the study. The researcher read through all the interviews and the notes jotted down many times during the process of data analysis. This was done in order to for the researcher to understand

the interviews. The process of re-reading was vital and useful because it offered insights into the thoughts, perspectives and experiences of the elderly.

Themes are said to be units obtained from patterns, for instance, conversation topics, feelings and meanings (Taylor and Bogdan, 1989). The use of themes for this research is appropriate because these themes that emerge from the participant's stories are put together to create a comprehensive picture of their collective experience. In addition, themes are recognised by bringing components or ideas together, experiences and perceptions, which usually are meaningless when viewed alone (Leininger, 1985).

The process of thematic analysis requires the researcher to read and reflect on the transcripts and recorded tapes, after that the data was coded. The researcher also had to refer back to the points raised in the literature, this was done in order to understand the themes in depth that emerged during the interviews. The process of coding involves identifying and organising the identified categories into groups, tags and labels, after which it is sorted as themes emerge and are identified (Boyatzis, 1998).

3.7 Ethical considerations

Before conducting the interviews, various ethical considerations were taken into account. Ethical clearance was obtained from the Social Sciences Research Ethics Committee of the University of KwaZulu-Natal (Appendix II). Once permission was granted, participants were recruited and interviews were conducted. The study was explained to each potential participant before they were given a consent form to sign, after which an appointment was made at a time suitable for them to be interviewed. The recordings and notes taken down during the interview sessions, including the informed consent form, will be kept in the cabinet of the Supervisor's office for safety reasons for five years, after which they will then be deleted and destroyed. The researcher ensured that any information included in the final report did not identify any participants by name, the data is kept anonymous.

3.8 Study Limitations

The study was supposed to be conducted in Umkomaas, but due to lack of elderly participants in the area, the researcher ended up collecting data in Ilfracombe which is an area under Umkomaas. Initially there was supposed to be 10 elderly women and 10 elderly men participants but due to difficulties in locating the latter, 15 women and 5 men were included,

resulting in a limited representation of elderly men. As the interviews were conducted in their homes, in which other family members stayed, some were interrupted by children or grandchildren who needed their attention. A number of participants provided information that was not necessary for the study, as they were given a platform to talk about their perspectives. This resulted in translation and transcription to be very time consuming. Also, as all the interviews were conducted in isiZulu, translating and transcribing them into English was very time consuming and in some cases, it is possible that they did not accurately reflect the original intended meaning of the participants. It is also possible that the participants were also afraid of negative comeback.

3.9 Summary

This chapter provided the rationale for conducting qualitative research in the Umkomaas, Ilfracombe area of southern coastal KwaZulu-Natal. It draws on semi-structured interviews used to obtain relevant data in the local isiZulu language, which was transcribed, translated into English and thematically analysed. Standard ethical considerations were applied, and care taken to ensure that the elderly participants understood the study and their rights to confidentially and privacy. This chapter also stated the limitations of the

Chapter 4

Results

4.1 Introduction

This chapter outlines the main findings from a qualitative study with men and women aged 60 years and over. The overall aim of this study was to explore healthcare provision from the perspective of the elderly. The findings are drawn from the in-depth interviews with 20 elderly participants. During the interviews, the participants narrated their experiences at health facilities. The chapter starts by outlining the socio-economic and demographic characteristics of the elderly and then their overall experiences and perspectives with regards to their healthcare.

4.2 Sample Characteristics

Table 4.1 shows the demographic characteristics of the participants of the study. All 20 participants spoke isiZulu, as it is the common language in the area, with 15 elderly women and 5 elderly men being interviewed. Their ages ranged from 60 to 87 years, 50% of the study participants were single and the rest were married except for one who was a widowed. Only one participant was employed. None lived alone, and most stayed with their children and grandchildren. Two participants did not receive any state or other pension. Four had other sources of income, such as child support grants, and foster care money. In addition, they were involved in selling homemade products (crochet clothing) and other temporary work. The interviews suggest that the elderly were struggling to make a living. The one participant that receives both the state pension and the child support grant claimed that she did not have sufficient funds to support herself and the grandchild as the father of the child does not send money every month. The women selling crocheted items stated that she is struggling to make money to support her grandchildren as no-one was helping her financially.

Table 4.1: Socio-demographic profile (n=20)

No.	Gender. F/M	Age. (60+)	Marital status	Employed? (Yes/No)	Live alone? (Yes/No)	Income source (None/Pension/Other/ Pension and other)
1	Female	63	Married	No	No	Pension.
2	Male	64	Married	No	No	Pension.
3	Female	62	Single	No	No	Pension.
4	Female	65	Single	No	No	Pension and other.
5	Female	64	Single	No	No	Pension and other.
6	Female	82	Single	No	No	Pension.
7	Male	82	Widower	No	No	Pension.
8	Male	62	Married	No	No	None.
9	Female	60	Single	No	No	Pension.
10	Female	87	Married	No	No	Pension.
11	Female	66	Single	No	No	Pension.
12	Female	77	Single	No	No	Pension.
13	Female	68	Married	No	No	Pension.
14	Male	70	Married	No	No	None.
15	Female	67	Single	No	No	Pension and other.
16	Female	60	Married	No	No	Pension.
17	Female	62	Single	Yes	No	Pension and other.
18	Male	63	Married	No	No	Pension.
19	Female	60	Single	No	No	Pension.
20	Female	69	Married	No	No	Pension.

4.3 Pension

Old age pension can create other positive wellbeing outcomes, including improved health status for the elderly (Lloyd-Sherlock and Agrawal 2014). Old age pension can be seen as a determining factor in seeking healthcare services and to accessing healthcare. While the availability of the old age pension may promote health benefits for the elderly, sharing it prevents many from taking care of their own financial and health needs (Legido-Quigley, 2003). In this study, most of the participants reported that their main source of income is the old age pension. They note that they used the grant to support the entire household, including their grandchildren who attend school. In the context of high levels of poverty and unemployment, the grant is a valuable source of support. However, eighteen of the elderly were grant recipients and of these six complained bitterly that the grant was relatively meagre and did not cover their many expenses.

"You see, what I can say is that we get pension but it is not enough because there is a grandchild that I need to give money to, for instance, school fees, school jacket where am I going to get this money, because I need to pay for the funeral insurance, buy groceries with this money, you cannot do it all. Yes the government does help us, but we cannot pay for the funeral insurance and look after a grandchild with this money" (Participant 11, 66 years).

"My child is a painter but he does not do it every day, it happens that he fails to get a job for the entire month so I am the only one who brings money here at home, the pension money" (Participant 12, 77 years).

Households that are headed by the elderly usually struggle to carry the burden of providing and caring for members of their household. In some cases the elderly receiving pension get financial assistance from their children but when this stops, they are required to fully intervene by having to carry the responsibility of caring for the entire household. They are expected to cover all the costs around the household. In households where there is no income, the pension of the elderly is shared in order to cover all the expenses around the household. The above quotes show that some elderly individuals plays a significant role in their households, especially those who are the heads of the family, as they take care of the entire household using the pension they receive from the government. This may result in the elderly neglecting their own health needs because of the pressure of having to take care of the needs around the household.

4.4 Health related challenges

According to Thakur et al. (2013), in developing countries, estimates of health related issues of the elderly are needed in order to predict trends in disease burden and to plan proper healthcare for the elderly. In most cases, health in old age is associated with health in earlier years of life for an individuals, meaning from womb to tomb (Thakur et al., 2013). There are different illnesses that are associated with aging among the elderly. For this study, the elderly revealed different health problems that require the elderly to access healthcare. Most of the participants reported that they have hypertensive disorder, of these participants there are also some participants that suffered with high blood pressure and arthritis.

"My child I have high blood pressure" (Participant 11, 66 years).

"I usually feel dizzy, I have high blood pressure which is a silent killer and sometimes I become very weak which leads me to dizziness" (Participant 14, 70 years).

"Blood pressure and arthritis, if my arthritis is stronger that day then I fail to even hold a spoon the only thing I would do is to sleep" (Participant 5, 64 years).

One participant reported that she has a skin problem that they fail to treat at the clinic. It is possible that this skin problem is caused by another chronic condition that has not been diagnosed.

"Yes they do not help me even if I show them, my skin is always itchy I now have black spots, I don't get pills that will help me as you can see my child, can you see?"(Participant 6, 82 years)

As people age they are more likely to experience condition health conditions. A number reported that they were suffering from hypertensive disorders, and diabetes. In addition, as they grow older they are more likely to experience sight and hearing difficulties. There were other participants that complained about bodily pains. They reported that they suffered from a sore body and swollen feet.

"Blood pressure, sometimes my body gets sore and I have a problem of swollen feet" (Participant 8, 62 years).

"It is usually arthritis and I have an ear problem, it is like I have water inside my ear" (Participant 16, 60 years).

"I suffer from diabetes" (Participant 18, 63 years).

In this study it was rare to find that any of the participants not complaining about health problems. Only one participant in the study revealed that she does not have any health related problems.

"Sometimes four or five months passes without me going to the clinic because my problem is that even when I go to the hospital they tell me that I do not have high

blood pressure and hypertension and plus I am not looking forward in getting those illnesses but when I do have a problem I do go to the clinic" (Participant 10, 87 years).

The above comments indicate that elderly have different health related issues and they access healthcare services due to these issues. The elderly are a mix of those who are thriving, those who are frail and those who are potentially approaching death.

4.5 Clinic visits

In the interviews participants were asked how often they visit the clinic. This question was asked in order to see how many times the elderly experience challenges when accessing the clinic. When the participants were asked how often they visit the clinic, the majority stated that they went once a month, while some go twice a month, depending on how sick they are or whether they are not getting better. Some did not attend as much as they should, while others sought remedies from traditional healers**.** Fourteen of the elderly people go to the health facility at least once a month to collect their chronic medication. Some prefer to rather visit a traditional healer than a health facility.

"I go every month but if the situation gets worse I go twice a month" (Participant 14, 70 years).

"I use to go there every month but now I go every after two months" (Participant 15, 67 years).

"I go after one month because I do not have major illness problems, if I need to go for a pap smear and blood test I do go because the government said we should test for these things twice a year" (Participant 17, 62 years).

"My child, I would be lying if I say I usually go, I let some weeks pass because I am not used to going to the clinic and doctors" (Participant 7, 82 years).

"I use tradition medication" (Participant 7, 82 years).

He added:

"They are more convenient for me and plus I grew up in a home were they strongly believed in ancestors and traditional healing. When I was growing up, I relied on traditional medication, which is why I hardly get sick even though I am this old. I do not usually go to the clinic and doctors" (Participant 7, 82 years).

4.6 Assistance getting to the clinic

During the interviews, the participants were asked if they were assisted by anyone when preparing to go to the clinic in the morning. Most stated that they prepare everything for themselves in the morning, meaning that they do not get assistance from anyone when going to the clinic.

"I do everything myself, I end up arriving late at the clinic because I do everything on my own, because I am staying with these children, first I have to get them ready for crèche and after that I then prepare myself" (Participant 3, 62 years).

"No, I help myself because I even prepare for my grandchildren at 4:30am, there is no one who wakes up if I do not wake up. I have to wake up at 4:30 and boil the water in order to make the porridge for them to eat" (Participant 4, 65 years).

"Everything is always ready, I pour myself water in the kettle then put them in a bathing dish and bath, at the same time my grandchildren have to go to school but during winter I put everything for them on the bed because there is an older one now amongst them who can assist the siblings" (Participant 12, 77 years).

Most participants are heads of the households and live with their grandchildren who are attending school. This is problematic because it results in their arriving late at the clinic or having to postpone their appointments, which means delayed access to health. According to Kenagy et al. (1999), this is assumed to negatively impact health due to delays in diagnosis and treatment. However, some participants stated that they do get

assistance from their household members. Those who are not able to completely take care of themselves often rely on other family members for support.

> *"My daughter is the one that usually helps me, even though she sometimes works, but she does help me when it comes to taking care of my life because my life is not going well" (Participant 5, 64 years).*

> *"Yes it is my wife who helps me" (Participant 14, 70 years).*

4.7 Waiting times at the clinic

Research suggests that long queues are usually found in most public sectors institutions and that they are a main source of patients' dissatisfaction (Jim, 2010). The majority of the elderly reported that they wait for a long time to be attended to due to a lack of assistance as they arrive as well as long queues. In some cases, the long waiting-times are due to nurses being lazy. The elderly perceived nurses as being lazy because even in cases were the lines are short at the clinic, they still waited for a long time before they are attended to at the health facility. According to Mokgoko (2014), when patients at the health facilities wait longer than expected, they often become frustrated, angry and anxious.

> *"…because when you get to the clinic you wait without no one assisting you, you wait until the afternoon without having eaten anything and maybe you go to the clinic very early in the morning because you have to wake up early in order for you to get help on that day, because if you leave at 8am it might happen that you will have to come back the next day to get help" (Participant 8, 62 years).*

> *"You see, my worry is that when I leave the house at 7am and I get there the line is from the inside all the way to the outside. And I usually wait for one hour and 30 minutes to get service" (Participant 2, 64 years).*

> *"Long waiting times at the clinic is a challenge to everyone, waiting for a long time at the clinic without having eaten is problematic for me because if you are*

an elderly person and you have not eaten you end up feeling dizzy" (Participant 5, 64 years).

The following responses indicate that sometimes the elderly feel that the nurses are lazy and it is why the waiting period is so long. Many of the elderly complained that they become hungry while sitting in the long queues and this is likely to also negatively impact their health.

"No…lines are always short…those nurses are just lazy" (Participant 13, 68 years).

"In some cases the lines are not long but because the nurses are lazy at times, they chat on their phones, they end up attending us after lunch, around that time you are already hungry, the only thing you want to do is to just go home" (Participant 20, 69 years).

Very few participants stated that they do not wait for a long time at the clinic. The individuals from the age 70 and above and those with physical inabilities indicated that they do not wait for a long time at the clinic. The individuals with physical inabilities or disabilities do not stand in the line, they get attended before everyone else.

"I do not know, because they attend to the ones using the wheelchairs first and we know this now, they go first and then we follow next" (Participant 15, 67 years).

"…at my age I do not stand on a queue and look at me, I'm using clutches, I just go straight to wherever I'm told to go" (Participant 14, 70 years).

"Even when I arrive at the clinic I don't wait for long, the nurse calls me and I follow her" (Participant 10, 87 years).

She added

"I think it is because I am very old, remember my age?" (Participant 10, 87 years)

One participant stated that they do not stand in a line when they are at the clinic as he has a disability. For this study, age is seen as a factor that determines the waiting times at the clinic. From the narratives above, the long waiting times at the clinic are due to a variety of reasons. The amount of time the elderly spend waiting at the clinic forms a challenge as it causes frustration, tiredness and anger for the patients, which can cause them to be reluctant to visit the clinic.

4.8 Challenges to access

4.8.1 Distance

In this study, the elderly had to either walk to the clinic or use transport. Four out of the eight elderly who indicated that they walked to the clinic stated that they did so because they did not have money for transportation. The participants reported that it is a long distance to walk from their place of residence to the clinic. The time it takes the participants to reach the clinic differs, and ranges from 30 minutes to three hours, depending on the where they live and their physical abilities.

"It is not easy because It is not easy for me to get R12, R6 to go to the clinic and another R6 to come back from the clinic, it is not easy and most people usually use transport but as for me it is a challenge, I am forced to walk" (Participant 4, 65 years).

"It takes me about two to three hours to get to the clinic because I use crutches, when I don't have money I walk, even though I don't know how many miles it is from home to the clinic, but it is a distance. It is really a long distance" (Participant 14, 70 years).

The elderly indicated that the cost of transport forces them to walk, as it can put pressure on their household budget, specifically if they have considerable healthcare needs. The cost of transportation influences their health seeking behaviour, as most are unemployed. The elderly are often frail, and having to walk long distances to access care can discourage them from

using the facilities. Accessing healthcare services is sometimes very complicated and time consuming, with one participant preferring to walk rather than use transportation.

> *"Yes I walk, but I took a taxi the time I had problems with my feet, but I must say, taking a taxi is very time consuming because you wait there by the container, yes it is easy to get to the container, but the problem is waiting and the time you get to the clinic it is already full, so I prefer walking" (Participant 12, 77 years).*

This indicates that it is sometimes more convenient for some elderly persons to walk than use transportation. This brings our attention to transportation as one of the challenge to accessing healthcare services.

4.8.2 Safety

Most of the respondent indicated that they do not encounter any safety related challenges when travelling from home to the clinic. The following are the responses of the participants who stated that they do not encounter any challenges on their way to the clinic.

> *"I have never encountered any problem, I must say, I have never had a problem because sometimes I usually walk from here to an area called P, and I would get a lift from one of my child's friend, he picks me up from that area and drops me off at the clinic but it is not something that happens all the time" (Participant 4, 65 years).*

> *"I have never encountered any problems, I would not lie to you. I would not allow you to write lies. I have never encountered a problem, I have never come across anyone trying to do something bad to me" (Participant 10, 87 years).*

> *"We walk in between people's houses. No there are no problems that I have encountered" (Participant 12, 77 years).*

> *"I do not encounter anything bad because I get to the clinic very safely and when I come back I take a taxi but for now one of my children drops me off to the clinic and fetches me later" (Participant 15, 67 years).*

There are some participants who reported that they encounter challenges when they were travelling from home to the clinic. The following are the responses of the participants who stated that they encounter challenges from the moment they leave their houses going to the clinic.

> *"Yes, there was this day where I had to turn and go back to where I was coming from and take a taxi. The story is, I was walking and I saw a boy carrying a knife and that time I was carrying my bag, I think he assumed that the bag had money on it and that is when I made a turn and took a taxi…" (Participant 11, 66 years).*

> *"There are challenges I encounter because I usually feel dizzy, I have high blood pressure, which is a silent killer, and sometimes I become very weak, which leads me to dizziness" (Participant 14, 70 years).*

It is important for the elderly to be safe when going to the clinic. For this study, safety can also be considered as a challenge for seeking healthcare services and accessing healthcare at the clinic especially for those who walks to the clinic.

4.8.3 Transportation

Transportation for this study refers to public taxis and private cars, with 18 participants using taxis and two using private cars. All the participants who use taxis to go the clinic stated that they encounter challenges such as having to wait for a long time before the taxi arrives. They also complained that the taxi takes a long route before dropping them off at the clinic, with drivers often refusing to drop them off close to where they stay, irrespective of their weaknesses and illnesses. In this study, more participants used transport (taxis) than walking.

> *"It is a challenge to get to the clinic, because the taxi does not pick us here, we have to go down in order for them to pick us up but even when we get there we wait, it happens that you stand for an hour or more and wait for the taxi" (Participant 8, 62 years).*

> *"… they refuse to take us from here, and even when you go down there by the container, they take forever to pick us up…we have to ask those driving the taxis coming from Durban and Isipingo to take us, after they have taken us, they refuse*

to drop us off closer to our houses, but instead they drop us there by the container at the same time you are sick you cannot even walk properly, they drop you off there by the container and it is very far from here to there…I know of a granny this side that has a lung problem, when she walks from the container to her house she walks for few minutes and she sits down, she walks again and take a break by sitting down along the pavements, this saddens me to the point where I wish to put her in a wheelbarrow…" (Participant 9, 60 years).

The above comments show that most of the participants rely on taxis to get them to the clinic as they cannot walk due to long distance and their illnesses. There is a great concern with regards to taxis to and from the clinic. Both transportation and distance to and from the clinic seem to have an effect on the health seeking behaviour of an individual and on how they access healthcare.

4.9 Service related challenges

4.9.1 Availability of nurses

According to Buchan and Aiken (2008), one of the major challenges related to achieving health system effectiveness is the shortage of qualified healthcare workers, including nurses. Nurses are well known for playing a significant role in promoting public health (Kemppainen et al., 2013). The role that the nurses play include clinical nursing practices, educating patients, consultation, giving treatment and preventing illnesses (Kemppainen et al., 2013). For this study, more participants raised concerns during the interviews about the shortage of nurses at the clinic.

"They usually worry about the staff because there are times where we would have to wait and even the sister in the clinic asks us to wait because of the shortage in staff but when there is enough staff everything goes fast" (Participant 4, 65 years).

"There is a shortage of staff at the clinic, sometimes we get there only to find that there is a shortage. They set an hour for us to wait at the clinic but we end up waiting for three hours because of a shortage of staff (nurses)" (Participant 9, 60 years).

"Yes there is a shortage, because it gets full and there are long queues" (Participant 18, 63 years).

"The way it gets so full there, they tell us that they will chase us to go back to our clinics because all of this is too heavy for them, and they complain about something we also see. They complain that the clinic is old. There is a shortage of nurses. They say that we come from our clinics to fill their clinics…" (Participant 3, 62 years) (This participant attends a clinic in Umkomaas town, she stated that she stopped going to the clinic because she was dissatisfied and angry, but did not want to elaborate).

The findings revealed that the shortage of nurses in the clinic causes service delivery to be poor and results in congestion at the clinic, which causes long queues for the patients. They stated that due to the staff shortage at the clinic, the pace of work is very slow, whereas if there were enough staff, things would function well at a faster pace and there would be no long lines, which is one of the factors that negatively impacts the elderly in accessing healthcare services at the clinic. Very few participants stated that there are no staff shortages at the clinic.

"This is a tricky question that we usually encounter because we usually see the staff member walking up and down not knowing if they are many or there is a shortage, we always see them up and down like there is many of them but on the other hand service is not good"(Participant 2, 64 years).

"There is no shortage even though sometimes the nurses are being moved but there are always those ones to replace them. They are always there" (Participant 12, 77 years).

"I do not see a shortage when I get there because there is always a nurse at the office when I go to fetch my medication" (Participant 17, 62 years).

4.9.2 Availability of Doctors

The interview probed how often the doctors visited the clinic. Most participants stated that there is a shortage of doctors, and that they usually attend the health facility only once a week.

> *"The doctor is not always around, they usually tell us when a person has got an illness that needs a doctor or any symptoms that needs to be treated by the doctor, they then tell you the date in which the doctor will be at the clinic, they tell to come back on that day. Sometimes you do come back on the assigned date but only to find out that the doctor did not come on the date that he or she was supposed to come" (Participant 8, 62 years).*

> *That is another problem, you find that there will be a doctor in this month and the next month they are not there, when we get there we find that the doctors are not there. They change the doctors every now and then. There is a problem when it comes to the availability of doctors. You find that maybe you have been seeing this particular doctor this month every Monday and the next month you hear that he or she is no longer there. There is really a huge problem when it comes to the doctors" (Participant 9, 60 years).*

> *"...I took medication that ended up making me sick and when I told the nurse they did not do anything about it, instead they said I should continue taking it but if the doctors where around they would know what to do about this..." (Participant 14, 70 years).*

> *"The doctor usually comes every Wednesday, and sometimes he doesn't come and we keep on waiting for him to arrive but he doesn't, they even call him sometimes at the clinic but still he takes forever to come (he doesn't come on time). He comes once a week, every Wednesday" (Participant 16, 60 years).*

The study revealed that there is a challenge regarding the availability of doctors at the clinic, which is problematic, as there are illnesses that require their urgent attention. The shortage of doctors affects the health of the elderly and puts them at risk, because if their particular

illnesses are not taken seriously, it can lead to death. The elderly often have chronic illnesses that necessitate regular check-ups from the doctors, which is difficult to achieve because the doctors are not always available. Shortage of healthcare workers, both nurses and doctors, can make the elderly reluctant to visit the clinic.

4.10 Satisfaction with healthcare services

The attitude that the elderly have towards healthcare service provision can be strongly influenced by the level of satisfaction. Responses from the participants regarding their satisfaction with healthcare service provision at the clinic varied. The majority of the participants stated that they were not satisfied with the healthcare services provided, their dissatisfaction being influenced by number of factors.

> *"I am not satisfied because as I am 63 years old, they are not paying attention to me because, according to the rules we were supposed to have our own waiting line as the elderly people so that they can be able to help us because some have high blood pressure, asthma and they are ignored" (Participant 1, 63 years).*

> *"…if only they take care of you as you arrive at the clinic and attend to you and do what you need to do and leave, then I would say I am satisfied, but now because when you get to the clinic you wait without no one assisting you, you wait until the afternoon without having eaten anything and maybe you get to the clinic very early in the morning because you have to wake up early in order for you to get help on that day because if you leave your house at 8am it might happen that you will have to come back the next day to get help" (Participant 8, 62 years).*

One elderly woman had previously attend the Danganya clinic, but due to her dissatisfaction with the poor services and various challenges that she encountered she refused to discuss it, she decided to seek healthcare at the clinic in Umkomaas town.

> *"I do not go to my clinic anymore because of their poor services and the situation was very bad, it is actually a long story and I cannot give all the details but I no longer do I go to the Danganya clinic, I go to the one in the town of Umkomaas" (Participant 3, 62 years).*

The following responses indicate that some participants were satisfied with the healthcare services provided to them at the clinic they attended. Satisfaction with the quality of healthcare is considered as an important variable of health seeking behaviours as it increases the chances of people continuing to seek healthcare and access healthcare services.

> *"I am satisfied with the healthcare services being offered to me, the nurses take really good care of me and I leave the clinic satisfied" (Participant 9, 60).*

> *"Yes I am satisfied, they take good of me, actually not me only, they take good care of us" (Participant 15, 67 years).*

> *"Yes I am satisfied because here I am still alive and working" (Participant 17, 62 years).*

The above comments indicate that health seeking behaviours are influenced by patient satisfaction, while patients' satisfaction is dependent on variables such as the availability and quality of services, attitudes of healthcare personnel and waiting times at the clinic.

4.11 Attitudes of healthcare workers at the clinic

According to Welford (2014), the attitudes, beliefs and values of the health professionals towards the elderly have an effect on how they see and approach those in their care, which can negatively impact the quality of care that the elderly people experience. All the participants stated that they have a good relationship with the healthcare workers at the clinic, with the exception of one. Although they do not always receive all the healthcare services they require from the clinic, they reported that the healthcare workers are friendly and very welcoming.

> *"They do not have a problem, they are nice people, there is no one fighting with anyone, they are good people, because even when they arrive in the morning you wouldn't find them speaking anyhow to us, but instead they are very kind all the time" (Participant 4, 65 years).*

"Everything is okay, I always get help from the nurses, they take good care of me there at the clinic, even 'sister' takes good care of us because when you raise a concern she does not ignore it" (Participant 9, 60 years).

"They are very welcoming towards us because we are elderly" (Participant 12, 77 years).

The attitudes of the nurses at the clinic is positive, and can be regarded as an enabling factor that encourages the elderly to seek healthcare.

One elderly man stated that the relationship between him and the healthcare workers at the clinic is neutral. The participants stated that the relationship is neutral due to the things he observes the moment he enters the clinic.

"I do not know when you arrive and you find that the staff is just chatting and they are not giving you their attention and also I do not know when you have to wait for a long time so after all these things I do not know whether to say we have a good relationship or not, I really do not know, let me just say the relationship is neutral" (Participant 8, 62 years).

The relationship between the healthcare workers and the elderly patients can be seen in two spaces. One is the actual space were they wait to get attended to and one is when they individually interact with the healthcare worker. Sometimes due to the long waiting period at the clinic, this can give rise to frustrations. In this case, nurses can be perceived as being lazy. The shortage of nurses needs to be taken into consideration, different perceptions can arise due to waiting for a long time at the clinic. Also, as the nurses enter the clinic they need to prepare, for instance sorting out the medications and equipment, the elderly may not know this, meaning that they can make assumptions. The concern raised about nurses chatting and using their cell phones, it could be that they have personal related matters to attend to.

The second space where the healthcare worker interacts with the elderly patients is the consultation room. The relationship is positive there because once healthcare workers interacts with the elderly patients, they treat them with respect, and they assist them. Positive

relationship is observed there. This implies that even though the elderly wait for a long time at the clinic, once they get attended to or interact with the healthcare worker they are respected and approached in an appropriate manner. Long-waiting times at the clinic does not imply that healthcare workers have a negative attitude towards the elderly, that is why all the participants stated that they have a good relationship with the healthcare workers except for one.

4.12 Knowledgeable healthcare workers

The elderly require nurses that are knowledgeable on how to take care of their needs (Welford, 2014), with most participants reporting that healthcare workers are knowledgeable about what is needed from them. They trusted the healthcare workers because they know that they are educated.

> *"The thing is, once you tell the nurses, the nurses are the ones that are educated and they know things, even though they do not give you everything that you need, but you tell them and they sometimes tell you that there is no medication" (Participant 5, 64 years).*

> *"They are because they are educated and I am "ibhinca" [someone who does not want to outgrow their roots and they believe in traditional ways of doing things] and all I know is that they are doing what they know" (Participant 10, 87 years).*

> *"I would say it looks like they know what they doing, but sometimes I wish I can get an injection. I started going to that clinic in 1991. Another thing is changing the medication, when I complain they say the doctor haven't said anything about changing the medication, but the question is, where is that doctor to tell the nurses to change the medication?. He or she is not around" (Participant 14, 70 years).*

One participant stated that the nurses at the clinic are not knowledgeable about what is required from them. This participant stated this is due to the lack of attention she receives from the nurses at the clinic.

> *"I usually see them socialising and not paying attention to us. I do see staff members but I feel like they don't know what they are doing" (Participant 1, 63 years).*

She added:

> *"They need to employ people that will pay attention to us because we are very old" (Participant 1, 63 years).*

Other participants were not sure if the healthcare workers were knowledgeable about what is required from them. One participant was unsure because in some cases the nurses are slow and ignorant but at the end they receive the healthcare they need. For the other participant, he was unsure because he observed how other nurses do things around the clinic, hence saying some do know what they are doing and some don't. This participant stated that by observing older nurses helping younger nurses made him unsure if the younger nurses were knowledgeable or not, that is why he stated that the young ones are usually the problem.

> *"I am not quite sure of that, because I see them working but they are slow, they do work and sometimes they just leave things as they are, maybe going to the kitchen, maybe chatting with whomever, but at the end you do get help, so it is difficult to say whether they do have experience or they don't" (Participant 2, 64 years).*

> *"Some do know what they are doing and some don't" (Participant 18, 63 years).*

He added:

> *"I say this because of how some nurses do things around the clinic, sometimes you find that the older nurse will help the younger nurse there at the clinic. The young ones are usually the problem" (Participant 18, 63 years).*

4.13 Alternative healthcare

The participants were asked where else they go when seeking healthcare, with most indicating that they go to Umshiyeni and Scottsburg Hospitals when they are referred by a doctor in the clinic. Umshiyeni and Scottburg are public hospitals that are closest to them. Two participants stated that they sometimes go to a private doctor, one to get an injection because she usually feels weak, as they do not inject her at the clinic. The other stated that he

seldom gets sick, and that when he does he usually uses traditional medicine, and in some cases visits a private doctor. All these alternative healthcare requires one to have transport money, this can be seen as an issue since some of these elderly are not working and are pension holders.

Some of the participant stated that they do not go anywhere else to seek healthcare, they only go to the clinic. As almost all the participants are unemployed, they depend on public healthcare for the management of ill-health because private care is costly, and therefore they take what is offered to them despite not being satisfied, as they do not have a choice.

> *"The time I was still working I used to go to private hospitals, I preferred them because people there take good care of you, they attended to me, but as for the government hospitals and clinics, the major challenge is ignorance. You find that the staff are busy chatting on their phones, they are talking and you find that the patients seeking healthcare are ignored you see… So if you can just look at how the patients live their lives in the public hospitals you would see that it is very scary, because most nurses there are very rude. You find out that as we are old you get a child who is about your age, my child. You see life is difficult here on earth, but still we do go to the hospitals because we hope that if you get lucky on that day you may get help, but they do not take good care of us"(Participant 8, 62 years).*

4.14 Summary

This chapter has presented results from the in-depth interviews conducted with elderly women and men in Umkomaas, Ilfracombe. It is evident that a number of factors influence the elderly when seeking healthcare and accessing healthcare services at the clinic. The chapter has attempted to narrate and deepen understanding of the perspectives and experiences among the elderly seeking healthcare and accessing healthcare services at the clinic of Umkomaas, Ilfracombe. The challenges encountered by the elderly when seeking healthcare and accessing healthcare services outweighed the enabling factors that encourages the elderly to continue utilizing these health services.

Chapter 5

Discussion and Conclusion

5.1 Introduction

Elderly in South Africa encounter numerous challenges when accessing healthcare services. The factors associated with the needs of the aging population have not received much attention in South Africa. In fact, various matters concerning the elderly have been neglected. Challenges encountered when accessing healthcare services pose as threats to the health of the elderly, especially in rural areas and semi-rural areas. The overall objective of the study was to shed insight into the provision of healthcare services for the elderly. This chapter discusses the study findings presented above while drawing on the literature to examine the perspectives and experiences of the elderly regarding the provision of healthcare services at public sector clinics. This allows for insights into the challenges they encounter when accessing healthcare services at the clinic. Thereafter, recommendations of the study are also discussed and lastly, the conclusion.

The overall objective of the study was to shed insight into the provision of healthcare services for the elderly. This study draws on the theoretical framework developed by Ronald M. Andersen to explore perceived challenges when seeking, accessing and utilizing healthcare services. The findings for this study suggest that the elderly encounter a number of challenges when seeking healthcare services and accessing healthcare.

5.2 Discussion

Studies suggest that the elderly encounter a number of barriers to utilizing healthcare services. In this study, transport was perceived to be one of the major challenges, with most participants utilizing taxis to get to and from the clinic encountering challenges, including arriving late. According to Syed et al. (2013), transportation is essential for accessing ongoing healthcare and medication, especially for those with chronic illnesses. Such conditions necessitate regular clinical visits, ongoing access in medication, and possible changes to the treatment plans, which is done to provide evidence-based care. However, without access to transport, delays in clinical interventions occurs, which may result in the absence of proper medical treatment, an increase in chronic illnesses and unmet healthcare needs, which accumulate and worsen the health results (Syed et al., 2013).

Harries et al. (2011) studied inequities related to accessing healthcare in South Africa and found that long distances and travel costs were among the challenges in rural areas. According to Kelly et al. (2016), many scholar have documented the distance decay association, which identifies that those people who reside closer to healthcare facilities have higher rate of usage, after adjusting for need, than those who reside further away. In the present study, almost all the participants who walked to the clinic reported that they did so as they did not have money for transport. Some stated that it is a distance to walk from their homes to the clinic, which results in them having to leave home very early to be attended to on the same day.

A study investigating the experiences and perceptions of the elderly when accessing healthcare facilities in rural Namibia showed similar results, and found that transport cost and walking long distance to the clinic were a challenge (Van Rooy et al., 2015). Some of the elderly participants chose to use traditional medication rather than having to walk long distances to the clinic. This implies that transportation was an inhibiting factor for the elderly to seek healthcare and access healthcare service. Opportunity for healthcare consumers to have transport when going to the facility is important for those in rural settings, as some have to walk long distances, the quality of the roads is often poor, and public transportation is limited (Chipp et al., 2011). The elderly lived in a semi-rural area that remains poorly developed with no healthcare facility. In the absence of a clinic in Ilfracombe, the nearest clinic is the one in Umkomaas town and one in Danganya, which are busy as they cater for the many poor people in the surrounding areas.

Another perceived challenge by the elderly was the long waiting-times at the clinic, which was also reported by Saxon et al. (2018) as being central to patient dissatisfaction. The majority of the elderly reported that they arrive early at the clinic but only receive assistance after a long period of time. This is due to lack of assistance from the nurses, many of whom are perceived as lazy because they always chatting on their cell phones, this has resulted in long queues. Most participants of the study revealed that there is shortage of healthcare workers at the clinic. This shortage is one of the causes for long waiting times at the clinic. The long waiting times at the clinic can discourage the elderly to seek healthcare and access healthcare services at the clinic.

A study conducted in Uganda that explored the challenges encountered by the elderly in healthcare facilities in both rural and urban areas revealed similar results (Annet, 2013). Insufficient or absent healthcare workers, long queues and hours of waiting at the healthcare facilities were seen as an obstacle for the elderly in accessing healthcare. In addition, some healthcare workers demanded bribes from the elderly before attending to them, this adding to their economic distress, however this was not the case for this study. These challenges have resulted in the elderly utilising herbs, visiting traditional healers, praying in churches, and visiting private health facilities and doctors (Annet, 2013).

According to Saxon et al. (2018), waiting times at the healthcare facilities for out-patients can be influenced by the demand for health services. The elderly population require healthcare service more often due to their chronic illnesses. Many elderly people at the clinic are frail, have chronic illnesses, take multiple medications and are more likely to be vulnerable to a negative result of waiting for treatment than a younger healthier persons (Saxon et al., 2018). There is a relationship between the long waiting time at the facility and poor patient satisfaction (Sastry et al., 2015).

Patient satisfaction has been investigated in healthcare research (Nadarević-Štefanec et al., 2011), and according to Jaipaul and Rosenthal (2003), it is a common measure of healthcare quality that has been associated with other outcome measures and to patient’s behavioural intentions. Patients who are satisfied with the healthcare provided are more likely to comply with their treatment and to return to providers for additional care (Jaipaul and Rosenthal, 2003). In this study, the majority of the participants indicated that they were dissatisfied with the healthcare provided to them. The strongest predictor for patients’ dissatisfaction was healthcare workers not paying attention to the patients, this gave rise to the long waiting times at the clinic. This implies that in this case the elderly had a negative attitude towards the healthcare system.

Despite all the challenges encountered by the elderly when going to the clinic and accessing healthcare services, there were enabling factors that encouraged their attendance. These factors were the positive attitude the healthcare workers had towards the elderly patients at the clinic. Furthermore, the elderly perceived the healthcare workers as being knowledgeable of what is required from them. The study found that the elderly at the clinic have a good

relationship with the healthcare workers, and corresponds with the study conducted among 300 nurses working with different healthcare services namely Imam Abdulrahman Bin Faisal University, King Fahd Hospital of University and geriatric healthcare setting. The study indicated positive attitudes among nurses towards the elderly (Huda et al., 2018). The poor attitudes of healthcare workers towards the elderly can discourage them from seeking healthcare and accessing services. There is a possibility for healthcare workers to develop an ageist attitude due to their exposure to a disproportionate percentage of ill or dependent elderly individuals (Doherty et al., 2011). In addition, some research indicates that the attitudes of healthcare workers are strongly influenced by the under-resourced care environments under which they work and this negatively influences their interactions with the elderly, however this was not the case for this study.

In contrast, other studies suggest that healthcare workers hold negative views about the elderly population, which is reflected in their attitudes towards them (Higgins et al., 2007; Deasey et al., 2014). A study conducted in Uganda indicated that healthcare workers are corruptive, with the elderly having to bribe them to receive care. With the growing elderly population, healthcare workers need to have the right attitude, and adequate knowledge and skills about geriatric care in healthcare settings. There is an urgent need to educate healthcare workers about the needs of the elderly as education plays a significant role in ensuring positive attitudes. According to Higgins et al. (2007), education programs need to address knowledge about ageing, ageism and the effect of negative thinking on the health and recovery of elderly people.

A number of studies have showed a relationship between advanced education levels for the healthcare workers and positive attitudes (Hweidi and Al-Hassan, 2005; Engström and Fagerberg, 2011; Yang et al., 2015). Furthermore, this shows that educational strategies focusing on meeting elderly’s needs are important because they encourage healthcare workers to consider working the elderly. This study also examined if the healthcare workers were knowledgeable of what was required from them and the majority of the participants indicated that indeed they were knowledgeable. The participants believed healthcare workers were knowledgeable because they were educated. For this study, most of participants indicated that the healthcare workers were knowledgeable about what was required from them and they had a positive attitude towards them. In contrast, a study conducted at multi-

purpose health service in Northern Queensland, Australia reported that nurses do not have enough knowledge about elderly care, but they had a positive attitude towards them (Mellor et al., 2007).

The theory that guided this research is the Andersen Behavioural Model of Health Service Use developed by Ronald M. Andersen, which suggests that many factors affect the utilisation of healthcare services, including predisposing, enabling and need factors. According to Glanz et al. (2008), the ABMHSU is a leading model of explaining contextual factors related to healthcare utilisation. This study focused on the predisposing and enabling factors. There were more enabling factors than predisposing factors that influenced the seeking and use of healthcare services among the elderly in Umkomaas, Ilfracombe. The predisposing factors were age and attitudes the elderly had towards healthcare services at the clinic. According to Statistics South Africa (2013), healthcare seeking behaviour differs with age and social background. Ageing is a process of growing old, and can be accompanied with chronic conditions, which results in elderly being bigger consumers of healthcare services than other age groups.

In this study, the elderly patients that were from the age of 70 and above did not complain about long waiting times at the clinic. Due to their age, they did not wait for a long time because they get attended to as they arrived at the clinic. Other participant that were below the age of 70 complained about long waiting times at the clinic. Age in this context determines who receives healthcare services first. The participants commented on satisfaction with regards to provision of healthcare services at the clinic. The majority of the participants indicated that they were not satisfied with healthcare services provided at the clinic. Dissatisfaction with the provision of healthcare services implies that the elderly holds negative attitudes towards healthcare services. Dissatisfaction of the elderly can discourage them to seek healthcare and access healthcare services at the clinic. Many studies have showed how much patients' perceptions of care and experiences of actual healthcare contribute to overall patients' satisfaction (Bleich at al., 2009; Boudreaux et al., 2000). Elderly's satisfaction reflects on their perceptions and needs towards the utilisation of healthcare services.

For this study, the enabling factors for one to continue seeking healthcare services and accessing healthcare at the clinic included transport, pension, attitudes and availability of healthcare workers and health facilities and waiting times. There are no healthcare facilities in Umkomaas, Ilfracombe. Due to this, the elderly accessed healthcare at the clinic in Umkomaas town and Danganya. The participants of the study had a challenge when accessing the clinic using taxis. There were elderly who walked to the Danganya clinic and those who used taxis. Most participants that walked to the clinic indicated that they did so because they did not have money for transportation. Walking early in the morning to the clinic is not safe for the elderly, even though most have indicated that they do not encounter any safety related challenges. These people are old and frail, walking should not be an option for them. The participants of the study indicated that pension is their main source of income and it is not enough because some support their families with this grant. The social grant pension was intended as a poverty relief program for the elderly, but has become a programme for poverty alleviation within households (Legido-Quigley, 2003), and also benefits younger generations. The ABMHSU describes income as an enabling factor, as it determines where an individual accesses healthcare services and what level of service they can afford (Andersen, 1995). The financial issues puts the lives of the elderly at risk because they have to walk long distances due to not having transport money. These issues can result in the elderly not seeking healthcare services and accessing healthcare. In addition, financial issues can prevent the elderly from accessing private healthcare because they are costly.

The majority of the participants of the study indicated that there was a shortage of healthcare workers at the clinic, which also caused long waiting times for the elderly patients. Irrespective of the shortage, the quality of social relationships with healthcare workers for this study was a positive one. This is said because the elderly perceived the healthcare workers at the clinic as being good people and respectful. In addition, the healthcare workers at the clinic were perceived to be knowledgeable of what was required from them. This means the healthcare workers were taught how to deal with the elderly and how to address their needs that is why they held a positive attitude towards the elderly patients. A good relationship between the healthcare provider and the patient plays an important role in healthcare seeking and utilisation (Mthembu, 2015). Although the elderly were not satisfied with the healthcare services provided for them, they had a good relationship with the healthcare workers at the clinic. The positive attitude of the healthcare workers towards the

elderly has an important impact on their continual use of healthcare services at the clinic. Despite the challenges the elderly encountered, they still seek healthcare and access the healthcare services at the clinic.

5.3 Recommendations

The elderly are the ones that consume a large percentage of healthcare resources and there are still major concerns remaining with regard to their healthcare. The recommendation based on the findings of the study is that more nurses need to be employed at the clinic, which would overcome the problems associated with the challenges encountered due to inadequate staff. Both the Danganya clinic and the one in Umkomaas town need to be open every day and for staff members to work in shifts. The staff trainees, such as doctors and nurses, can also assist if there are not adequate healthcare workers, which would help to reduce the long queues and long waiting times. More clinics need to be built around the area to address the issues related to the high patient numbers. Doctors need to be available in every clinic more often to see patients and provide them with the specialised care that nurses cannot provide. The nurses at the clinic should not use their cell phones during t working hours. If they have to attend to personal matters, the calls can be directed straight to the clerk. When this happens during a consultation, the nurses should inform the patient and only then they can be excused.

The municipality or councillor needs to organise transport for the elderly that can no longer walk long distances to the clinic. Programmes need to be created that will enable people to be educated about healthy living, and health promotion programmes are needed from early age in order to prevent illnesses. The Department of Health should enhance the quality of healthcare by improving the infrastructure at health facilities, and providing qualified workers and essential medicines. Innovative policies are needed that address healthcare, social protection and public services for a growing population of elderly. There must be a greater emphasis on gerontological education for healthcare professionals in order to response to the needs of the growing elderly population.

5.4 Conclusion

As the number of older people increases, providing healthcare services is important due to their growing healthcare requirements. For this study, there were enabling factors that

encouraged the elderly to continue seeking healthcare services and access healthcare and there were challenges they encountered that discouraged them to seek healthcare and access healthcare services. The challenges that were encountered for this study were distance, transport, lack of assistance from the household members when preparing to go to the clinic, availability of healthcare workers and long waiting times. Some of these challenges gave rise to dissatisfaction with regard to quality of healthcare. The enabling factors for this study were the nurse's attitudes towards the elderly patients and them being knowledgeable about what is required from them. As most of the elderly population access public healthcare facilities, they should be ageing friendly to ensure that they look forward in seeking healthcare services and accessing good quality healthcare in a timeous manner.

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Appendix A: INTERVIEW SCHEDULE

SECTION A
Demographic Profile:

- How old are you?
- What is your marital status?
- Are you still employed? If yes, please elaborate.
- Are you living alone? Who else lives with you?
- What is your main source of income? Grant? Other

SECTION B
Challenges that they face in getting healthcare services:

- What are some of the major health problems affecting the elderly in your community? What about you?
- Have you visited a health facility in the last 6 months? How often do you go?
- How long does it take you to get to the local clinic? How do you get to the local clinic? Is it easy to get to the health facility? Who assists you?
- Is there a shortage in the healthcare workforce (nurses)? How often do medical practitioners visit the local clinic?
- Are you satisfied with the healthcare services that is offered in the local clinic? Please elaborate.
- Where else have you gone to for seeking healthcare services? (other clinics, hospitals, private doctors)? Reasons for this.
- How would you describe your relationship with the healthcare practitioners?
- Please describe your experience when going to the clinic.
- Do you think the healthcare practitioners are knowledgeable about what is required from them? Explain.
- What would you recommend or suggest to reduce the challenges that one encounters in the local clinic?
- Would you like to add anything on this topic?

Appendix B: GATE KEEPER'S LETTER

GATEKEEPER'S LETTER

TITLE OF THE RESEARCH PROJECT: Provision of Health Care Services: Perspectives and Experiences of the Elderly in Umkomaas.

Researcher's detail: Sindiswa Gininda

214502759

Masters student in Population Studies.

073 4964 513

sindiswagini@gmail.com

Department name and address: School of built environment and development studies.

College of Humanities.

UKZN (Howard College).

I.....Ellia.....Buyisiwe.....Rebecca.....Gumede.....................
allow Sindiswa Menzi Zamaswazi Gininda to conduct a study on the provision of health care services by looking at the perspective and experiences of the elderly in this area of Umkomaas. You are granted permission to interview the members of the area that are relevant for your study given that the individual agrees and their information is kept confidential.

Position held.........Ward.........Counsillor.....................

Date........17-08-2018...

Signature...[redacted]...

Councillor Buyisiwe Rebecca Gumede
...d No. 99
17/08/2018
...NER OF OATHS
... MUNICIPALITY
EX OFFICIO DISTRICT OF DURBAN IN
TERMS OF SECTION 6 OF ACT 16 OF 1963
(AS AMENDED) CITY HALL SECRETARIAT
Dr Pixley Ka Seme Street, Durban, 4001

Appendix C: INFORMED CONSENT FORM (English)

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL
For research with human participants

INFORMED CONSENT RESOURCE TEMPLATE

<u>Information Sheet and Consent to Participate in Research</u>

Date:………………………………
This consent form has two parts:
Part 1: Information Sheet (to share information about the study with you).
Part 2: Consent Form (for signatures if you choose to participate).

PART 1: INFORMATION SHEET.

Title of the Research Study: *Provision of healthcare services: Perspectives and experiences of elderly in the case study of Umkomaas.*

Principal Investigator/s/ researcher: Prof Pranitha Maharaj.

Dear Sir/ Madam

Introduction.
I would like to thank you for making and dedicating your time to meet up with me. My name is Sindiswa Menzi Zamaswazi Gininda from the University of KwaZulu Natal at Howard College campus. I am from the school of Humanities under the department of Built Environment and Development Studies. My cellphone number in 073 496 4513 and my e-mail address is sindiswagini@gmail.com. The name of my supervisor is Professor Pranitha Maharaj under the School of Built Environment and Development Studies, tel no: 031 260 2243 and e-mail address: maharaj7@ukzn.ac.za.

You are kindly invited to take part in a study that involves *the perspectives and experiences of the elderly in the provision of the healthcare services in Umkomaas.* The aim and purpose of this research is to explore healthcare provision from the perspectives and experiences of

the elderly. The study is expected to interview the elderly people (from the age of 60+) within Umkomaas located within the eThekwini Municipality in the Province of KwaZulu-Natal.

Procedures.

The procedure that will be involved includes participants answering all the questions that are required about their perspective and experiences when it comes to the provision of healthcare services in Umkomaas. The duration of your participation if you choose to enroll and remain in the study is expected to be an hour or less. This will enable the participants to pull out of the interview at any time if they encounter any discomfort in answering the questions. During the conduction of interviews, I will be taking down notes, and a voice recorder will be used to capture all the information correctly. During the interview sessions, please ensure that you are vocal enough in order for all the information needed for the study to be captured.

Voluntary participation.

Participation is voluntary and you are free to withdraw from the study at any time without giving reasons, and without prejudice or any adverse consequences.

Possible Risks.

The study may involve discomfort such as when the participants are asked to explain their relationship with healthcare practitioners. The participant may get easily intimidated by this question especially if the relationship is not good. The participant may also find it difficult and uncomfortable to explain the cause of their illness. The interviews will be conducted in households of the participants, this may enable them to be more comfortable and safe.

Benefits.

Participants will not experience any costs except their time taken to participate in the study. There will be no compensation of any kind and also, there will be no payments for taking part in the study.

Confidentiality & sharing of results.

The responses of the participants will be kept confidential, only the researcher and the supervisor will have access to it for academic purposes. The people that will have access to these records will be the researcher and the academic supervisor Prof Pranitha Maharaj who is under the School of Built Environment and development studies at UKZN. The recordings and notes captured during the interview sessions, including this content form will be kept in the cabinet of the Supervisor's office for safety reasons for 5 years. After 5 years, it will then be deleted and destroyed so that no one will have access to it. I will make sure that any information that will be included in the final report will not identify you as the respondent, you will be kept anonymous. If the participants mentions their name by mistake, it will be trimmed out in the recordings. Identity protection is very crucial for this study.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number……………..).

In the event of any problems or concerns or questions you may contact the researcher via e-mail at sindiswagini@gmail.com or call: 073 496 4513, alternatively the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus
Govan Mbeki Building
PrivateBagX54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Participation in this research is voluntary, this implies that no one is forced to partake in this interview, participants are free to withdraw at any time if they encounter any discomfort. In the event of refusal or withdrawal of participation, the participants will not be punished or treated with less respect when they wish to withdraw from the interview at any time, the

decision made will be respected. In the event of refusal/withdrawal of participation the participants will not incur penalty or loss of treatment or other benefit to which they are normally entitled.

THANK YOU.

Part 2: Consent to Participate in Research.

--

CONSENT (Edit as required)

I………………………………………………………… have been informed about the study entitled *provision of healthcare services: Perspectives and experiences of the elderly in the case study of Umkomaas* by Sindiswa Menzi Zamaswazi Gininda (student no.: 214502759)

I understand the purpose and procedures of the study which involves answering questions that requires me to draw on the perspectives and experiences in accessing healthcare services.

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

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

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at (Cell: 073 496 4513 or Email: sindiswagini@gmail.com)

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

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

PrivateBagX54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Additional consent, where applicable

I hereby provide consent to audio-record my interviews.

____________________ ____________________

Signature of Participant **Date**

____________________ ____________________

Signature of Witness **Date**

(Where applicable)

____________________ ____________________

Signature of Translator **Date**

(Where applicable)

Appendix D: INFORMED CONSENT FORM (isiZulu)

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL
For research with human participants

<u>Ishidi lokwaziswa Kanye nefomu lesivumelwano.</u>

Usuku:

Lelifomu lenezingxenye ezimbili:

Ingxenye yokuqala: Ishidi lokwaziswa (ukwabelana ngolwazi mayelana nesifundo nawe)

Ingxenye yesibili: ifomu lesivumelwano (okokusayina uma ukhetha ukubamba iqhaza)

Ingxenye yokuqala: Ishidi lokwaziswa

Isihloko: Provision of healthcare services: Perspective and experiences of the elderly in the case study of Umkomaas.

Umphathi: Prof Pranitha Maharaj

Mnumzane/Nkosazane

Isibingelelo.

Mhlanganyeli othandekayo. I gama lami nginguSindiswa Menzi Zamaswazi Gininda. Ngimfundi waseNyuvesi yakwaZulu-Natal (ekolishi yaseHoward). Ngiqhamuka ngaphansi kwesikole sakwaHumanities kanye nomnyango wakwa Built Environment and Development Studies. Inombolo yami yocingo ithi 073 496 4513 kanti ikheli le-imeyili yona ithi sindiswagini@gmail.com. Igama lomphathi wami uProffesor Pranitha Maharaj naye ongaphansi komnyango weBuilt Environment and Developmental Studies, inombolo yocingo: 031 260 2243 kanye nekheli le-imeyili: maharaj7@ukzn.ac.za.

Uyamenywa ukuba ube ingxenye yocwaningo olumayelana ne Perspective and experiences of the elderly in the provision of the healthcare services in Umkomaas. Inhloso kanye

nenjongo yalolucwaningo ukuhlola Ihealthcare provision from the perspective and experiences of the elderly. Lolucwaningo luzobandakanya abantu abadala abaqala kwiminyaka engu60 kuyaphezulu, eMkhomaas ngaphansi kwaMasipala weTheku, esifundazweni sakwaKwaZulu-Natal.

Izinqubo.

Inqubo ezolandelwa ibandakanya abahlanganyeli ukuba baphendule yonke imibuzo edingekayo mayelana nokuhlinzeka kwezinsizakalo zezempilo eMkomaas. Ubude bokubamba iqhaza kwakho uma ukhetha ukubhalisa nokuhlala ocwaningweni kulindeleke ukuthi kube ihora noma ngaphansi. Lokhu kuzokwenza abathintekayo bakwazi ukukhipha uphenyo nganoma yisiphi isikhathi uma behlangabezana nanoma yikuphi ukungathandeki ekuphenduleni le mibuzo. Ngesikhathi sokuqhutshwa kwengxoxo, ngizobe ngithatha amanothi, futhi i-recorder yezwi izosetshenziselwa ukuthatha lonke ulwazi ngendlela efanele. Phakathi nesikhathi sokuxoxisana, sicela uqinisekise ukuthi ukhulume ngokwanele ukuze yonke imininingwane edingekayo ibambeke kahle. Uma abahlanganyeli bekhuluma ngegama labo ngephutha, kuzokwenziwa ukuba likhishwe kumarekhodi.

Ukuzibandakanya ngokuzithandela.

Ukubamba iqhaza kungokuzithandela futhi ukhululekile ukuhoxisa esifundweni nganoma yisiphi isikhathi ngaphandle kokunikeza izizathu, futhi ngaphandle kokubandlululwa noma ngaphandle kwemiphumela emibi.

Izingozi ezingenzeka.

Lolucwaningo lungase luhlanganise ukungathandeki njengokuthi abahlanganyeli bebuzwa ngobuhlobo babo nabasebenzi bezempilo. Umhlanganyeli angasatshiswa kalula ngalo mbuzo ikakhulukazi uma ubuhlobo bungalungile. Umhlanganyeli angathola futhi kunzima futhi engakhululekile ukuchaza imbangela yokugula kwakhe. Izingxoxo zizoqhutshwa emakhaya abahlanganyeli, lokhu kungabenza bakwazi ukukhululeka nokuphepha.

Izinzuzo.

Abahlanganyeli ngeke bahlangabezane nezindleko ngaphandle kwesikhathi sabo esithathwe ukuze bahlanganyele esifundweni. Ngeke kube khona isinxephezelo kwanoma yiluphi uhlobo futhi, ngeke kube khona izinkokhelo zokuthatha ingxenye kulolu cwaningo.

Okiyimfihlo kanye nokwabelana kweniphumelo.

Izimpendulo zabahlanganyeli zizogcinwa ziyimfihlo, kuphela umcwaningi nomqondisi bazokwazi ukufinyelela kuwo ngezinhloso zemfundo. Abantu abazokwazi ukuthola la marekhodi kuzoba umcwaningi nomphathi wezemfundo uProf Pranitha Maharaj ongaphansi kwesifundo se-School of Building and Environmental Development e-UKZN. Ukurekhoda kanye namanothi athunyelwe ngesikhathi sokuxoxisana, kufaka phakathi leli fomu lokuqukethwe lizogcinwa kwiKhabhinethi yehhovisi likaMqondisi ngezizathu zokuphepha iminyaka emihlanu. Ngemuva kweminyaka engu-5, iyosuswa bese ibhujiswa ukuze kungabikho muntu oyokwazi ukufinyelela kuyo.

Ngizoqinisekisa ukuthi noma yiluphi ulwazi oluzofakwa embikweni wokugcina ngeke lukwazi ukutshengisa ukuthi ubani umhlanganyeli, uzogcinwa engaziwa. Ukuvikelwa kobunikazi kubaluleke kakhulu kulolu cwaningo.

Lolucwaningo luye lwabuyekezwa ngokomthetho futhi luvunyiwe i-UKZN Humanities and Social Sciences Research Ethics Committee (inombolo yokugunyazwa_____).

Uma kwenzeka kunoma yiziphi izinkinga noma ukukhathazeka / imibuzo ungaxhumana nomcwaningi ku (iseli: 073 496 4513 noma i-imeyili: sindiswagini@gmail.com) noma UKZN Humanities & Social Sciences Research Ethics Committee, imininingwane yokuxhumana kanje:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
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Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Ukubamba iqhaza kulolu cwaningo kungukuzithandela, lokhu kusho ukuthi akekho ophoqeleka ukuba ahlanganyele kule ngxoxo, abahlanganyeli banenkululeko yokuzihoxisa nganoma isiphi isikhathi uma behlangabezana nanoma yikuphi ukuhlukumezeka. Uma kwenzeka ukwenqatshwa noma ukuhoxiswa kokubamba iqhaza, abahlanganyeli ngeke bajeziswe noma baphathwe ngenhlonipho encane uma befisa ukuhoxisa ekuxoxweni nganoma yisiphi isikhathi, isinqumo esenziwe sizohlonishwa. Uma kwenzeka ukwenqatshwa / ukuhoxiswa kokubamba iqhaza abahlanganyeli ngeke bathole isigwebo noma ukulahlekelwa ukwelashwa noma enye inzuzo abajwayele ukuba nayo.

SIYABONGA.

Ingxenye yesibili: ifomu lesivumelwano.

CONSENT (Hlela njengoba kudingeka)

Mina .... ngiye ngaziswa mayelana nesifundo esinesihloko esithi: The provision of healthcare services: Perspectives and experiences of the elderly in the case study of Umkhomaas, lolucwaningo lwenziwa u-Sindiswa Menzi Zamaswazi Gininda (Student number.: 214502759).

Ngiyaqonda injongo nenqubo yocwaningo olubandakanya ukuphendula imibuzo edingayo ukuba ngidonsele emibono kanye nokuhlangenwe nakho ekufinyeleleni ezinsizakalweni zokunakekelwa kwezempilo.

Nginikezwe ithuba lokuphendula imibuzo mayelana nalolucwaningo futhi ngibe nezimpendulo kokwaneliseka kwami.

Ngimemezela ukuthi ukubamba iqhaza kwami kulolu cwaningo kuphelele ngokuzithandela futhi ngingahoxisa nganoma yisiphi isikhathi ngaphandle kokuthinta noma yiziphi izinzuzo engivame ukuzenza.

Ngiyazi ukuthi ukubamba iqhaza kwami kulolucwaningo kungokuzithandela futhi ngingahoxisa nganoma yisiphi isikhathi ngaphandle kokuthinta noma yiziphi izinzuzo engivame ukuzenza.

Uma ngineminye imibuzo / ukukhathazeka noma imibuzo ephathelene nokucwaninga ngiyaqonda ukuthi ngingathintana nomcwaningi ku- (Cell: 073 496 4513 noma I-imeyili: sindiswagini@gmail.com).

Uma nginemibuzo noma ukukhathazeka ngamalungelo ami njengomhlanganyeli walolucwaningo, noma uma ngikhathazekile ngesici sesifundo noma abacwaningi ngingaxhumana no:

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

Okwengeziwe ngemvumo okudingekayo
Ngiyanikela ngemvumo ukuthi kusetshenziswe isiqophamazwa.

______________________ ______________________

Signature of Participant **Date**

______________________ ______________________

Signature of Witness **Date**

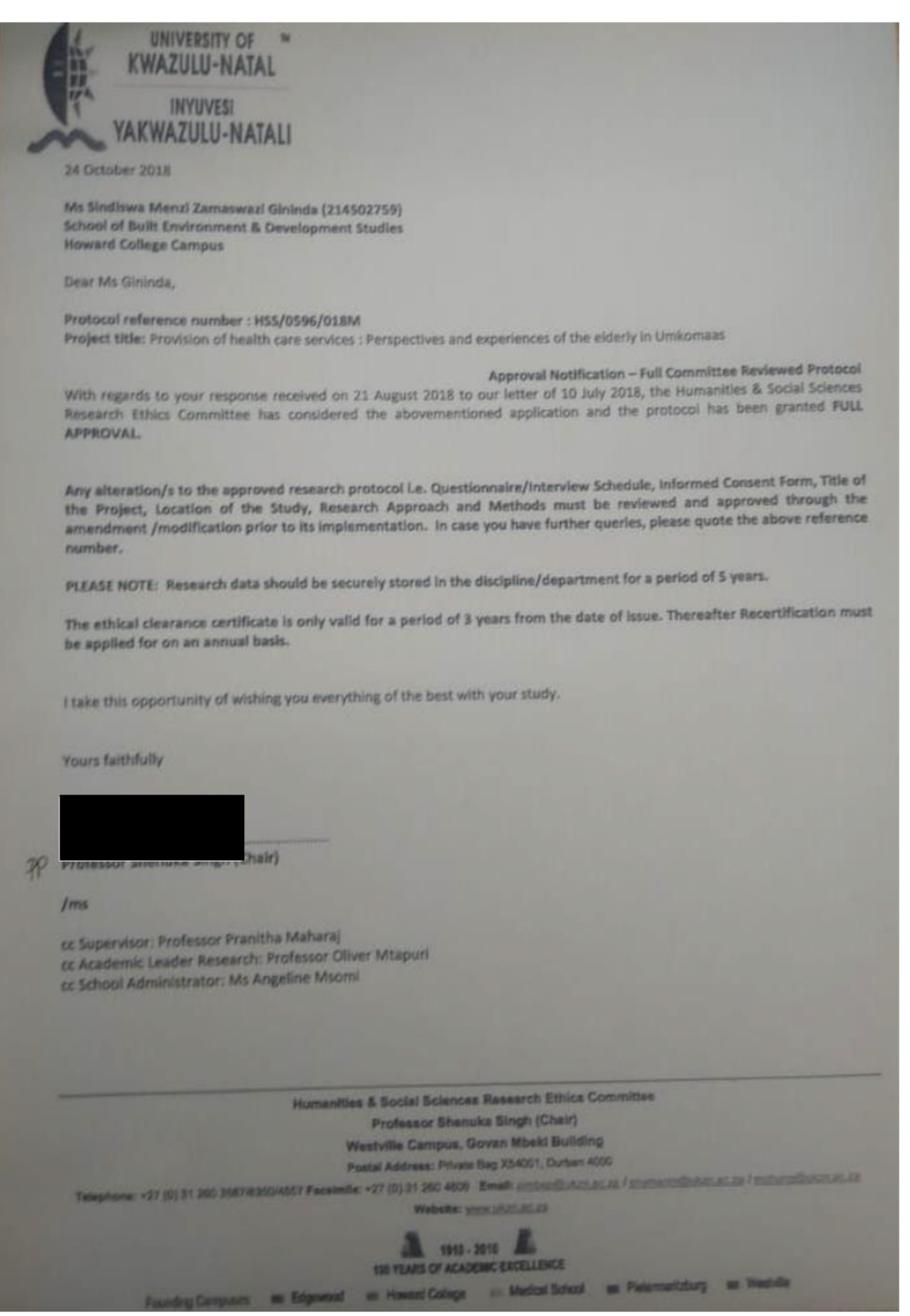
(Where applicable)

______________________ ______________________

Signature of Translator **Date**

(Where applicable)

Appendix E: ETHICAL CLEARANCE LETTER



UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

24 October 2018

Ms Sindiswa Menzi Zamaswazi Gininda (214502759)
School of Built Environment & Development Studies
Howard College Campus

Dear Ms Gininda,

Protocol reference number : HSS/0596/018M
Project title: Provision of health care services : Perspectives and experiences of the elderly in Umkomaas

Approval Notification – Full Committee Reviewed Protocol

With regards to your response received on 21 August 2018 to our letter of 10 July 2018, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application 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.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

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

Yours faithfully

Professor … (Chair)

/ms

cc Supervisor: Professor Pranitha Maharaj
cc Academic Leader Research: Professor Oliver Mtapuri
cc School Administrator: Ms Angeline Msomi

Humanities & Social Sciences Research Ethics Committee
Professor Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
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