

**DESCRIPTION OF HEALTH SEEKING BEHAVIOURS AND EXPERIENCES
OF HOMELESS PEOPLE IN SOUTH CENTRAL DURBAN,
SOUTH AFRICA**

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BY

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DECLARATION

This is to certify that Mrs Dorien Wentzel has prepared this dissertation report entitled "Description of experiences relating to health seeking behaviours of homeless people in South Central, Durban, South Africa". This dissertation is my own work and all primary and secondary sources have been acknowledged. This dissertation has not been submitted to any other institution as part of an academic qualification.

This Dissertation is prepared in partial fulfilment of the requirement of the Master of Public Health degree at the School of Family and Public Health Medicine, Nelson R Mandela School of Medicine, University of KwaZulu-Natal, Durban South Africa.

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“For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came and visited me.”

Matthew 25 vs. 35-36, NIV Bible

This dissertation would not have been completed without the help of my family, friends, colleagues and members of my church. To my family, thank you for putting up with take away dinners and for waiting patiently to be picked up late from school. To my colleagues, friends and members of my church, thank you for all the support in many forms, that you have given me e.g. emotional, translating, photocopying, critiquing, advice and prayers.

Thank you, to all those who gave me permission to do the research, e.g. Dalton Hostel, eThekweni Health, healthcare workers and KVC Primary Health Clinic. Thank you to all the healthcare workers that were interviewed, for giving up your valuable time and suggesting relevant practical recommendations. To all healthcare workers who assist homeless people, thank you for time and skills in administering healthcare.

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Last but certainly not least, Mum, thank you for believing in me and encouraging me to do the best I can do. The research is finally over...you can now rest in peace.

ABSTRACT

The study aimed to describe the health seeking behaviours and experiences of homeless people in South Central Durban.

Homelessness is a broad and complex term that affects many people in South Africa. Homelessness inevitably causes serious health problems, conditions that are closely associated with poverty. Health problems experienced by homeless people are numerous and multifaceted. Homelessness is a complex issue that not only damages both physical and mental health, but also contributes to the spread of disease to the non-homeless (National Health Care for the Homeless Council, 2008:1).

Drawing on interviews with homeless participants and healthcare workers, this study depicted the experiences, and the observed, felt and perceived needs of homeless people in accessing healthcare. The study reveals why, when and where homeless people access healthcare and the factors facilitating and hindering their access to healthcare. The researcher primarily used a qualitative methodology with a small quantitative component. The qualitative component comprised one on one in-depth interview. The quantitative component comprised a record review showing frequency distribution of health problems experienced by homeless people presenting at the Kathleen Voysey clinic.

The findings highlight the unique lived experiences which include health problems, basic needs, accommodation, safety and security, community networks, access to pensions and grants. Findings show that homeless people are accessing healthcare facilities however there are mixed responses as to the service that they have received. A number of recommendations were suggested by both homeless participants and healthcare workers for policy makers, healthcare services, and homeless people and for future research regarding the care of homeless people.

Keywords: Homelessness, Faith-based organisation, needs, healthcare facilities, healthcare worker, experiences, access to health

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LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
ARV	Anti retroviral drugs
DPMM	Department of Preventative Medicine for Migration, Tourism and Tropical Dermatology
FBO	Faith based organisation
HIV	Human immunodeficiency virus
ID	Identification document
KVC	Kathleen Voysey Primary Health Clinic
MPH	Master of Public Health
NGO	Non governmental organisation
STI	Sexually transmitted infection
TB	Tuberculosis
VCT	Voluntary counselling and testing
WHO	World Health Organisation

CHAPTER ONE: INTRODUCTION

1.1 Background to the problem

Homelessness is a multifaceted and complex problem that has profound socio-economic and socio-political consequences for society. Homeless people frequently delay seeking healthcare as they are primarily concerned with meeting their own needs for shelter, food, clothing and safety.

The state of homelessness has a significant influence on the health of homeless people. Due to circumstances of inadequate shelter, poor access to food, susceptibility to communicable diseases, vulnerability to violence and injuries, homeless people suffer from a higher rate of serious morbidity and premature mortality (Wright & Tompkins, 2006:287, Olufemi, 1999:483).

Homelessness is a dual-edged sword as health problems may contribute to homelessness, whilst at the same time, the condition of homelessness may cause and exacerbate health problems (McMurray-Avila, 2001:11).

Furthermore homelessness presents serious challenges to healthcare providers.

One important need of homeless people is access to healthcare. A controversial issue is whose responsibility is it to provide healthcare to homeless people? In the United States of America and the United Kingdom this responsibility is partnered between central and local governments and non-governmental organisations. In providing healthcare for homeless people, numerous targeted programmes have been implemented (Wright & Tompkins, 2005:6, Shiner, 1995:527, Hwang, Tolomiczenko and Kouyoumdjian, 2005:321, National Health Care for the Homeless Council, 2008:3, Manfellotto, 2002:73). Whilst these crucial programmes do provide some relief to homeless peoples' needs, these programmes do not prevent homelessness

nor provide solutions to end homelessness (National Health Care for the Homeless Council, 2008:1).

Despite substantial international evidence which documents multiple morbidity and mortality, homeless people do have problems in obtaining adequate healthcare (Wright & Tompkins, 2006:286, Manfellotto, 2002:76, National Health Care for the Homeless Council, 2008:3, Riley, Harding, Underwood & Carter, 2003:474, Hwang et al, 2005:314, Van der Heyden et al, 2003:155, Wiecha, Dwyer & Dunn-Strohecker, 1991:368). Are the healthcare services provided adequate for homeless people? The inverse care law proposed by Tudor Hart (1965), cited in Riley et al (2003:473) refers to the least health utilisation by people with the greatest need. What factors hamper homeless people in accessing healthcare?

Homelessness is a broad and complex term that affects many people in South Africa. Homelessness inevitably causes serious health problems, leading to conditions that are closely associated with poverty. Homeless people have a higher morbidity rate, mortality rate and a lower life expectancy (Hwang et al, 2005:311). As a result of their complex health issues and lack of stable housing, homeless people present with serious challenges for healthcare providers (Hwang et al, 2005:313, Van der Heyden et al, 2003:154). Thus homeless people are in desperate need for basic needs and healthcare services. Provision for these needs is promulgated in the declaration of human rights (Article 25 UN Declaration of Human Rights, 1994:4), “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family”.

There are different models of healthcare provision for homeless people. Not all public health services can meet the challenges of providing healthcare for homeless people. South Africa is one such an example. Non- profit organisations and faith based organisations play a partnering role in providing these services (Sasix, 2007:1).

The care of homeless peoples' health is of utmost importance especially to preserving health of all citizens, for example limiting the spread of communicable diseases (Manfellotto, 2002:78, Martins, 2008:421). Communicable diseases can quickly spread to become deadly public health emergencies (National Health Care for the Homeless Council, 2008:1). Besides the costs incurred for the provision of health and the provision of basic needs, the greatest costs are "the moral and social results of the needs" of the most vulnerable people –the homeless (National Health Care for the Homeless Council, 2008:1).

As homelessness is a very broad and complex topic the researcher has narrowed the focus for the aim of the study. In the international literature it is shown that homeless people have a high incidence of drug and alcohol abuse and mental illness and that homelessness then results from serious addiction to substances and from untreated mental illness. In the South African context, homelessness results from severe socio-economic conditions, including general poverty, rural to urban migration and inadequate provision of housing. It is in this context that homeless people seek access to healthcare.

1.2 Problem statement

Homeless people encounter barriers in accessing healthcare which can impact in a delay in receiving healthcare. These multiple barriers include lack of finances, cultural barriers due to marginalisation and barriers due to a lack of comprehensive healthcare provision (Wright & Tompkins, 2005:4). These barriers could result in a delay in deciding to seek healthcare, a delay in reaching a healthcare facility or a delay in receiving adequate healthcare (Thaddeaus & Maine, 1994:1092).

In South Africa, healthcare for homeless people is provided by governmental health services and non-governmental organisations (Seager & Tamasane 2008: 24, Olufemi, 1999:488). However homeless people are just part of the

general clinic population and if there are special needs related to being homeless these are not necessarily catered for. Due to a number of homeless people seen in the Berea/ Musgrave suburbs in Durban, a soup kitchen was formed at the Berea Presbyterian Church, a central accessible venue, to provide a morning meal. Currently between one hundred to one hundred and fifty homeless people are given soup on a daily basis. At observing the health needs of homeless people who came to the soup kitchen, the ministers of the churches involved in the feeding scheme suggested a free primary health clinic should be established. The Kathleen Voysey Primary Health Care clinic (KVC) was started in 1997 as an outreach programme of the Musgrave Methodist Church, Durban. The clinic is open one morning a week and comprises doctors and nurses. The medical team provides promotive and curative primary healthcare. It was envisaged by the ministers of the participating churches that the time span of the clinic would not last long, as public health services were offering health services for the homeless for free. Over the ten years that the clinic has been operational, the number of attendees (the majority homeless people) has been increasing from fifteen clients per morning to seventy clients per morning (Kathleen Voysey primary health care clinic brochure, 2007: ii).

The researcher queried as to why the increased need for the services as provided by the KVC? It is for this reason that the researcher decided to explore the health seeking behaviours and experiences of homeless people.

1.3 Purpose of the study

This study aims to describe the experiences relating to the healthcare seeking behaviours of homeless people in South Central Durban. The researcher aims to increase awareness about the health, and access to healthcare, of homeless people.

1.4 Specific objectives of the research

- 1) To describe the health care needs of homeless people in South Central Durban.
- 2) To describe the experiences relating to the health seeking behaviours of homeless people in South Central Durban.
- 3) To describe factors facilitating access to health care by homeless people in South Central Durban.
- 4) To describe factors influencing access to health care by homeless people in South Central Durban.
- 5) To make recommendations to the Kathleen Voysey Primary Health Clinic and other health services regarding health care services for the homeless in South Central Durban.

Based on the above research objectives, the following questions formed the basis of this study:

1.5 Research Questions

What are the healthcare needs of homeless people?

- 1) What are the perceived health care needs of homeless people?
- 2) What are the felt needs of homeless people?
- 3) What are the observed needs of homeless people?

What are the health seeking behaviours of homeless people?

- 4) What influences the decision by homeless people to seek health care? i.e. Why do they seek care?
- 5) What influences the decision by homeless people of when to seek health care?
- 6) What influences the decision by homeless people of where to seek health care?

What are the factors influencing access by homeless people?

- 7) What are the factors that facilitate the seeking of health care by homeless people?
- 8) What are the factors that hinder the seeking of health care by homeless people?

1.6 The significance of the study

For this research the researcher primarily used a qualitative methodology with a small quantitative component. The qualitative component comprised one on one in-depth interviews. The quantitative component comprised a record review showing frequency distribution of health problems experienced by homeless people presenting at the Kathleen Voysey clinic.

One of the main reasons that the researcher chose this area to research is that she could not obtain information on the provision of healthcare for the homeless in South Africa, particularly Durban. The researcher was of the considered opinion that the research produced will be of benefit, not only by highlighting the plight of the homeless, but also by providing information and statistics for the eThekweni Health Department for the provision of healthcare to this hitherto neglected segment of the population.

The research will identify areas of further investigation and will propose different models and policy changes required to improve healthcare provision for homeless people.

1.7 Operational concepts / Definition of terms

These definitions have been included so as to define some of the core concepts under investigation in this study.

Homeless

A complex concept embracing states of rooflessness, houselessness, living in insecure accommodation, or living in inadequate accommodation (Wright & Tompkins, 2006:5).

Need

A condition or situation in which something is required or wanted by someone (www.ask.com).

Felt Need

These conditions/ needs are experienced and verbalised by homeless participants.

Observed Need

These conditions/ needs are seen/ witnessed by healthcare workers

Perceived Need

These conditions/ needs are assumptions made by healthcare workers after observing needs of homeless people. The perceived needs by healthcare workers may or may not be felt by homeless people.

Experience

An event or series of events that one has lived through or participated.

Faith Based Organisation

A voluntary group sponsored by a church/ religious organisation which provides free charity work. These organisations are also non-profit organisations.

Health

Health as defined by WHO “ a state of complete mental, physical and social well being and not merely the absence of disease or infirmity” (Green, 1997:44).

Healthcare worker

A professional person either a doctor or a registered nurse working in a primary healthcare setting.

Health seeking behaviour

This is the behaviour that a person displays in the conscious effort to promotes one's optimum wellness, medical treatment for an ailment / illness and rehabilitation (www.ask.com –medical dictionary).

Access to health

This is when a person actively seeks for a healthcare service.

South Central Durban

This area is south of central Durban and includes the suburbs Congella (Berea South), Berea, Mayville (Bellair) and Cato Manor (Bellair).

1.8 Overview of how research report is structured

Chapter one introduces the background to the problem; this is then followed by the problem statement, purpose of the study, objectives and research questions and significance of the study. The operational concepts describe the terms used in this study. In chapter two, literature concerning the definition and causes of homelessness is discussed. The needs of homeless people together with health problems that homeless people encounter are highlighted. The provision and utilisation of healthcare services is then described together with the conceptual framework underpinning the research. Chapter three describes the methodology used in the research process. Chapter four presents the findings of the study. Chapter five presents a discussion of the results. Chapter six offers recommendations that have arisen from the study.

CHAPTER TWO: LITERATURE REVIEW

2.1 Purpose of the literature review

This chapter explores issues around the needs of homeless people, with special reference to their health needs. This chapter also looks at poverty, the triple burden of disease that homeless people suffer as well as the provision of health care for homeless people.

2.2 Scope of literature review

Five sources were used in the literature search. These were:

- 1) Printed materials such as journals and books. This entailed a hand search of the Lancet, World Health Forum and Health Policy journals at the Medical School and the Howard College libraries at the University of KwaZulu-Natal.
 - 2) References obtained from the reference list at the end of journal articles.
 - 3) Electronic databases: Pub Med, Google-scholar, CINAHL.
 - 4) International health related websites such as that of the World Health Organisation.
 - 5) Policy document: Department of Health 'The white paper for the transformation of the health system in South Africa' (1997)
- The search words used in retrieving relevant material include: homeless, healthcare for homeless, health services for homeless.

The Harvard referencing system has been used throughout this document.

2.2.1 Definition of Homelessness

The World Health Organisation (2005) defines homelessness as "a complex concept embracing states of rooflessness, houselessness, living in insecure accommodation, or living in inadequate accommodation" (Wright & Tompkins, 2005:5). Seager & Tamasane (2008:4) define people who sleep in the open,

one or more nights per week as absolute homelessness. Shiner (1995:526) further describes different living conditions as constituting homelessness; some homeless people live on the road and are known as “rough sleepers”, other homeless people live in shelters which provide short term accommodation. At these shelters the facilities provided are minimal.

Homelessness is not confined to a total lack of shelter. For many children and young people it signifies a state of detachment from the family and results in vulnerability to potential dangers, including exploitation and abuse, from which the family normally insulates the child (Smith, 2008:756).

2.2.2 Factors contributing to Homelessness

There is no single cause of homelessness. Wright & Tompkins (2006:286-293) have identified risk factors which may lead to one becoming homeless. These factors include: breakdown of relationships, physical or sexual abuse, lack of qualifications, unemployment, alcohol and /or drug misuse, mental health problems, contact with the criminal justice system, debt, lack of a social support network, institutionalisation as children and death of a parent during childhood. For many of these, it is difficult to identify the cause versus the consequence of homelessness. For example, Biswas-Diener & Diener (2006:186) question whether depression and alcohol abuse are causes or effects of homelessness. Laurenson & Collins (2007:654) suggest that deinstitutionalisation of mentally ill people in the United Kingdom and the United States of America has also contributed to homelessness. Wiecha, et al (1991:365) also state this as a cause and suggest that homelessness is exacerbated by not providing those deinstitutionalised with adequate community-based care. Homelessness would also exacerbate mental illness.

Additional causes of homelessness include an inadequate supply of affordable housing, lack of social support systems and job losses to disabilities (Wiecha et al 1991:365; Wright 2000:29; Olufemi 1999:484). Olufemi (1999: 485) further elaborates that the 1997 study on the health of

homeless women in South Africa, indicated that poverty and unemployment constitute the major causes of homelessness.

Tabibzadeh & Liisberg (1997:298) and eThekweni Municipality (2009) discuss urbanisation as a factor contributing to homelessness. Tabibzadeh & Liisberg (1997:298) describe the push and pull dynamics which lead to urban migration. Once rural migrants and illegal immigrants have arrived in the “asphalt jungle” they find that the prevailing conditions are far from favourable. “Poor, unemployed, illiterate and malnourished”, the migrants of necessity are forced to squat in makeshift shacks built on “land unsuitable for human settlements” which lack any access to essential services. These unfavourable conditions lead to disease and hopelessness (Tabibzadeh & Liisberg, 1997:267). This is evidenced in Italy and Poland as Manfellotto (2002:70) and Turner (2001:96) describe, with illegal immigrants to Italy and Poland using both countries as stepping-stones into Europe.

2.2.3 Needs of Homeless People

What specific needs do homeless people have? Potter & Perry (2005:50-51) define the very basic needs of all people as food, shelter and clothing and water. Maslow (1943) in Potter & Perry (2005) further divided these and other needs into five levels. The lowest level, physiological needs consist of eating, drinking, sleeping shelter and warmth. The next level, safety needs, comprise of a certain acceptable level of personal security from crime, health and well being. The third level, love/belonging/social needs, embraces such personal aspects as friendship and having a supportive and communicative family. The fourth level comprises of esteem needs and possessing self esteem, self respect and respect for others. The fifth level, self actualisation refers to the state where humans are able to make the “most of their abilities and strive to be the best that they can be” (Potter & Perry, 2005:66). Maslow (1943) proposed that once the more basic needs are met, the individual can progress to higher levels.

How do homeless people fit into Maslow's (1943) theory of needs? In the first level, the majority of homeless people do not have their physiological needs met. Wright (2007:28) states that one of the main causes of homelessness is the lack of accommodation. Seager & Tamasane (2008: 3) state that of the homeless people that participated in the study 56.4% mentioned that they slept on the streets (Sager & Tamasane, 2008:4). A number of studies have attributed lack of shelter and warmth to the increase and/ or the exacerbation of illnesses amongst homeless people (Shiner, 1997:526). Do homeless people source enough food? Wiecha et al (1991:365) state that homeless people do not have enough income to source food. Food is sourced either from soup kitchens or rummaging in rubbish. The result is that homeless people "sometimes or often consume inadequate amounts of food" (Wiecha et al, 1991:367).

For homeless people, safety is threatened. Hwang, Orav, O'Connell, Lebow & Brennan (1997:625) state that homicide was the leading cause of death amongst homeless people aged 25 to 44 years of age. Wright & Tompkins (2006:287) state that homeless men have high rates of committing offences and imprisonment as well as being victims of crime. Due to social and economic differences homeless women are more vulnerable to domestic violence, rape and muggings, which sometimes results in loss of life (Olufemi, 1999: 482).

Wright (2000:27) reinforces that homeless people do not have an adequate income or employment. Biswas-Diener & Diener (2006:186) refer to a larger body of literature that suggests that higher income is directly related to increased longevity, better health and greater life satisfaction. Stein, Andersen & Gelsberg (2007:792) reiterate that homeless people severely lack the "financial and non-financial resources" needed to meet their personal and healthcare needs. Wright (2000:30) emphatically states that there is a lack of proper health and social services which can "provide the solution to homelessness".

Loss of the family support structure hinders homeless people from achieving the third level of needs (Wright 2000:30). Wright (2000:30) refers to homeless people being hindered by “personal limitations”. These limitations include mental illness, substance abuse along with the inability to sustain relationships, which affects homeless peoples’ self esteem. This is further compounded by the negative social perceptions of homeless people as they often are referred as “hobos, tramps or bums” (Wright, 2000:30). Biswas-Diener & Diener (2006:202) reinforce the ability to form good social relationships. These relationships are essential for well-being and may forestall “the psychological costs of material deprivation”.

Wright (2000:27) emphatically states that the increase in homelessness “reflects the deep neglect of basic human needs”.

2.2.4 Health problems related to being Homeless

The World Health Organization (WHO) European Health Report (WHO, 2002:50) identifies the following as the consequences of poverty: material deprivation, low educational achievement, poor health, vulnerability and exposure to environmental and occupational risks, along with both powerlessness and voicelessness. The report further explains that poverty deprives individuals of the freedom to satisfy hunger, to achieve sufficient nutrition, to obtain remedies for treatable illnesses or to enjoy clean water or sanitary facilities.

In her definition of homelessness, McMurray-Avila (2001:11) describes the relationship between socioeconomic factors and health. On one level, health problems very uncommonly lead to homelessness. However, the condition of homelessness can both cause and exacerbate health problems. Stein et al (2007:792) elaborate that homeless people are “severely lacking in financial and non-financial resources” that are essential in order to meet their daily personal and health needs.

The homeless consume such sustenance as whatever is obtainable, resulting in a poor diet which easily leads to nutritional deficiencies, thereby lowering the immune system, and increasing the risk of morbidity. In its conclusion the WHO reiterates the vicious circle prevailing as regards poverty i.e. ill health and unemployment (WHO, 2002:49).

The condition of homelessness and the concomitant poverty lie at the root of many of the health problems experienced by homeless people. Such health problems that have been documented include tuberculosis, HIV/AIDS, malnutrition, severe dental disease, alcoholism, mental illnesses, diabetes mellitus and hypertension. This reflects only partially the dimensions thereof. People without shelter are also prone to parasitic infestation, frostbite, infections and violence (National Health Care for the Homeless Council, 2008:1).

Homelessness also severely complicates delivery of health services. Shiner (1995:526) and Riley et al (2003:473) describe the inverse care law as proposed by Tudor Hart (1971), which states that “the availability of good medical care tends to vary inversely with the need for it in the population served”. Due to lack of access to healthcare, both acute and chronic health problems may go undetected and untreated. This may lead to severe medical complications (McMurray-Avila, 2001:1).

Homeless people are confronted with the reality of poverty; one of the consequences of poverty is poor nutrition. Homeless people lack the financial means to purchase nutritious food, a safe storage place for foodstuffs, along with inadequate facilities for preparing meals (Wiecha et al, 1991:365). The aforementioned factors together further compound health related problems relating to nutritional deficiencies experienced by homeless people. One of the main modalities in the management of chronic diseases is the control of the diet consumed; due to poor nutrition, homeless people are not able to access the necessary diet in order to control the chronic disease (Wiecha et al, 1991:365, Martins, 2008:426). Health problems commonly prevailing

amongst homeless people possessing a nutritional component either in the etiology or management of the health problem include the following; alcoholism, anaemia, dental problems, gastric ulcers, cardiovascular disease, hypertension, tuberculosis, acute and chronic infections, malnutrition and acquired immunodeficiency syndrome (Wiecha et al, 1991:368).

Tabibzadeh and Liisberg (1997:287) describe the “triple burden of disease” that homeless clients suffer from. The first burden of disease relates to poverty, lack of water and sanitation, sub standard housing, overcrowding and the resulting increase in communicable diseases. This is affirmed in the European Health Report 2002 (WHO, 2002:33) which states that the biggest factor associated with communicable diseases remains poverty. The report advocates for the reduction of poverty by European countries as a public health priority. The second burden includes ill health due to changes in living conditions. Examples hereof include diseases due to air pollution, smoking, mental and psychosomatic disorders related to stress. The third burden looks at social instability and cultural and social alienation. These factors can lead to a sense of helplessness developing, which in turn may result in crime, violence, drug abuse, sexual promiscuity and prostitution. This triple burden of disease, together with scarcity of means to promote health and prevent illness, amounts to the “drama which is known as the urban health crisis” (Tabibzadeh & Liisberg, 1997:269).

Wright & Tompkins (2006:291) state that multiple morbidity and premature mortality are more prevalent amongst homeless populations. Research conducted on autopsy and post mortem findings, performed on homeless people in Germany, indicate that the average age of death was 45 years. The major causes of death were unnatural, due to factors including intoxications. Van der Heyden et al (2002:2) reiterate that with decreasing socioeconomic levels, health expectancy also reveals a decline.

In their discussion, of a study conducted on the causes of death in homeless adults, Hwang et al (1997:3) emphasised that the research depicted the “enormous effect” of the AIDS epidemic on the homeless population.

Due to inability to source adequate nutrition, exposure to various environmental factors, unsafe sanitary practices, social problems together with sporadic contact with providers of food, shelter or healthcare, “homelessness may cause or exacerbate health problems” (Wiecha et al, 1991:372).

2.2.5 Health seeking behaviours of, healthcare provision to and healthcare utilisation by homeless people.

2.2.5.1 Health seeking behaviours

Health as defined by WHO “is a state of complete mental, physical and social well being and not merely the absence of disease or infirmity” (Green, 1997:44).

McMurray-Avila (2002:12) extends this definition further: “health is one of the fundamental rights of every human being and is dependent upon the fullest cooperation of individuals and states”.

Health seeking behaviours are dependant on how people perceive their own state of health. The questions arise: “How do homeless people perceive their own health? When do homeless people access healthcare services?” Shiner (1995:529), Olumfemi (1999: 488), and Martins (2008:426) address these issues and argue that homeless people do not consider health matters to be a priority, thus allocating a low expectation to their health requirements. Many homeless people are more concerned with meeting their basic needs for food, shelter, clothing and safety, than seeking healthcare (National Health Care for the Homeless Council, 2008).

2.2.5.2 Healthcare provision

Healthcare provision is a fundamental right as in the United Nations Universal Declaration of Human Rights (Universal Declaration of Human Rights, 1994:4). Governments possess an inherent responsibility for the health of their population, which can be fulfilled only by the provision of adequate health and social measures (McMurray-Avila, 2001:11). It was this premise that spurred the development of Primary Health Care at the International Conference held in Alma Ata in 1978, where accountability for health was further extended to social and economic sectors in “addition to the health sector” (Mc Murray-Avila, 2001:12).

Seager & Tamasane (2008:24) emphasise that a homeless lifestyle exposes one to numerous health risks, risks which are preventable with basic public interventions. Government policies need to look at the provision of health care for homeless people. Hwang, Tolomiczenko, Kououmdjian and Garner (2005:311) assert that the provision of coordinated health care programmes consisting of treatment and support interventions for homeless adults, as compared with current “sporadic and substandard care”, would yield improved health outcomes for homeless adults.

Poland and Italy are two countries who have showed their obligation to provide healthcare for homeless people.

In Italy in 1995 urgent regulations were implemented to allow the right to health care for all illegal and clandestine people. In 1998, Act 49 stated “no one can be excluded from access to health care”. This was followed up in 1999 with a Presidential decree 394/ 1999 that “all foreign citizens whether legally in Italy or not are allowed unrestricted access to preventive, curative and rehabilitative health care under the National Health System” (Manfellotto, 2002:70).

Manfellotto (2002:74) observes that Italy has introduced a very pro-active approach towards healthcare for the homeless. In Italy, the Department of

Preventive Medicine for Migration, Tourism and Tropical Dermatology (DPMM) have been offering healthcare services for homeless people. Furthermore, in order to cater for the health needs of the homeless, these services are also offered at night. The DPMM also actively provides preventive and screening measures, thereby promoting prevention, prophylaxis, detection and treatment of diseases at an early stage, thereby limiting and controlling the “progression to more severe conditions that would be expensive to treat” (Manfellotto, 2002:78). In addition to offering healthcare services to homeless people, the DPMM also studies and monitors health problems thereby collecting important data on homeless people and their health problems which require medical attention (Manfellotto, 2002:78).

Turner (2001:93) explains that in Poland shelters for the homeless are financed by the Provincial Administration. Palma Hospital started the Palma Initiative, whereby health care professionals visit these shelters and provide primary health care.

In America the National Health Care for Homeless Council (2008:1) strongly advocates for the creation of a single health system that provides the homeless with access to high quality comprehensive health care.

All South Africans have a constitutional right to access health care. In South Africa, The White Paper for the Transformation of the Health System (1997) identifies as one of its goals in Chapter 1.1. “To promote equity, accessibility and utilization of health services: increase access to integrated health care services for all South Africans focusing on the rural, peri-urban and urban poor and the aged with emphasis on the vulnerable groups”. In order to achieve the above goals, a primary health care philosophy has been implemented in South Africa. The South African Social Investment Exchange (Sasix, 2008:1) describes challenges that South Africa faces, including health care interventions to meet the needs of vulnerable children, people with HIV/AIDS, people living in informal settlements and homeless people. The public health system currently unable to meet the aforementioned challenges,

therefore relies on intersectoral partnerships between government, non- profit organisations and business, to assist in providing these needs (Sasix, 2007:1).

In order to form and promulgate policies for homeless people, we need to know the precise scope and dimension of the problem of homelessness, the health problems with which homeless people present and at what stage of illness.

Hwang et al (1997:628-629) expressed their concern over increasing deaths amongst homeless people due to AIDS. Hwang states that the findings “have serious implications for clinicians and policy makers”.

Potter & Perry (2008:50-51) reiterate that due to the scarcity of research conducted into healthcare provision for homeless people, inadequate data is available in order to guide decision making.

2.2.5.3 Healthcare utilisation

Barriers to accessing healthcare services

The World Health Report (WHO 2000: ix) ‘Health Systems: Improving Performance’ identifies many discrepancies existing in relation to healthcare available for the poor. These arise owing to the fact that since the poor are being identified as the main disadvantaged group, they are subsequently treated with less respect for their dignity, have access to a more circumscribed choice of health providers, are offered poorer quality amenities, and less prompt attention. Seager & Tamasane (2008:11) reiterate that homeless people suffer from verbal abuse when accessing health services. Martins (2008:427) describes that homeless people were often treated differently and with disrespect when accessing healthcare.

The Polish Department of Public Health states that people in the shelters remain ineligible for primary health care. Their status of unemployment does

not allow access to health care, except in an emergency situation (Turner, 2001:94).

Homeless people experience higher rates of illnesses and injuries than people who live in secure housing. McMurray-Avila (2001:11) explains that these factors can further complicate the satisfactory provision of healthcare. The author elaborates that problems with access to healthcare services, as experienced by homeless people, can effect a delay in health problems being diagnosed and treated. This can further lead to additional medical complications and “impede the individual’s’ ability to overcome homelessness” (2001:11).

In their article ‘Homelessness: a problem for primary care?’ Riley et al (2003:475) discuss the subjects’ impact on health services in the United Kingdom. Riley et al allude to the fact that many homeless people have been inappropriately utilising local accident and emergency departments as a result of barriers preventing access to primary care.

As a result of the influx to accident and emergency departments by homeless individuals, primary care services have been successfully implemented to enable the homeless better access to appropriate medical care. It appears that, due to the lack of consistency in the level of services provided, these services have not been well utilised by the homeless.

Hwang et al (2005:320) strongly propose the development of programmes to improve the health of homeless people. Hwang et al comment that no rigorous survey has been undertaken to assess whether health programmes have resulted in noticeably improved health outcomes for homeless people. In the systematic review undertaken by Hwang et al (2005:320), there is further mention of the need for the provision of coordinated health programmes that have been specifically designed for the needs of homeless people.

2.3 Conceptual framework underpinning the study

For this study the researcher adopted the Three Delays Model first described by Thaddeus and Maine (1994) to identify barriers in accessing healthcare by pregnant women, from the onset of an obstetric complication to receiving care in a health facility. Many of the delays described would apply to those experiences by homeless people.

The three phases of delays identified in the model are:

Phase I delay: Delay in deciding to seek care on the part of the individual, the family, or both.

This stage includes the decision on the part of the individual to seek care. Factors that could hinder the decision making process of homeless people include perceptions of illness, distance from a health care facility, financial costs, previous experience with health care systems, staff attitudes and the perceived quality of care.

Phase II delay: Delay in reaching an adequate health care facility.

Having made the decision to seek healthcare, factors may be present that hinder homeless people from reaching the health facility. These could include distance from a health care facility, financial barriers, for example availability and cost of transport.

Phase III delay: Delay in receiving adequate care at the facility.

This stage looks at the factors which could hinder receiving adequate health care once a healthcare facility has been reached. Such factors affecting homeless people would include shortages of supplies and medications, shortages of staff, inadequate management and attitudinal barriers.

Phase one describes the barriers to seeking healthcare and subsequent utilisation of the healthcare service. As previously mentioned in this literature review, homeless people do not consider health matters to be a priority. This complicates the matter as homeless people often seek healthcare late when

their condition is serious and has become an urgent medical emergency (National Health Care for the Homeless Council, 2008:1-3). Travelling to a healthcare facility can prove problematic as homeless people do not have the financial means to travel to a facility. The distance to be travelled can constitute a disincentive which can delay a client's choice to seek healthcare (Thaddeus & Maine, 1994:1094).

Another obstacle that could influence the decision to seeking healthcare is cost. Cost, as in payment of the healthcare, cost of transportation, doctor's fees, and the cost of medication. Economic status is an important factor when considering health seeking behaviours, especially for the poor. The literature presents evidence that the lower the socioeconomic status the greater the mortality and morbidity.

Homeless people do not have health insurance, which limits homeless people as to which healthcare facilities they can use. Wright & Tompkins (2005:289) discuss the discrimination homeless people experience at healthcare facilities; these represent attitudinal barriers and in turn this may be perceived as a lower quality of care rendered. The National Health Care for the Homeless Council (2008:1-3) reiterates that for some homeless people past ill experiences with the healthcare system will cause homeless clients to avoid seeking healthcare.

Thaddeus & Maine (1994:1096) suggest that people may have had previous experiences with healthcare facilities, which may impact in delaying their decision to seek healthcare. Factors identified that may lead to dissatisfaction in the quality of care provided include; "staff attitudes, hospital procedures, availability of supplies, long waiting times, lack of emotional support, lack of privacy" (Thaddeus & Maine, 1994:1095). A homeless client may feel too ashamed and fear being stigmatised, that they do not seek healthcare, a decision that may further compound the severity of the illness.

Once a homeless client has decided to seek healthcare, obstacles are encountered in making the decision of where to seek care and how to get to the facility. Phase two describes the factors involved in reaching a healthcare facility. As not all healthcare facilities offer services to homeless people, travelling to a healthcare facility that does provide free services for homeless people may be far. This reason mentioned along with other mitigating factors may explain the increased use of accident and emergency departments by homeless people. Once homeless people have accessed a healthcare facility, lack of finances could further complicate access to healthcare, as homeless people may be unable to purchase medications or afford other medical expenses e.g. dressings. Lack of finances could also hinder homeless people from joining programmes for substance abuse (Stein, Andersen & Gelberg, 2007:792).

When a homeless client has reached a healthcare facility, the client could encounter a delay in receiving adequate care at the facility. Factors affecting adequate care could include shortages of supplies and medications, shortages of staff, inadequate management and attitudinal barriers.

As homeless people commonly present with multiple morbidities, this puts further stress on the healthcare system as additional medications and interventions are needed to treat and manage homeless clients.

2.4 Summary of Chapter

The review of the literature discusses definitions and causes of homelessness. The specific needs of homeless people are compared to Maslow's (1943) theory of needs. The review then describes health problems, health seeking behaviours, healthcare provision and healthcare utilisation by homeless people. Thus, the Three Delays Model serves as a suitable framework to underpin this research, since it is most relevant to the barriers that homeless people may encounter when seeking healthcare.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter describes the methodology adopted in this study on describing the health care seeking behaviours of homeless people in South Central Durban. The research objectives, research questions, study design, study location, study population, sampling strategy and size, data collection, data management, data analysis, mechanisms to assure quality of the study, ethical considerations and limitations of the study are described.

3.2 Objectives

The objectives of the study were to:

- 1) Describe the health care needs of homeless people in South Central Durban.
- 2) Describe the experiences relating to the health seeking behaviours of homeless people in South Central Durban.
- 3) Describe factors facilitating access to health care by homeless people in South Central Durban.
- 4) Describe factors influencing access to health care by homeless people in South Central Durban.
- 5) Make recommendations to the Kathleen Voysey Primary Health Clinic (KVC) and other health services regarding health care services for the homeless in South Central Durban.

The research questions were developed to explore the above objectives:

Health Care Needs

- 1) What are the perceived health care needs of homeless people?
- 2) What are the felt needs of homeless people?
- 3) What are the observed needs of homeless people?

Health Seeking behaviours

- 4) What influences the decision by homeless people to seek health care? i.e. Why do they seek care?
- 5) What influences the decision by homeless people as to when to seek health care?
- 6) What influences the decision by homeless people concerning where to seek health care?

Factors facilitating/hindering access

- 7) What are the factors that facilitate the seeking of health care by homeless people?
- 9) What are the factors that hinder the seeking of health care by homeless people?

3.3 Methodology

For this research the researcher primarily used a qualitative methodology with a small quantitative component. The qualitative component comprised of one on one in-depth interviews. The quantitative component comprised of a record review showing the frequency distribution of health problems experienced by homeless people.

3.3.1 Qualitative methodology

Qualitative research is descriptive and constitutes an excellent way of obtaining information and exploring a particular phenomenon (Brink & Wood 1998:336). Patton (2002:5) describes qualitative research as research whose primary focus is on people and the “meanings they attach to or derive from their experiences”. Creswell (1998:15) explains that qualitative research involves research undertaken in a natural setting, thus creating a “holistic picture” of the research study.

Burns & Grove (2001:38) describe applied research as a scientific investigation conducted in order to generate knowledge that will improve or influence clinical practice. Sim & Wright (2002:50) reinforce this definition and state that, by conducting applied research, practical solutions can be offered in order to address specific problems and issues. Patton (2002:217) discusses the ability of applied researchers “to bring their own personal insights and experiences into any recommendations that may emerge”, due to the researchers’ ability to understand the problems whilst conducting the fieldwork.

The rationale behind the choice of a qualitative methodology for the current study was to try to understand health seeking behaviours both from the perspective of homeless people as well as from that of health care workers.

The researcher aimed to increase knowledge regarding health seeking behaviours of homeless people that would result in improved health care provision to this marginalised segment of society in Durban.

3.3.2 Quantitative component

Katzenellebogen, Joubert & Abdool Karim (2001:66) describe a descriptive study as a survey “which sets out to quantify the extent of a problem”. By determining the extent of a problem, service providers and planners gain the essential information necessary in order to plan services and provide the resources needed. The researcher used quantitative cross-sectional descriptive summaries of data contained in service registers, in order to complete the findings for study objective one, which calls for a description of the observed health needs of homeless people.

Table 3.1 Research questions and methods used per research question.

Research Questions	Methods used
Health Care Needs	

1) What are the perceived health care needs of homeless people?	One on one in-depth interview with homeless people and healthcare workers
2) What are the felt needs of homeless people?	One on one in-depth interview with homeless people and healthcare workers
3) What are the observed needs of homeless people?	Record review - Quantitative frequency distribution of health problems treated at KVC from January 2006 to December 2006. In-depth interviews
Health Seeking Behaviours	
4) What influences the decision by homeless people to seek health care? I.e. why do they seek care?	In-depth interview with homeless people and healthcare workers
Research questions	Methods used
5) What influences the decision by homeless people of when to seek health care?	In-depth interview with homeless people and healthcare workers
6) What influences the decision by homeless people of where to seek health care?	In-depth interview with homeless people and healthcare workers
Factors Facilitating/Hindering access	
7) What are the factors that facilitate the seeking of health care by homeless people?	In-depth interview with homeless people and healthcare workers
8) What are the factors that hinder the seeking of health care by homeless people?	In-depth interview with homeless people and healthcare workers

3.4 Study location

The study location is an area in which homeless people are known to reside i.e. within the boundaries of Congella (Berea South), Berea, Mayville (Bellair) and Cato Manor (Bellair), which is zoned as South Central Durban. In the map provided on the next page, this area is indicated in blue. The study area is an urban area which consists of small businesses, residential homes and flats.

Healthcare workers were interviewed from all clinics within the study location namely: Lancer Road Primary Health Care Clinic, Cato Crest Primary Health Care Clinic, Communicable Disease Clinic, Hope Clinic and Kathleen Voysey Primary Health Care Clinic (KVC). These clinics all function independently.



Figure 1. Map of Durban showing study location – South Central Durban

3.5 Study Population

Homeless people aged 18 years and above and healthcare workers in health services in South Central Durban which provide health care to homeless people.

3.6 Sampling

3.6.1 Sampling strategy

For gathering data from healthcare workers all the clinics in the study location were included in the study. From each of these clinics (three municipal clinics and two NGO based clinics) one healthcare worker was interviewed.

A total of six interviews were held with healthcare workers. For gathering data from homeless people, homeless people were approached from the soup kitchen queue at the Berea Presbyterian Church and Dalton Hostel. A total of twelve interviews were held with homeless people.

For the qualitative component of the study a purposive heterogeneous sampling method was used. The aim of purposive sampling was to recruit participants who possess the most knowledge or information regarding the phenomenon of interest. In using both homeless people and health care workers the researcher used heterogeneous sampling. By using heterogeneous sampling the researcher was able to obtain similarities and different views from the two sample groups (Ulin, Robinsin, Tolley & McNeill, 2002:60).

For the quantitative component of the study, information was collected in relation to what diagnoses/ health needs homeless clients were presenting with at the healthcare facilities. This data were contained in service registers, kept at healthcare facilities. However, only one healthcare facility (KVC) kept a specific record of attendance by homeless people, together with the conditions that they presented with. Thus the researcher could only present a record of such data from one health care facility.

3.6.2 Sample size

Patton (2002:246) suggests stating a minimum expected sample size “based on expected reasonable coverage of the phenomenon to be studied”. By stating a minimum size one may change the size of the sample as data is collected from the interviews. The principles in determining the ultimate sample size in qualitative data collection include redundancy and saturation.

When collecting data for any research, a common problem is the adequacy and sufficiency of necessary data. Ulin et al (2002:58) cite Glaser and Strauss (1967) who suggest that “when little new information is coming from your

observations and interviews you can be reasonably confident that you have saturated that source of information to the point of redundancy”.

New participants were approached until the researcher felt that theoretical saturation had been obtained, in that “no new data or new inputs were obtained” (de Vos, Strydom, Fouche & Delport 2005: 329).

Twelve homeless people were interviewed and six healthcare workers. The healthcare workers interviewed were either in charge of the clinic or deputies.

3.7 Recruiting Participants

3.7.1 The Homeless

Participants were approached from the soup kitchen queue at the Berea Presbyterian church which is the location from which the Kathleen Voysey Primary Health Clinic operates. The research assistant approached and enquired in English and isiZulu, of those in the soup kitchen queue as to their willingness to participate in the research. In total eight interviews were conducted at this site.

Dalton Hostel in Congella constitutes a hostel operated by the eThekweni Municipality offering sheltered accommodation. Together, the researcher and the research assistant visited Dalton Hostel, whereupon the research assistant approached and enquired of those at Dalton Hostel as to their willingness to participate in the research. In total four interviews were conducted at this site.

3.7.2 The Healthcare workers

Healthcare workers were recruited from clinics in South Central Durban. Three healthcare workers interviewed were from municipal clinics and the remaining three healthcare workers came from clinics run by Faith Based Organisations (FBO's).

Permission to conduct interviews was obtained from the eThekweni Municipality and FBO's. After permission was granted, the researcher then contacted the clinics directly and spoke to the Doctor or the Chief Professional Nurse Manager, the clinic manager then decided who was to be interviewed and a convenient time to conduct the interview.

3.8 Data collection, management and analysis

3.8.1 Data collection techniques

In order to access the information for the quantitative data, the researcher collected and analysed the daily statistics chart at KVC which supplied a brief overview of:

- Clinic attendance
- Diagnosis
- Level of health care professional was consulted
- Medication prescribed and dispensed
- Referrals and the facility where referred

From this information the researcher then compiled a list of:

- The total number of attendances at the clinic
- The associated conditions

Information relating to the above factors were counted and recorded over the period of one year preceding the study (January to December 2006). The researcher entered the data in Microsoft Office Excel and then developed frequency distributions indicating the ten most frequent conditions/ attendances over a period of twelve months.

The researcher was unable to collect similar information at the other clinics participating in this study. At the other health facilities similar information is kept, however, there is no indication as to which clients are homeless or not

homeless. At one clinic, the professional nurse interviewed mentioned that she did not know if clients attending the clinic were homeless or not. The professional nurse further elaborated that all clients provided an address, but she did not know if the client actually lived there. Another professional nurse further suggested that clients give an address (any) so that they will neither be victimised nor refused treatment. (Reflective diary 4th June 2007)

All interviews were conducted at the interviewees' place of work by the research assistant. Due to the researcher's involvement in a Faith Based Organisation that provides healthcare for homeless people in the research setting, all interviews with healthcare workers were conducted by the research assistant. The interviews with homeless participants were also conducted by the research assistant as the majority of homeless participants spoke isiZulu.

Interviews were conducted with both homeless people and healthcare workers, using a general interview approach. Data were obtained by conducting in- depth interviews, thereby allowing an individual to reflect experiences and events pertaining to the focus of the research (de Vos et al, 2005:287). Roberts (2003:23) describes how "during the interview he tried to talk as little as possible so as to try to maintain as natural a conversation as possible, jotting down key words, phrases and imagery". As soon as Roberts left the field he would then compile the field report. After each interview the researcher also compiled field notes.

3.8.2 Data collection instruments

For quantitative data, data was obtained from the daily statistics charts at KVC. For qualitative data in-depth interviews were held. In order to perform the interviews an interview guide (Annexure H for healthcare workers, Annexure K/L for homeless participants) was compiled by the researcher. The interview guide contained main and probing questions.

The research assistant was trained in use of the interview guide and thereafter conducted interviews using the interview guide.

3.8.2.1 From Healthcare workers

Prior to each interview with healthcare workers, the researcher telephoned each participant to arrange an appointment at a time suitable and venue accessible to the participant. Once this had been arranged, both the researcher and the research assistant proceeded to the venue. Interviews were conducted in a private room. After explaining the reason for the interview and showing the relevant ethical clearance documents and obtaining informed consent, the researcher then excused herself from the interview. The researcher is known to some of the healthcare workers, therefore so as not to influence the interview, it was decided that the research assistant should conduct the interviews. The research assistant conducted the interviews using the interview guide, all such being tape recorded. Interviews conducted with healthcare workers took between 45-60 minutes. All interviews were conducted in English.

3.8.2.2 From Homeless Participants

The interview guide employed in the research was available in both English and isiZulu. The guide used in the interviews was developed by the researcher in English. The guide subsequently was submitted to a colleague who translated the questionnaire into “street” isiZulu. Thereafter it was forwarded to a colleague who translated the guide into English again. Further modifications were undertaken, thereby ensuring its reliability in translation by another colleague. The research assistant conducted the interviews utilizing the interview guide.

Interviews with homeless participants were conducted at the Berea Presbyterian Church, and at the Dalton hostel. At both venues separate offices were provided, thus providing privacy during the interview process.

Once homeless participants agreed to be interviewed, the research assistant took the participant to a private room. Here the research assistant explained in detail what the interview entailed, reviewed the guidelines (as discussed) and then obtained informed consent. All interviews were tape recorded, thus enabling the recording of rich and valuable data.

Initially, homeless participants were hesitant about allowing the recording of the interview and two participants asked if they could have the interview played back so that they could hear their voices. Once the interview had started homeless participants grew comfortable with the tape recorder operating. After the interview had finished, some homeless participants still wanted to talk. However, as regards certain information, they requested that the tape recorder be switched off. The research assistant asked questions as per the interview guide and also probed with a view to elicit more information. Interviews with homeless participants ranged from between 30-40 minutes. Of the twelve interviews, eleven were conducted in isiZulu and one interview was conducted in English.

The individual interviews were conducted until the researcher had reached theoretical saturation, as the data collected contained no new information. After each interview had been conducted the researcher and the research assistant met and compiled field notes (reflective diary). These field notes were used in the discussion of the study. All interviews conducted in isiZulu were translated by the research assistant. All interviews, both English and isiZulu, were transcribed together by the research assistant and the researcher. All silences and pauses were recorded as '...'.

3.8.3 Training the research assistant

An African female assistant was identified who was fully conversant in both isiZulu and English. In addition, she was also familiar with health care

terminology as she was a current nursing student. The assistant was not connected to the KVC or any of the healthcare facilities in the study location. The researcher conducted a training session with her. The training session was held in the researcher's office, thus providing a quiet and private venue, and all precautions were undertaken to prevent interruptions during the session. The researcher discussed the purpose of the research and its methodology. The assistant was provided with a copy of general guidelines for conducting interviews and, as she would be conducting the interviews, these were discussed with her. Points that were covered included:

- The location of interviews with homeless people. These included the Berea Presbyterian Church, where the KVC clinic is held, and Dalton Hostel. Both facilities have separate offices which provided privacy during the interview.
- Aim of research: obtaining informed consent and maintaining confidentiality/ ethical concerns, content of interview, establishing rapport and trust, language, cultural norms, ensuring comfort of the participant and acquiring the ability to listen.
- Guidelines before conducting an interview were discussed and these included: a quiet venue with no distractions, explanation of the purpose of the interview, explanation of the format and length of the interview, how to locate and access the researcher later if so required and the research and bioethics committee.
- All interviews would be tape recorded, thus facilitating the recording of rich data obtained during the interview. The assistant was instructed as to the use of the tape recorder.

A colleague was invited to the training session in order to role play an interview, so that the assistant could practice her interview skills. The researcher vacated the room to allow the assistant and colleague time alone to practice. Informed consent was obtained from the colleague and the tape

recorder was switched on. In this initial practice, the colleague assumed the role of a healthcare worker and then assumed the role of a homeless person. Feedback elicited from the research assistant included that she appreciated this opportunity to practice both interviewing skills and the use of the tape recorder.

During this role play, both the assistant and colleague expressed concern over the wording “health seeking behaviours” (in the healthcare workers interview guide), and whether healthcare workers would be capable of understanding the exact meaning. The assistant also expressed concern over the wording “health aid” (in the interview guide for homeless people) and suggested that the words ‘health assistance’ be used. Both the colleague and the research assistant felt that the session had been extremely useful. The assistant requested another session, which was subsequently held the following day.

The following day involved only the researcher and the assistant, both reviewing the two interview guides. After obtaining informed consent, the assistant interviewed the researcher as a healthcare worker and subsequently as a homeless person. Both interviews were recorded. In playing back the recorded interviews the assistant noted that her voice was too loud whilst the researcher’s voice was quieter and sometimes too faint to hear. The assistant then noted that for future interviews the tape recorder needed to be placed nearer the person being interviewed. The assistant expressed the opinion that this session had proved beneficial and that she had gained more confidence in conducting interviews.

3.8.4 Pilot study

Two pilot interviews were conducted, one with a healthcare worker and the other with a homeless person.

The first pilot interview was conducted with the former. Due to time constraints, as the health care facility was extremely busy the researcher and the assistant visited the healthcare worker at home. To obviate the introduction of bias, the researcher vacated the room whilst the interview was being conducted. After informed consent was obtained, the interview was conducted and recorded. The interview was approximately 30 minutes long.

Comments from the research assistant included that the interviewee was both extremely helpful and easy to converse with. Comments from the interviewee included:

- For question two: “Can you describe the health seeking behaviours of homeless people coming to your clinic?”

The interviewee queried as to what exactly did the researcher want to know? Did the researcher want to know the frequency with which homeless people came to the clinics? The interviewee then queried as to whether question two is not similar to question one, which asked “Can you describe the healthcare needs of homeless people?”

- For question five: “Can you describe factors that hinder access to health care by homeless people?”

The interviewee suggested that, instead of the word ‘hinder’, perhaps another word could be used e.g. delay, hamper, obstruct.

The research assistant provided the following reflections regarding the pilot interview with the homeless. “Interview went well, no difficult questions”. “Interviewee appeared confused at times: early in the interview, clarification was needed. Information received was interesting.” “Initially client not relaxed, but he became relaxed and gave the information”. After the interview was conducted and the tape recorder was switched off, the client continued talking and giving information.

Based on the information with the two interviewees, the researcher arranged a meeting with the research supervisor. Revisions were suggested for the questionnaire for healthcare workers. The revisions in the questions consisted of probes, to aid in eliciting richer responses.

- For question one: “Can you describe the health care needs of homeless people coming to your clinic?”
- Suggestions included the possibility that, in order to obtain a baseline/ initial response, an introductory probe could elicit the person’s basic needs in order to maintain well being. Thereafter problems that the homeless encounter e.g. health, social, and economic problems could be probed.
- For question two: Can you describe the health seeking behaviours of homeless people coming to your clinic?
- Suggestions included dividing this question into three sections. For the first section, this involved probing at what stage of illness they attend the clinic e.g. little minor aches or late serious problems. The second section investigated whether the homeless come for follow up appointments... are they compliant with their medication? The final section sought to elicit a response as to whether the homeless came for health problems or other concerns e.g. disability grants?
- For question five: “Can you describe factors that hinder access to health care by the homeless?”
- It was suggested that this question includes barriers/ hinder.

3.8.5 **Data Management**

After the interviews were conducted, each interviewee was furnished with a number, thus ensuring anonymity. After the interview the researcher immediately monitored all notes obtained from the interviews and no problem areas were identified.

The taped recordings of all interviews were stored in a lock up cabinet. The researcher and the research assistant transcribed the data from the interviews verbatim onto the researcher's computer. The researcher maintained two copies of the data: one serving as a back-up to be safely stored in an appropriate location and the other copy was employed for the researcher to work on. The access to the computer was limited by installing passwords therefore the researcher would serve as the only individual who would have access to the researcher's computer. In the writing up of the data the researcher did not use names of the clients, thus not subjecting anyone to any victimization or embarrassment. All data obtained from the research will be stored securely until the research had been published. Data will be destroyed after five years.

3.8.6 Data Analysis

The researcher employed a manual method to analyze the data obtained. All information obtained was collated e.g. interviews, field notes and memos to form a data base.

Initially, the researcher read, re-read and immersed herself in the detail of the transcripts from the interviews and the field notes, "trying to get a sense of the interview before breaking it into parts" (Ulin et al, 2002:144).

As the researcher read the data, patterns/ categories of themes and sub-themes were identified, which represented the "central core of the data collected" e.g. relationships with health care workers (Patton, 2002:453). Whilst reading homeless people's transcripts, the researcher used different colour highlighters for the different themes that the researcher identified,

carefully recording a key indicating the particular pattern represented by each colour.

Once the researcher had read the data, checked for inaccuracies in transcription, identified patterns and coded them; it was necessary for the researcher to answer two questions, namely

- “How to arrive at the essential meanings of the qualitative data?
- How to ensure that the interpretation offered is trustworthy?”(Ulin et al, 2002:160).

A deductive approach was used whereby the data were analysed according to predetermined categories that was guided by the research questions and research objectives. An independent researcher agreed with the coding (analyst triangulation). Findings from the data were reported in the narrative form. Negative cases were reported in the results.

3.9 Study Period –Actual

Table 3.9 Study Period

Write Research Proposal	March/ April 2006
Higher Degrees and Ethical Clearance	Dec 2006
Data Collection	June –Sept 2007
Data Analysis	Oct 2007– Apr 2008
Complete Research Report	October 2008

3.10 Research Team

The research team comprised of the following personnel:

- Three isiZulu interpreters assisted in the translation of the interview guide.
- One English/ Zulu speaking assistant, who was not connected to the KVC or any of the other health services in any way, aided in

conducting interviews and translation of the questionnaires to both the clients and the healthcare workers.

- Researcher

3.11 **Mechanisms to assure the quality of the study**

Patton (2002:544) identifies five groups of criteria which are utilised for judging the “quality of qualitative inquiry”. Within the paradigm of this study social construction and constructivist criteria were used.

3.11.1 **Credibility (truth value)**

Patton (2002:552-553) identifies three points which need to be considered when assessing the credibility of research, viz:

- Rigorous methods must be used for the collection of data during fieldwork. An important source of data is the compiling of field notes, which the researcher and assistant completed immediately after the interview process was finished, while the interview remained both clear and fresh. Field notes contained a description of what was observed during the interview process, inter alia the “physical setting, what activities took place, direct quotations, non-verbal communication, assistant’s own feelings and reactions whilst conducting field work” (Patton, 2002:303). By using field notes, together with transcribed verbatim interviews, it is possible to acquire a better and complete overview of the subject being researched. A thick description includes more than a mere recording of what transpired during the interview process. Thick description describes the emotions and feelings and “establishes the significance of events for the person in question” (Patton, 2002:503).

- Credibility of the researcher: the researcher is currently a MPH (Master of Public Health) student and has studied two modules in research. The researcher's strengths (bracketing) lie in that the researcher has been personally involved in the KVC clinic for nine years, which satisfies the criteria of prolonged engagement. The researcher's weakness is that she is a novice researcher with limited experience. To overcome the researcher's inadequacies, a research supervisor both oversees the process and is available for advice. In addition, the services of two colleagues as peer reviewers have been utilised in order to obtain the maximum input possible in order to achieve credibility.
- Philosophical belief in the value of qualitative research. The research design employed is that of applied, qualitative research. Applied research was used so as to produce knowledge and information regarding the health seeking behaviours of homeless people that will assist in improving health services for homeless people. The applied researchers "bring their own personal insights and experiences into any recommendations that may emerge" (Patton, 2002:217). This is further augmented due to the ability of the researchers to understand the problems whilst conducting fieldwork.

3.11.2 Triangulation

By performing triangulation during the research process, one can ensure to the maximum reasonable extent that the results and conclusions obtained by the research are credible. Patton (2002:247) suggests four triangulation methods which will "contribute to verification and validation of qualitative analysis".

These methods are:

Methods triangulation: this involves checking the consistency of data that has been collected by using different data collection methods. In the research, the researcher used data from the daily statistics sheet, interviews and observations (Patton, 2002:556).

Triangulation of sources: This refers to the process whereby the consistency of data is checked when different data sources are utilised (Patton, 2002:556). By conducting interviews with homeless people and with healthcare workers who provide health care services to homeless people, the researcher triangulated views from different sources. Once the transcripts were completed, the researcher then contacted the healthcare workers (either by telephone or email) and requested that they check whether the transcript provided a true reflection of what had been said during the interview (member check). All healthcare worker participants replied in the affirmative. The researcher was not able to trace the homeless participants to query whether the transcripts were a true reflection of information they had provided.

Analyst triangulation: The researcher read and re-read the data, and analysed the data according to five broad themes which were predetermined as the research objectives. By re-reading the data sub themes were inductively identified. An independent researcher, expert in qualitative data analysis, independently read the data and formulated sub themes. The independent researcher was in general agreement with the coding and emerging themes, thus rendering the research more credible. This researcher verbally agreed to maintain confidentiality regarding the findings of the research study.

3.11.3 Attention to Negative cases

Whilst data was being collected, it is important to identify any negative cases, which consists of data that fails to agree with the bulk of that collected, including exceptions to the rule (Patton, 2002:554). Negative case analysis can provide alternative “dissenting voices” and thus challenge the researcher to continue the process of searching until all possible alternatives can be ascertained and accounted for.

3.11.4 Reflexivity

The process of assessing and making explicit the researcher's own subjective experience and how it may have influenced the research process is very important in qualitative analysis. Person (s) reading this study will understand and appreciate the researcher's world view and then conduct their own personal judgement as to whether the researcher has in any way influenced this research. By "bracketing" the researcher's own experiences in undertaking voluntary work, it will then be possible to check the data collected along with the findings of this research.

The researcher is a white female, in her forties, who has been a professional nurse for twenty-six years. The researcher has been involved with the KVC since 1997. These nine years of working at the clinic have influenced the researcher in that she is sympathetic to the health needs of the homeless. This could potentially influence the research results.

The researcher kept a reflective research diary, in which the researcher reflected on-going self evaluation and critique throughout the research process. The researcher recorded her sentiments experienced during the data collecting process. The researcher also recorded biases and experiences and the manner whereby they may have influenced the research process, the results and interpretation of the research.

3.11.5 Transferability

The study should be described in such a manner that it will facilitate the transfer of the research process to another setting (Engelbrecht, 2005). Someone may read the research report and thereafter conduct similar research in a different geographical setting, thus identifying the problems of the homeless population and allowing comparison of findings.

3.11.6 Dependability

In order to ensure dependability in qualitative research, the researcher needs to meticulously represent, explain and logically motivate all steps

and study decisions taken (Engelbrecht, 2005). All data collected were stored in a safe place, as well as decisions about coding and is available so that the researcher can provide evidence of the research findings (audit trail).

3.12 **Ethical considerations**

Subsequent to obtaining ethical clearance from the Bioethics Committee at the University of Kwa-Zulu Natal, permission was obtained from all Dalton Hostel and all the clinics i.e. eThekweni Municipality (Lancer Road Primary HealthCare Clinic, Cato Crest Primary Health Care Clinic and Communicable Disease Clinic) Hope Clinic and KVC Primary Health Care Clinic.

The researcher has attempted to meet the ethical requirements for research as proposed by Patton (2002:408-409), by:

- Explaining the purpose of the study to the respondents: As the majority of the homeless people in South Central Durban are isiZulu speaking, the researcher used an isiZulu speaking research assistant to assist in developing the interview guides and in conducting the interviews. Prior to obtaining informed consent, the research assistant furnished information to the potential participants regarding the researcher, as well as providing an overview of the research according to the educational level of the participants.
- Risk assessment: The researcher did not place any of the participants at any risk of psychological stress, legal liabilities, ostracism by peers or even political repercussions. The researcher was not accused of exploiting a vulnerable population by increasing their social stigmatization and employing bribery and coercion to attain or even influence research results, thus not adhering to the principle of justice. One aspect wherein the researcher promised confidentiality lies in the area of illegal activities e.g. illegal drugs, illegal squatting and prostitution. Working with homeless people, entails being aware of

such antisocial activities, as the abuse of alcohol and the frequent prevalence of the “sweet” smell of dagga being smoked.

- Confidentiality: All interview guides were numbered and the names of participants did not appear in any aspect of the research material. All data collected was retained on the researcher’s computer and locked in a cabinet. Access to the computer was limited as the researcher was the sole individual who had access thereto. In the formal compiling of the data the researcher did not use names of the clients, and thus has not subjected the latter to any victimization or embarrassment.

Informed consent: which entailed a rational free decision to participants was made by all participants in this research. Firstly, the research assistant disclosed to the participants a covering letter which explained the identity of the researcher, the purpose of the research, potential benefits/ risks of the research, provision of anonymity and confidentiality (Letter of consent Annexure I and J). In the letter the issues of voluntary consent and the option to withdraw were included. The researcher ensured that the translator signed a contract of confidentiality. At all times privacy was maintained, thereby an atmosphere of honesty and trust was promoted. Before the interview was conducted, the interviewer obtained written permission from the participant and then only proceeded with the interview. Signing informed consent proved to be problematic, as two of the homeless participants were illiterate and one homeless participant refused to sign consent as she was afraid that this information would be forwarded to the authorities. The researcher approached her supervisor who contacted the BioMedical Ethics Committee at UKZN and requested their advice in this regard. The question arose: If a client is illiterate and wishes to participate in research study, does one need another witness to sign that the client has given his/ her consent?

- The reply from the BioMedical Research Ethics Administrator was:
“As long as the witness is independent of the study and well known

to the participant, not the nurse or anyone involved in the project”.

Thereafter the permission documents were adapted to incorporate a witness's signature and date.

The research assistant recruited volunteers from the soup kitchen queue, when people were already on the premises. Thus, provisions were not provided for potential inducements, including bus fare. For interviews conducted at Dalton Hostel, a small private room was provided.

3.13 Data access and ownership.

Since this research project is self funded the researcher does not owe any obligations to sponsors or donors. Upon request the researcher has furnished three-monthly reports to the KVC Committee regarding the research development.

3.14 Interviewer's mental health.

A possibility existed that both the assistant and the researcher could be affected by conducting the interviews and processing the data obtained there-from. In the event that this should materialise, the researcher enlisted the assistance and expertise of a minister of religion who would conduct a debriefing process, should the need arise. This anticipated service was not needed.

3.15 Data collection boundaries.

As the researcher collected data from twelve homeless people and six health care workers. If, during the interview, the assistant discovered that the participants failed to supply sufficient information for the research, the researcher would forgo the interview as opposed to “pushing” for information.

3.16 Limitations to the study

- The study was limited to homeless people, the majority of whom are black and residing in South Central Durban. Therefore the results from the research cannot be generalized to the entire homeless population in South Africa. The methodology chosen for the research study does not lend itself to the generalisation of results.
- The homeless are by nature suspicious. Thus, in order to persuade the homeless to answer questions, both trust and confidentiality were essential. The researcher was very conscious of finding an assistant who could develop a good rapport with interviewees without the interviewee feeling intimidated and victimised.
- For this study homeless participants identified their place of “residence” as being in the suburbs of Congella (Berea South), Berea, Mayville (Bellair) and Cato Manor (Bellair), which is zoned as South Central Durban. However homeless people are known to be migratory, and sleep anywhere that might prove safe and dry. Therefore, the researcher can not assume 100% accuracy in stating that those homeless people who participated in the research originate from South Central Durban.
- As other health care facilities used in this study did not keep a specific record of attendance by homeless people and the conditions that they presented with, the researcher could only present a record of such data from one health care facility (KVC).
- In the translation of the questionnaire for homeless participants from English to isiZulu, and in the translation of verbal responses of homeless participants, there could have been loss of meaning.

3.17 Summary of Chapter

This chapter described the methodology used in this qualitative study. Interviews were conducted with homeless participants and healthcare workers. Training of the research assistant and recommendations from the

pilot study has been discussed. Methods to ensure credibility, ethical considerations and data management and data analysis have also been described. In conclusion of the chapter limitations of this study are presented.

CHAPTER FOUR: PRESENTATION OF FINDINGS

4.1 Introduction

This chapter presents the findings of the study. The introductory section provides an overview of the participants in the study. In the subsequent sections the findings are reported according to the major categories and sub-categories for this study, which were predetermined and arose from the study objectives and research questions.

4.2 The Participants

4.2.1 Homeless participants

The homeless participants comprised of six males and six females. All the female participants were black; five of the male participants were black and one was white.

As an introductory question the homeless were asked about their geographical origin. Three came from rural areas within the Eastern Cape, six came from rural KwaZulu-Natal, one from Mpumalanga and two from Durban. Participants were asked how long they had been homeless in Durban. Responses varied from 6 months to three years to “*all my life*.” (HL 2)

With regard to their reasons for migrating to Durban, nine participants responded that they came to Durban to seek employment, while one responded “*because of HIV positive, to get better care*.” (HL 6) The remaining two participants were born and grew up in Durban.

4.2.2 Healthcare worker participants

The six healthcare worker participants interviewed were all women. Two of the participants were registered doctors; the remaining participants were professional nurses. Two healthcare worker participants were black (n=2), The remaining were white (n=2), coloured (n=1) and Indian (n=1). The

healthcare workers fell into the following age groups: 30's (n=2), 40's (n=2) and 50's (n=2).

4.3 The healthcare needs of homeless people in South Central Durban.

The health care needs of homeless people were determined by:

- Analysing the clinic statistics of the Kathleen Voysey Primary Health Clinic, to obtain the observed healthcare needs of homeless people attending this clinic.
- Eliciting responses from homeless people themselves about what they felt were their healthcare needs.
- Eliciting responses from healthcare workers about what they perceived were the healthcare needs of homeless people in South Central Durban.

4.3.1 Observed healthcare needs

The Kathleen Voysey Primary Health Care Clinic is only open on a Thursday morning. The analysis of the clinic statistics for the period January to December 2006 revealed that during this time there were a total of 2493 attendances. Of these 47% (n=1170) were male attendees and 53% (n=1323) female attendees. Over the period of the year 284 new clients were seen, which indicates that out of the total number of consultations (n=2493), 87% (n=2209) were to existing clients.

The conditions that clients presented with are reported in Table 4.1. The results depict that the majority of client attendances related to diabetes, hypertension/ cardiac conditions, respiratory problems and retroviral conditions.

A total of 621 attendances were treated for respiratory conditions during the year. On average 15 to 65 attendances were seen on a monthly basis, with

the highest number thereof being treated for respiratory problems during the month of June (n=115). This also coincides with the month with the highest frequency of attendances.

Regarding diabetes, attendance numbers ranged from 8-32 per month, the total number for 2006 (being 264). The month with the greatest number of diabetic attendances (n=32) was during the month of June. Hypertensive/ Cardiac attendances ranged from 7-33 attendances per month, the total number for 2006 (being 275). Regarding dressings, attendance numbers ranged from 6-32 per month, with a total number of 220 attendances for 2006. Attendances where healthcare workers were querying Retroviral conditions numbers varied from 2-12 per month, the total number for 2006 being 64. Retroviral attendance ranged from 16-49 per month, with most of this category attending the clinic in March (n=49), with a total for 2006 (of 423).

During 2006, 59 attendances were referred to the Durban Communicable Disease clinic for TB follow up and treatment; 16 attendances were referred for treatment of sexually transmitted infections. During 2006, 140 attendances were referred to hospitals for further management; 25 attendances were referred for dental management; 4 were assigned to the district surgeon, and 25 attendances received direction for assistance in obtaining grants.

Table 4.1 Clinic attendances at KVC during 2006 (see overleaf)

	January	February	March	April	May	June	July	August	September	October	November	December	% case load	TOTAL
Total Patients seen	68	183	290	112	245	293	229	273	189	193	290	128		2493
Total Female Patients	27	81	113	49	100	142	124	128	90	84	157	75	46.8	1170
Total Male Patients	41	102	177	63	145	151	105	145	99	109	133	53	53	1323
New Patients	10	26	38	9	31	44	28	25	19	29	20	5	11.4	284
Old Patients	58	157	252	103	214	249	201	248	170	164	270	123	88.6	2209
Asthma/ Chest	17	49	65	29	57	115	53	65	56	46	54	15	24.9	621
Diabetes	8	18	21	20	27	32	24	24	25	14	34	17	10.6	264
Hypertension/ Cardiac	7	21	32	15	27	25	24	33	25	19	27	20	11	275
Dressings	6	16	31	10	15	22	14	32	20	20	25	9	8.8	220
?Retroviral	2	6	11	1	12	5	6	5	1	4	7	4	2.5	64
Retroviral Positive	16	32	49	16	42	52	35	39	33	36	46	27	17	423
Referral DCC ?TB	2	6	7	1	2	6	7	5	5	7	7	4	2.4	59
Referral DCC ?STI	1	/	4	1	1	2	/	2	/	/	/	/	0.6	16
Referral Hospital	1	5	7	6	37	15	11	15	5	11	21	6	5.6	140
Referral Dental	/	2	4	/	3	/	3	4	2	4	2	1	1	25
Referral District Surgeon	/	1	/	/	1	/	/	/	1	1	/	/	0.2	4
Referral Grants	2	2	2	2	1	3	/	1	1	4	6	1	1	25

4.3.2 Felt healthcare needs

Homeless people reported health, social and welfare problems.

4.3.2.1 Health Needs

Homeless participants reported suffering from minor ailments, communicable and non-communicable diseases and trauma.

The minor ailments reported included body pains and wounds.

“My whole body is paining [he indicates his chest]. ...And when I’m sleeping at night I find it difficult to turn, inside my body there is pain and I sometimes feel my tummy windy and when I cough I feel pain inside my body.” (HL P)

“For my legs ... I have these sores on my legs because I have not been looking well after myself properly.” (HL 3)

Another homeless participant lamented that his wound was taking a long time to heal. He also offered a reason for why the wound was not getting better.

“ Today I came because I am having a sore in my left leg ... I have had it sometime, it was better but now it is coming back...the wound is not getting better...I think it is because of the tight shoes that I am wearing” [he points to the old shoes he is wearing]. ” (HL 7)

Homeless participants revealed that they suffered from various communicable diseases including TB, STI, scabies and HIV/ AIDS.

“As of now I am taking TB treatment from the TB chest clinic.” (HL P)

"...but what I remember I went to clinic for STI. For the first time my left testicle was swollen and I developed swollen glands... and then they helped me at the clinic." (HL 1)

"I came today because my body is itching, the itching of the body... that has been happening quite a long time. The pain is not on the skin but it is inside. The pain comes and goes as if it never existed, sometimes it starts as if something is tickling me and it gets worse." (HL P)

"I'm not well... I went for testing and I was told that I am HIV+ ...sick person. I'm having a running stomach." (HL 4)

"I'm not well...I'm HIV positive." (HL 6)

The non-communicable diseases that the homeless participants reported included high blood pressure, diabetes, and gynaecological problems.

"I have diabetes... I came for BP treatment because it has been going up and down ... for BP they gave me Metformin.... For my sugar I am on injection. Today I came for meds for BP." (HL 5)

"I'm feeling dizzy, I'm having nausea and I haven't had my periods since 27 June, I only had periods for one day. So I even feel that my womb is sore. I'm not sure it is because I haven't has periods." (HL 6)

Participants at the Dalton Hostel described that on the weekends when drunkenness occurs, fights ensue, which result in traumatic injuries.

"I was beaten by people with a crate." (HL 1) This participant sustained injuries to his arm, which was swollen and which he could not straighten.

"I was run over by a food trolley." (HL 7) This participant had a painful left leg and ankle along with wounds which had become septic.

4.3.2.2. Social Needs

The social needs that were identified by homeless participants were shelter, food, safety/security, work, family life and community networks.

Homeless participants reported on their places of shelter.

“I sleep at the verandas at the shops and at the hostel...Its not one fixed place, but not exactly on the road. Sometimes I stay on the verandas. People at Dalton Hostel, citizens of Dalton know about us.” (HL P)

Homeless participants elaborated on sleeping anywhere that is safe where one can avoid being disturbed.

“We don’t sleep in one place because today we will sleep here and then someone will chase us away.” (HL P)

“I’m sleeping outside; I can’t say exactly where I sleep because the policeman keeps chasing us away...I just sleep where I can’t be bothered.” (HL 1)

Some homeless participants stated that they sleep at Dalton Hostel. Dalton Hostel is a hostel run by the eThekweni municipality and caters for monthly and longer, cheap accommodation. Currently the hostel is running at a 100% capacity, and a long waiting list exists for future occupants. At the hostel, men and women stay in separate blocks. Family units had, in the past, been available. However, they were,

“phased out due to shortage of accommodation.” (HL 10)

The price the participants pay for monthly accommodation at Dalton Hostel varies from R25 to R45, depending on the number of occupants sharing a room. The number of occupants per room varies from four to thirty-two

people. A four bedded room costs R45 and includes access to water and electricity. In this room, occupants can also cook their own food.

“Each and every one of us has his own stove and pots.” (HL 8)

One homeless participant described the double burden of unemployment and yearly rent increases (R10.00) at the Dalton Hostel. This can result in,

“people leaving the hostel, and forces people to stay in the streets and verandas.” (HL 9)

Healthcare worker participants emphasised the urgent necessity of providing hygiene facilities, showers and toilets for homeless people.

“We use the toilets at the train station, sometimes the hostel toilets or sometimes an open space. It is difficult at the station when there are cleaners around as they chase us away.” (HL P)

“If I need to shower I need to go down to the beachfront ... and use the showers there ... you know if I leave it too long I break out into sores. ... they normally ask for R5... R5 to use the showers... they have an office there for the showers... and you go and pay at the office... and then you can go and shower... very organized, run by the municipality.” (HL 3)

One homeless participant provided a description of her own personal hygiene.

“and here at the clinic they give us soap and sometimes food...so with the soap you can wash, and your clothes in the sun and get clean [showing how clean she was] and when you get R2 you buy a roll-on and apply it on your armpit... and again with that money from the boxes [homeless participant collected cardboard boxes and then sold same to paper waste] you can buy the body lotion.” (HL 2)

“In all fairness staying in the road does not mean you have to be dirty... if you are dirty, people will take you as otherwise and that you are poor, does not mean that you don’t have to take care of yourself... even coming here to the clinic ... we need not to come daily... just wake up in the morning clean yourself and see what else you can do... I don’t usually bath myself in the morning. I wait until the sun is up and then I nicely wash myself.” (HL 2)

Homeless participants agreed that food is a very important need. A few of the homeless participants identified that a reason for coming to one of the Primary Health Care clinics was that there is a soup kitchen before the clinic opens.

“Yes for only for food.... It’s the first time [coming to the clinic] and I’m very very hungry... then I decided to come.” (HL 1)

Homeless participants described other sources where they obtained food:

“People staying at the hostel whenever they are having a braai [buy meat together] they give us as well. Whenever people that stay at the hostel go home, any left over food is given to us.” (HL P)

“When we get temporal [temporary] jobs from people living in the flats, when they are moving their goods, we don’t often get paid and sometimes, are given rotten food.” (HL 1)

Additional social problems experienced by homeless people include sexual abuse, fear of exposure, fear for life and criminals.

As a result of little sheltered accommodation for homeless people, they are at risk of physical and sexual abuse. One homeless participant described in detail the threat of abuse from young boys, and taxi drivers:

“You see whenever someone wants to touch me and I don’t want that I have to fight because I am old... I’m not of their age...they must go to their age group.” (HL 2)

“I am scared of getting HIV/ AIDS. When the taxi drivers come [for sex] to the homeless all I see is HIV/ AIDS on their foreheads and I stay away.” (HL 2)

One way of attempting to protect oneself is not to sleep in the same place.

“So you see now we have to go and sleep there, we don’t stay in one place. I will be lying if I say that I stay in one place.” (HL 2)

A homeless participant elaborated another way of protecting herself,

“I have two pairs of tights/ leggings, I always wear a tight legging in case of gang rape, the leggings protect me at night.” (HL 2)

She further described how homeless people protect each other,

“Ja, remember that its not only me that lives here, there we are many, there are many people... we protect each other, even yesterday we did not sleep well because of these young boys...” (HL 2)

Another illustration of the threat to safety and security was when a participant was asked to sign the informed consent for this research. She did not want to sign for fear of exposure. She was scared that,

“my name would be forwarded to SAPS as they are informed that it is illegal to stay on the road.” (HL 2)

The quote below further reinforces the vulnerability felt by homeless people.

“The only thing that we are scared of, are people rather than animals, because we have heard that the sangomas want body parts to make muti.”

(HL P)

There is a preconception that homeless people are involved in criminal activities. A homeless participant explained,

“Being homeless does not mean that we are criminals, I don’t do smash and grab. Criminals steal our possessions... but I fight for my belongings.”

(HL 1)

Despite not having many possessions, homeless people are proud and possessive of their belongings, as described by one homeless participant,

“Yes I carry everything with me... My blankets here...” [he tried to take them out to show the research assistant who told him that he does not have to take them out]. (HL 3)

All the homeless participants emphasized the need for employment. At the time the interviews were held, four homeless participants had some form of temporary employment and the remaining eight homeless participants did not have employment.

One homeless participant who resided at Dalton hostel stated that:

“For life to go on perfectly, one must have a steady job, be able to maintain your family. As I am unable to work, life is really difficult for me, and in order to get better things in life, one must have some money for things for health care.”

(HL 10)

Many homeless participants described the psycho-social importance of being employed. Besides getting remuneration, employment also increases self-

worth and the sense of belonging. A homeless participant described his experiences:

"I'd like to have money one day so that I go back home, because at home they would not like seeing me like this...and I've never disappointed them." (HL 1)

"Because I am homeless "other people" don't take me seriously because I do not have a job." (HL1)

Responses from homeless participants show that participants have resourcefully tried to find temporary employment ranging from selling vegetables, fruit, peanuts, cigarettes and boxes to sewing clothes. In desperation some homeless turn to prostitution.

"Some of the homeless females turn to prostitution, but I say they are good females." (HL 2)

When the researcher and the assistant went to Dalton Hostel, they noticed that there were only a few residents at the hostel. When they enquired about possible respondents for the research, the supervisor of Dalton Hostel explained that during the day residents are often out looking for work.

A concern from homeless participants is that when they are able to get employment, they are often exploited as they do not receive an adequate wage. A homeless participant described her job of distributing flyers, advertising sangoma services. If a client used the service then the homeless person received a meagre commission. She further elaborated,

"There are so many people that are going for the consultation, but we are paid peanuts at the end of the day." (HL 6)

Another homeless participant described his disappointment.

“When we get temporal [temporary] jobs from people living in the flats, when the people are moving their goods, we don’t often get paid.” (HL 1)

Homeless people are opportunistic in attempting to get money. After the interview was over one homeless participant asked for R10.00 from the research assistant. The research assistant did not give any money. This action was reiterated by a healthcare worker participant, who described,

“some homeless ask for money.” (HCW 5)

A social problem identified by a homeless participant who resides at the Dalton Hostel is that of separation of families. The participant stated that males and females are accommodated in separate blocks, and that children stay with their mothers in the female block. The homeless participant further elaborated that,

“we have children here but it is not conducive for them because there are no crèches and for those who attend school; it costs money to transport them to school.” (HL 9)

In the descriptions of accommodation, food and sexual abuse, homeless participants reinforce the concept of a social network that also provides a sense of community.

4.3.2.3 Welfare Needs

Homeless participants were asked whether they received pensions. One participant received an old age pension. Another participant used her child’s grant. A homeless participant described her problems in accessing a pension.

“They organized for my pension but it was unsuccessful...I don’t know they just told me that.” (HL 4)

Homeless participants describe the means by which they obtain money for accommodation.

“my grandmother helps me out of her pension money.” (HL 10)

Whilst, *“my brother sometimes pays for me.”* (HL 9)

4.3.3 Perceived healthcare needs.

When asked what they perceived were the healthcare needs of homeless people, healthcare workers reported on health, social and welfare problems.

4.3.3.1 Health Needs

Healthcare workers reported that homeless people suffer from minor ailments, communicable diseases, non-communicable diseases and trauma.

The minor ailments reported included colds/flu, aches and pains, sore bones, boils, ear, nose and throat problems and chest infections.

“Health problems diabetes, hypertension, aches and pains, sore bones is the favourite and we give out more Brufen [anti-inflammatory] for sore bones than anything. Skin conditions, scabies +++, boils, all these sort of things, ear, nose and throat problems and chest problems.” (HCW 3)

“People in Cato Crest like coming to the clinic for minor things, others come when they see no change in home treatments e.g certain herbs boiled with lemon for a cough.” (HCW 1)

The communicable diseases reported include scabies, TB and HIV and AIDS.

“We see the odd child...Streetwise bring them. And they are normally full of scabies and we have to treat them.” (HCW P).

“TB, they do get follow up due to the community health workers and clients coming to the clinic for medication.” (HCW 1)

Another healthcare worker who works at a Communicable Disease Clinic stated:

“We do have homeless people.” (HCW 2)

Another communicable disease identified is HIV and AIDS.

“We get patients coming in with AIDS. We are not an AIDS testing centre but if we suspect they have got AIDS we send them for testing.” (HCW 3)

“Most of the time we see people if they get sick, like some of them will get TB or a skin infection etc...they go to another facility and that facility says that they should have an HIV test... and they come. So a lot come with health related problems that could be related to HIV.” (HCW 4)

When asked what non-communicable conditions homeless people present with, one healthcare worker replied:

“Health problems e.g. diabetes, hypertension.” (HCW 3)

There were no responses regarding trauma from the KVC clinic. However a response was offered from a municipal clinic:

“There are a lot of shebeens in Cato Crest. They drink and they have a fight and then when they are hurt they come to the clinic, especially in the evenings and the weekends.” (HCW 1)

4.3.3.2 Social Needs

The social needs of homeless people identified by healthcare workers were shelter, ablution facilities, food and social problems. The needs were summed up by one healthcare worker participant from the KVC clinic:

“They need food, they need shelter, they need medical care, and very often they also need tender loving care, basically. I think it goes like the Maslow theory of needs, where you need warmth, shelter, food and sociable.”(HCW P)

“The needs of homeless people is the same as other people, because they are also people as well, so all the needs that a human being needs to survive they also need the same thing.” (HCW 5)

Regarding the provision of food, a response from a healthcare worker at KVC:

“They get soup every day Monday to Friday. Yes they need food. The soup kitchen queue is much longer than the clinic queue.” (HCW 3)

The need for the provision of food is reiterated by a healthcare worker from another clinic:

“The added bonus is that there is a feeding scheme that’s run here every day.” (HCW 4)

A healthcare worker from another clinic recounts:

“Or they come and say that they are hungry. We give them food parcels, whenever they are available.” (HCW 5)

All healthcare worker respondents agreed on the need for the provision of shelter:

“They need shelter; if they are not living in hostels then they are living under the bushes/ trees, near the railway line.” (HCW 3)

One KVC healthcare worker suggested that due to the lack of shelter, health has deteriorated:

“We have had HIV folk who have already gone into the AIDS state who are sleeping down at Maydon Wharf and they have nowhere to go.” (HCW P)

Healthcare worker participants reinforced the need for hygiene facilities, showers and toilets. One healthcare worker described:

“They need hygiene facilities, showers and some way in the form of a loo.” (HCW 3)

Healthcare worker respondents emphasized that homeless people encounter various types of social problems, for example unemployment, which could lead to alcohol abuse. This was described by a healthcare worker:

“Social problems, some of them have got big social problems. Do you know they have been thrown out of homes or they have been retrenched for some reason or other, so therefore this is why they are on the streets a lot of them. A lot have been retrenched and have taken to drunkenness and so they get thrown out and live on the streets. They have got family problems all the usual sort of social problems that people have.” (HCW 3)

Another healthcare worker reflected on her experiences encountered whilst counselling homeless people:

“Because we offer counselling, which is general counselling, so sometimes they will come for spiritual needs and social problems, because they may want us to pray for them to get a job etc.” (HCW 4)

The above responses show a range of social problems from rejection of homeless people to social problems which are the same as anybody else's. The responses also highlight that homeless people also encounter emotional and spiritual problems.

4.3.3.3. Welfare Needs

Healthcare workers unanimously agreed that homeless people needed access to money. One healthcare worker from KVC clinic stated that there is a demand from homeless people for grants.

“Well a lot of them ask, especially the 45 to 50 year old, asking for grants. The street people don’t have homes, they don’t have money, they haven’t even got a pension half of them, and we do try and send them down to get pensions, welfare.” (HCW 3)

4.4 The health seeking behaviours of homeless people in South Central Durban.

The process for eliciting the health seeking behaviours of homeless people was influenced by the 3-delays conceptual framework. Thus the health seeking behaviours of homeless were determined by:

- Establishing what prompted homeless people to seek health care. This included establishing what homeless people perceived their health status to be and why they sought health care.
- Eliciting responses from homeless people about the factors influencing when they sought care. This included comments from health workers in their observations about when homeless people sought care in relation to the severity of the presenting problem.
- Eliciting responses from homeless people about the factors influencing where they sought care.

4.4.1 Why homeless seek care?

As an introductory question homeless participants were asked what their perceptions of health were. There was a mixed response to perceptions of health, with some perceiving themselves as healthy and others as not healthy.

Reasons for not being healthy included that they did not have a permanent job and therefore they could not buy food or *“better things”* (HL 10) to enable a healthier lifestyle. Other contributing factors included:

“I would say that I have managed to keep myself in good health...but my legs, I have not been able to shower properly, and I have picked up these sores on my legs ...that’s why I came here to get them fixed up.” (HL 3)

One participant stated the need to keep well, as his family would not like to see him unhealthy.

“Yes, I see myself as a healthy person but only if I can get some few cents then I will live a normal life in my mind and in my heart. But now my problem is that I am not working. I’d like to have money one day so that I go back home, because at home they would not like seeing me like this... and I’ve never disappointed them...” (HL 1)

One homeless participant from Dalton hostel stated that he was not healthy. Only one homeless participant expressed that she had:

“never been to the clinics or hospitals.” (HL 11)

The participant went on to explain that,

“I have never been sick”,

The participant went on to explain that she keeps herself healthy by using traditional herbs and *“by sticking to good foods.”* (HL 11)

A contributing factor as to why homeless people seek health care is that of compliance.

One homeless participant explained:

“Today I’m here to collect my medication, it is my date... and today what is the date today [talking to herself] so it means I must come back next month on the 10th.” (HL 2)

Healthcare workers who responded regarding non-compliance to medication and follow up visits, gave the following reasons: stopping medication when symptoms have improved, medication stolen and no money to pay for transport to hospitals. Another factor is that of having no fixed address which further compounds the problem of non-compliance, as healthcare workers are unable to follow up care of homeless clients.

“What we have found is that a lot of times when they would not take their medication, was when other homeless friends or whatever would steal their medication... then they would not have taken their medication.” (HCW 4)

One healthcare worker further explained the choice in medication as they anticipate non-compliance,

“... so that is why sometimes you use your opinion and use your judgment that this person is not really going to take the medication but rather opt for injection rather than tablets. We do this because they do not come for the follow up. They do default.” (HCW 5)

4.4.2 When homeless people seek healthcare

In answering the question; When do homeless come to seek health care? Responses from healthcare workers ranged from homeless clients presenting with minor ailments to homeless clients presenting with major ailments.

“At what stage they come, yes they come with lots of minor aches and pains, cough, cold or a headache.” (HCW 3)

“From those we have seen a lot of them will tend to come when they are late in their illnesses...they are actually very sick ...and sick for quite some time”.
(HCW 4)

4.4.2 Where homeless people seek care.

Of the homeless participants, only one expressed that she had *“never been to the clinics or hospitals.”* (HL 11)

The remaining homeless participants stated that they had previously used a clinic and/or hospital. Responses from participants varied as to which clinics/hospitals they had attended. These ranged from accessing primary health care clinics for minor ailments to a TB clinic for treatment, and being referred to a government hospital for further treatment. These responses were confirmed by responses from healthcare workers.

“If they do come with other problems we refer them to the PHC clinic (Lancer’s Road) here by the taxi rank. The other point is that the clinic is convenient. If you look at where it is situated, it is situated right in the centre of all the taxis and transport. Everything is close by. There are a lot of clinics that are run by NGO’s.” (HCW 2)

The findings show that if the clinic is unable to deal with the health problem, there is a good referral network that health workers use.

There was a mixed response to whether homeless clients prefer urban or rural healthcare facilities. One homeless participant and one healthcare worker mentioned that clients are coming to urban clinics from rural areas:

“because there is care this side. In the farm the person with HIV positive is not taken care of.” (HL 6)

Whilst one participant described his reasons for accessing a rural clinic:

“In the clinic they are the ones who said I must go to the Dududu Clinic because that is where I come from...when I am sick I see it better to go home so that I’ll die next to my wife.”(HL 9)

4.5 Factors influencing access of healthcare by homeless people in South Central Durban.

4.5.1 Factors facilitating access

The factors facilitating access to health care identified by both homeless and healthcare workers, included: incentives to seek care, financial implications of seeking care, quality of care and accessibility of healthcare facilities.

Both healthcare workers and homeless participants responded that offering food could be an incentive for homeless clients to access healthcare facilities.

“They (those I stay with on the street) brought me to the clinic because they also come to the clinic, due to the food that is offered. So they come Monday to Friday and there is a free clinic on Thursday.” (HL P)

The healthcare workers from the Faith Based Organizations stated that a soup kitchen was run in conjunction with the healthcare facility.

“Secondly the added bonus is that there is a feeding scheme that’s run here every day. We don’t run it. The church [Durban Christian Centre] here actually runs it.” (HCW 4)

The idea of the provision of food is further reiterated by a healthcare worker from a municipal clinic:

“We used to provide them with food parcels. I think that is what attracted them to come to this clinic. But we don’t give them any more.” (HCW 5)

Another factor that could facilitate access to healthcare facilities relates to the financial implications of seeking care. How much does it cost to travel to access healthcare facilities? On reaching healthcare facilities what sum of money did the homeless need to pay for the services?

Homeless participants responded that travelling to the healthcare service did not cost them anything, as the majority walked.

“We didn’t come with money; we just walked with our feet.” (HL 1)

The amount paid to access a healthcare facility varied from R3.50 to R25.00. One participant declared *“today I don’t have money so I will walk.”* (HL 4) Another homeless participant was able to reach the healthcare service by taxi, *“It cost me R3.50.”* (HL 5)

Another homeless respondent explained, *“It depends on my health whether I decide to walk or take a taxi.”* (HL 9)

Healthcare workers elaborated further that a major reason that homeless people access their clinics, is that services offered are free. Clients attend such clinics for this very reason.

“The main thing is that we are free. I know that cost is a major factor in terms of coming here. They get a meal a day and they can come to the clinic for free. I think for us those are two things that really facilitate accessing healthcare. The second thing is that they get medication for free. Some of them live around here, some in Albert Park and so there’s no transport costs involved, so they just walk, those that are living in the area...” (HCW 4)

To obviate payment being demanded, KVC healthcare workers supply homeless clients with a referral letter.

“No, no there’s no problem especially with a referral letter from here, it open’s doors for me ... and the letter states that I don’t pay.” (HL 2)

Residents at Dalton Hostel are also furnished with a letter stating that they stay at the residence, which facilitates access to healthcare facilities.

Another factor that could facilitate access to healthcare facilities relates to the quality of care that homeless people received. Homeless participants provided positive responses concerning the service that they had received, both from clinics and from government hospitals.

“Well there’s nothing that I can say, but when I was beaten by people with a crate, I went to the hospital by the beach. They gave me the tablets. Down by the hospital they wanted R20... but I didn’t have. They said when I come back I must pay next time.” (HL 1)

[KVC] I found it very good ... I have always had good attention.” (HL 3)

Reasons why healthcare workers thought respondents reported positively about the treatment they had received at healthcare facilities:

“I think that they get a lot more tender loving care from us, and I think they become aware by word of mouth that we are very happy to talk to them and be open about their HIV status. I think that’s the big plus. The other is with the chronics. We try and stress compliancy and we hope that they do. With reinforcement we seem to get clients coming back to us. A lot of new ones come for HIV testing. We then refer, but they are happy to bring us their results.” (HCW P)

Another reason could relate to the greater resources available to health care facilities in the urban areas vis-à-vis rural areas.

“Sometimes people came from Eastern Cape, visiting their relatives in Cato Crest, and these people when they come, come with long term sicknesses, hoping to get better assistance from the urban clinic. The clinic offers many resources. This could be a reason as to why clients are coming.” (HCW 1)

Homeless participants also gave negative responses concerning the services encountered.

“I have to wait. I know that they are very busy here and I sit and wait...” (HL 3)

“This clinic [KVC] is much better than Cato Crest.... They are treating us bad there... I got a better treatment.” (HL 4)

Another factor that could facilitate access to healthcare facilities is how geographically accessible healthcare facilities are.

Half of the homeless participants described the distance travelled to healthcare facilities as “near” and that the time taken to travel was between 20-30 minutes.

“It’s not that far, but it takes half an hour to get there [clinic].” (HL P)

The distance travelled was reinforced by a healthcare worker:

“The clinic is easily accessible to Cato Crest, as clients walk.” (HCW 1)

The remaining half of the homeless participants stated that walking to healthcare facilities could take up to an hour. Two homeless respondents also mentioned that it also depended on their health as to how far and fast they could walk. A homeless participant mentioned:

“It is far... you see as I will leave now I will get there about 12 [approximately 2 hours].” (HL 4)

To ascertain the process followed by homeless clients in choosing KVC healthcare facility the question was posed to them about how they came to use the health facility (KVC).

Homeless participants' responses ranged from, being told by a friend, to a sister, to *"a certain lady that I attend church with."* (HL 5)

"Those I stay with on the streets told me about this clinic. I didn't know about it." (HL P)

A homeless participant responded that it was the food being served that enticed him to come and join the queue.

"Well me and my friends were passing by then we saw that people were given food, then we entered. When we were in we find out that there is a clinic." (HL 7)

4.5.2 Factors hindering access

The categories of factors identified by both homeless and healthcare worker participants were: types of healthcare services available at facilities, problems encountered at healthcare facilities, problems with money and identification documentations and discrimination.

A healthcare worker participant mentioned that the ideal healthcare facility would contain all services available:

"... the facility, they would have everything at one place...which is where we have a bit of a drawback because we don't provide ARV's...but if I can get everything I need at one place it saves me having to go from x to y to z." (HCW 4)

Homeless participants lamented the long waiting time at healthcare facilities. One homeless participant described such an experience, despite his earnest effort to arrive early (five o'clock) to ensure his priority status in the queue.

"I've been to Addington Hospital I find that I have to wait, wait, wait sometimes the whole day and they can't see me because they are too busy...I have to wait to see a doctor/ sister and sometimes they are just so busy that I do not get seen that day...." (HL 3)

Another homeless participant described her experience when she arrived at lunch time (approx 12.00):

"I went to the clinic next to Chesterville rank, but I could not be attended as I was told I came late. The nurse told me to be early if I want to be attended." (HL 7)

Another problem encountered at healthcare facilities concerned the receiving of medication. A participant commented:

"Sometimes if I go there they do not give me the tablets ... they say that they are finished." (HL 4)

Another problem identified by healthcare worker participants concerned the lack of money:

"Money...half the time they can't get to wherever we want to send them.... for instance at one stage Wentworth would give ARV's, but they can't afford to get to Wentworth. If you haven't got any money how are you going to get to Wentworth?"(HCW 3)

Healthcare workers reiterated that besides the need of money for transport to other healthcare facilities that provide ARV's, clients also require identification and a fixed permanent address.

“This is a great problem for us referring for ARV, is that the clients have to have an ID [identity document], they have to have a buddy to go with them...this is a big factor... they have to have a permanent address. As most of our clients don’t have a permanent address, they are sleeping under the bushes.” (HCW P)

Possession of an identification document also poses problems in obtaining grants and pensions, as illustrated by one healthcare worker:

“Many of them don’t have IDs and then this presents a problem. If they haven’t got IDs... if they haven’t got an ID book they usually don’t have a birth certificate either... they have to access a birth certificate and that sometimes is a problem when they are at death’s door...” (HCW 3)

The issue of healthcare for non-South African citizens was raised by one healthcare worker participant:

“If they are from another country like Malawi, they are not considered South African residents and they will not attend to them. So they are chased away.” (HCW P)

One healthcare worker offered a possible reason hindering access to healthcare by homeless people as that of discrimination against homeless clients by healthcare workers.

“Just depends on the staff that you have... because a lot of the time people don’t want to go to other facilities because the staff are unfriendly, or the staff don’t provide an atmosphere that is non- discriminating.” (HCW 4)

The problem of discrimination was reiterated by a few homeless participants,

“... They [KVC] giving me a better service, I wish that they can always be like this.... Well it can sometimes happen that there are those individuals on a bad mood but its not like us (black)...people say hey hey hey... these things that live on the road...hey they are so full of nonsense....how would you feel if people say that to you?” (HL 2)

4.6 Recommendations of respondents regarding care for homeless people in South Central Durban.

Recommendations identified by both homeless and healthcare worker participants included: assistance with obtaining identity documents, accommodation, food parcels, clothing and shoes, employment and grants. There were further recommendations proposed on the management of health problems experienced by homeless people.

There were suggestions from both healthcare workers and homeless participants that there should be assistance in obtaining identification documents:

“And also if they don’t have ID then they can’t even access their disability grant, poor grants or even their old age pension.” (HCW P)

Another recommendation from both homeless participants and healthcare workers was that shelter for the homeless should be available.

“We had HIV folk who have already gone into the AIDS state who are sleeping down at Maydon Wharf and they have no where to go. And we have had people dying on the streets. And that is so unacceptable...it really is. We need somewhere where we can refer people, especially in their last days, so that they can be comfortable.” (HCW P)

When the researcher and assistant went to Dalton Hostel it was noted that the hostel was full and that there was a long waiting list for potential residents.

Homeless participants and healthcare workers were unanimous in the suggestion for the provision of food parcels. One healthcare worker suggested:

“Food parcels are given to TB patients when available... I feel that these parcels should also be given to HIV + and those who are really hungry and malnourished.” (HCW 2)

Homeless and healthcare workers also suggested:

“Clothing to make them look as human beings. This clinic receives clothing for children and they give to the vulnerable ones. Soap so that they’ll look after their personal hygiene, to be accepted by society.” (HCW 5)

Homeless participants suggested employment so that *“I’ll keep on and survive”* (HL 7). This suggestion is confirmed by a healthcare worker, however she cautioned:

“... We must be careful that we don’t want to develop a dependent society – people need employment. Even the government grants are not enough, how can you feed a family on a government grant?” (HCW 2)

The research assistant wrote in her field notes reflections of the same interview:

“The healthcare worker feels that young ones are purposely defaulting on their TB treatment, for government grant purposes. This has been picked up on her statistics looking at the age of defaulting clients. The young ones ask about

the social grant and can they get a letter to take to social welfare” (20th August 2007).

Suggestions from residents at Dalton Hostel included the provision of a health service at the hostel and to attend to the overcrowding. All participants requested a clinic at the hostel or for a permanent healthcare worker to be appointed, to be able to deal with emergencies.

“There are a lot of women that get ill, and others are seriously ill.” (HL 9)

“Because sometimes people get sick at night or injured and the need for first aid.” (HL 8)

The same participant further explained that when an ambulance is called for a sickness or an injury, residents often have a long wait. One participant reinforced the need for a clinic as her concern is for the newborn babies that:

“get sick and mother do not have money, and then the babies get seriously ill.” (HL 11)

Homeless hostel dweller participants mentioned that overcrowding is a big problem. They were concerned regarding the lack of hygiene, and the risk of contracting communicable diseases.

The category of managing health problems of homeless people was further divided into sub-categories, as identified by both homeless and healthcare worker participants. The sub-categories identified were equity, accessibility, affordability and empowerment.

Equity

During the time period of data collection for this research, healthcare worker participants were not able to state how many homeless people were to be

found in the research setting. One of the suggestions from a healthcare worker participant is that there:

“should be a register of homeless people.” (HCW 2)

By keeping a register one can know how many homeless people there are and make plans for providing health care. The healthcare worker participant further elaborated:

“I think that there is a major gap in managing the homeless, if you compare with other parts of the world, obviously the homeless need to be monitored on a regular basis for TB, drug abuse.” (HCW 2)

Accessibility

Healthcare worker participants and one homeless participant suggested better access for ARV's for homeless people. One healthcare worker participant suggested:

“I think that it would be good if we had some government intervention regarding ARV treatment.” (HCW P)

A suggestion from a healthcare worker that one way of providing healthcare and ARV's for homeless people could be by providing:

“a mobile clinic providing health services for homeless people.” (HCW 5)

Affordability

Currently, if you are homeless, healthcare at government health services is free/ reduced. However homeless clients still have to produce identification documents and proof of unemployment. There are also the hidden costs e.g. transport. One healthcare worker participant described:

“limitations/ barriers for people to access healthcare, whilst most government clinics don’t charge, if you go to hospital there is a minimal fee that you have to pay ...do we have the facilities to be able to say, that people who are homeless, that we waiver that.” (HCW 4)

Availability

A healthcare worker explained the factors which do not make these services available:

“A lot of the time, the government clinics if you are not there by a certain time... you just don’t get seen. Like here at the Chest clinic you have to be here by eight o’clock or else you will not be seen for that day.” (HCW 4)

“.... Is it possible for us to have 24-hr clinics? You can look and see are there enough clinics in the area? If there are clinics, are the clinics big enough to accommodate the population of the area, and do they have the staff?” (HCW 4)

Empowerment

A healthcare worker participant asked the question:

“What is government doing to get homeless people off the streets?” (HCW 4)

The participant then went on to make some strong suggestions to empower the homeless. The first suggestion involves that of education, as none of the homeless participants interviewed had completed their Matric. ABET should be involved to allow people to finish their education. This suggestion was also made by a homeless participant. The healthcare worker participant further elaborated that education will empower homeless people and

“get people economically viable.” (HCW 4)

“a better environment will improve health.” (HCW 4)

Further suggestions included empowerment programmes on becoming economically sustainable for homeless people, and preventative health education programmes.

“There is not a lot of initiative in terms of health seeking behaviour, therefore they come and see you later rather than earlier...not much in terms of preventative work for the homeless e.g. HIV, TB. Preventative programmes are available on the TV, radio and newspapers which does not reach the homeless.” (HCW 4)

The suggestion was reiterated by a homeless participant who requested for health education programmes, as this participant shares a thirty two bedded room and is very concerned about contracting TB.

“Other people when they come to stay with us, you see a person being healthy but as time goes on she loses weight and gets seriously ill.” (HL 10)

In conclusion a healthcare worker participant emphatically stated that:

“We don’t have enough information and hopefully this study will facilitate this information.” (HCW 2)

4.7. Summary of Chapter

This chapter describes the findings which have answered the five objectives of the study. In order to obtain a clearer understanding of the relationship between health seeking behaviours of homeless people and access to healthcare facilities, these results need to be put into the wider context of the existing literature, and subjected to further discussion and interpretation.

CHAPTER FIVE

DISCUSSION OF THE RESULTS

5.1 Introduction

The results in Chapter Four are discussed according to the objectives of the study and compared against previous research and literature, in the context of the conceptual framework. New areas of exploration are identified and presented.

5.2 The participants

The sample used in this study was heterogeneous. Responses were obtained from both homeless participants and healthcare workers. Amongst the homeless participants the different demographic factors identified included: sex, race, geographical origin and reasons for migration. The study included homeless participants from equal numbers of both sexes and included a range of ages. The findings seemed to suggest that older homeless females were more vulnerable to sexual abuse and assault. Older homeless people may have better access to social grants particularly the state pension. The generalisability of these findings would need to be tested through a larger, representative quantitative study.

All healthcare workers were female. Due to the nature of the questions posed to the healthcare workers, the researcher is of the opinion that the same responses would have been generated by male healthcare workers and thus a gender perspective did not seem to be an important analytical consideration.

5.3 The healthcare needs of homeless people in South Central Durban.

The findings presented common observed health problems which were experienced globally by homeless people. From the data obtained from the 2006 register at KVC it was observed that the percentage attendances of male and female homeless were the same. A large majority of these attendances were repeat attendances. This demonstrated relatively good treatment compliance of patients that attend the KVC. By homeless participants demonstrating good follow up attendances, this in turn shows a good level of awareness of health and health problems. The data also shows that homeless attendances are referred for further management. The scope of the study did not extend to verify whether referrals actually took place.

The researcher was unable to access treatment compliance and continuity of care at municipal and provincial health facilities as these facilities did not keep a record of which patients were homeless. From the findings, a healthcare service that is user friendly for homeless people, such as the services offered by the FBO's, can promote continuity of care and reduce non-compliance with treatment, especially given that the incentives provided by the clinic attract patients.

The findings indicated that a common complaint described by homeless participants was that of general malaise. Homeless participants described suffering from non-communicable diseases, communicable diseases and injuries due to trauma. Non-communicable diseases included diabetes, hypertension and gynaecological conditions. Communicable diseases included TB, HIV/AIDS and STI's. Conditions due to trauma included foot trauma and violence. These conditions are also reported in Turner (2001:99), Wright & Tompkins (2006:286-269), Wiecha et al (1991:368), Roberts (2003:37), National Health Care for the Homeless Council (2008:1), Hwang et al (2005:313), Riley (2003:475), Manfellotto (2002:77) and Shiner (1999:526).

For example the prevalence of foot trauma is supported by Wright & Tompkins (2006:268) who ascribe foot trauma experienced by homeless people to wearing inappropriate shoes together with walking long distances. Perry & Potter (2005:50-51), Olufemi (1999:484) concur that the lack of resources available to homeless people exacerbate chronic health problems.

Homeless participants described accessing specific healthcare facilities for the treatment of TB and STI's. One of the homeless participants mentioned the names of the medication that she was taking, demonstrating awareness of the health problem and the required treatment.

The findings showed that a minority of homeless participants acknowledge that they are suffering from HIV/ AIDS. This finding is of important value as it shows that some of the homeless participants are aware of the clinical manifestations of HIV/ AIDS and shows acknowledgement that they have this infection. Furthermore the participants who were HIV infected talked to the research assistant about their illness, without the fear of stigmatisation.

All homeless participants in the study, when asked about their health problems, also stated their basic needs e.g. shelter, ablution facilities and food for survival. This finding supports the WHO definition of health, as being a "state of physical, mental and social well-being not merely the absence of disease or infirmity" (Green, 1999:7).

Homeless participants in this study revealed a lack of security and safety, as they are not always able to find a safe place to sleep. They attributed their "nomadic" lifestyle to ongoing threats to safety and security, in that, if they sleep in the same place night after night, they are vulnerable to attacks, exploitation and victimisation, including from the police. This is supported in research conducted by the National Health Care for the Homeless Council (2008:1-3) that asserts that people who do not have shelter are prone to attacks of violence. The National Health Care for the Homeless Council (2008:1-3) further asserts the vulnerability of homeless people and that

homeless people are in danger of being exploited and abused. Homeless participants vividly described the traumatic injuries to which they have subjected. Homeless participants reinforced their vulnerability of being exposed by refusing to sign informed consent for this study and by acknowledging that they are frightened of people.

Homeless participants described their fears and the measures that they took in order to attempt to allay these fears. A homeless participant described wearing two pairs of tights/ leggings at night to try and protect herself from being sexually abused. In her response the same participant described how homeless people sleep together so as to protect themselves. This response provides evidence to support the formation of a social network by homeless people. This finding is supported by Smith (2008:756) who described the “self-supportive networks, commonly called street families” that homeless people form.

In their description of the triple burden of disease that homeless people experience, Tabibzadeh and Liisberg (1997:288) commented that with the third burden, homeless people experience social alienation which can in turn leads to crime, alcohol abuse and prostitution. Responses from homeless participants demonstrated that not all homeless turn to crime and prostitution. By fighting for their belongings and carrying their belongings with them, the homeless demonstrate self preservation and pride in the little that they own.

In contrast to the situation faced by ‘rough sleepers’, homeless participants at Dalton Hostel experienced a degree of safety and security. The problem experienced in the Hostel is that of overcrowding. Both situations carry health risks, as described by Shiner (1995:526) “inadequate shelter and warmth, exacerbates respiratory, musculo-skeletal and skin-related conditions”. These conditions were observed in the 2006 KVC data.

Another basic need emphasised by both the homeless people and the healthcare workers, is the provision of ablution facilities that would assist

homeless people to maintain basic hygiene. The inability to find secure ablution facilities distressed homeless people, as they were fully aware of the need to keep clean, both for health reasons and in order to preserve self-pride and dignity. Homeless participants revealed themselves to be resourceful in finding ways and places to attempt to keep themselves clean. Any health intervention to improve basic hygiene in homeless people needs to take cognisance of this awareness and resourcefulness.

Access to food was a major concern for the homeless people. They are often dependant on the 'alms' of others to have this need met. This need drew them to the FBO health facilities which provided soup. They often offered their labour in exchange for food. They were dependant on other residents at the Dalton Hostel to share any left over food with them. Although in the way that this was spoken about by Respondent HL P, there may be elements of a supportive social network in place. There is doubt however, that the food obtained is sufficient to meet daily caloric and nutritional needs. Wiecha et al (1991:372) call for food assistance programmes and nutritional services for homeless people in order to "meet their dietary and nutrition-related needs".

There is consensus among homeless participants that employment is seen as a means of not only being able to provide basic needs and furthering one's life, but also to improve self esteem and sense of belonging. All the homeless participants wished for employment. Many participants had attempted some form of job in order to access some money. Seager & Tamasane (2008:24), Martins (2008:428) describe the resourcefulness of homeless people despite being homeless. In order to obtain money one homeless participant mentioned prostitution, the participant then defended women that they are still 'good' despite resorting to prostitution. By asking for money, the homeless could be seen as being dependent or, seeking a means to survive.

Responses from the homeless participants regarding welfare needs, show that there appears to be a lack of knowledge regarding accessing pensions/ grants. Riley et al (2003:476) state that homeless people commonly encounter

problems in registering for social assistance and healthcare. The findings could suggest that due to unemployment, the homeless are dependent on pension/ grants as a means of obtaining money.

Healthcare workers stated that homeless participants suffered from minor ailments, non-communicable diseases, communicable diseases and injuries due to trauma. Minor ailments included colds/ flu and aches and pains. Non-communicable diseases included diabetes, hypertension and skin conditions. Communicable diseases included scabies, TB, HIV/AIDS and STI's. Traumatic injuries occurred due to fights in shebeens.

With regard to HIV/ AIDS, a healthcare worker, explained the problems that homeless people encountered. In order to receive ARV's, patients' need to have a form of identification, need to have a fixed address and a person who will act as their support. Not all homeless people have the afore-mentioned requirements, which are imperative for acceptance into the treatment programme. The findings pose reflection concerning the care of homeless HIV positive clients. Has the client had blood samples taken for CD4 counts or viral loads? Has the client been offered access to anti-retroviral therapy? Hwang et al (1997:3) stress the "enormous effect of the AIDS epidemic on the homeless population" and further propose that the findings have serious implications both for policy makers and clinicians.

Healthcare workers reiterated similar perceived social problems as stated by the homeless participants. These needs included shelter, ablution facilities, food and unemployment. A healthcare worker offered a vivid description of homeless people who are in the terminal stages of HIV/ AIDS, sleeping outside by the harbour, as they have no where to go and die with dignity. Healthcare workers mentioned that soup kitchens are available. However do these soup kitchens provide three nutritious meals a day? Weicha et al (1997:364) stress that homeless people need improved access to nutritional food, especially in certain health problems which have a nutritional component in the treatment or cause.

Healthcare workers described similar perceived welfare problems as mentioned by the homeless participants, namely that of obtaining grants and pensions.

5.4 The health seeking behaviours of homeless people in South Central Durban.

There were mixed responses from the homeless participants regarding whether they perceived themselves as healthy. The findings showed that when asked for a definition of health, homeless participants were able to offer a holistic definition that included not only health aspects but also social and economic concerns. The findings also showed that homeless participants knew when they were not healthy. Thaddeus & Maine (1994:1096) affirm that before deciding to seek medical treatment, people need to recognise that they have a condition requiring medical attention. All participants agreed that if their circumstances were improved, then this would better their health.

Riley et al (2003:473) and Shiner (1995:526) quote the inverse care law (Mares, 1985) which states that medical care is inversely available to the need of the population. Faith Based Organisations provide special health services for homeless people, but state health facilities do not especially cater for the needs of homeless people. Wright (2000:42) stresses that the responsibility for the health of the homeless people lies firmly at global, national, state and local government's doors. These authorities need to provide adequate facilities to combat health and social problems. This study describes that there is no special provision of healthcare services for homeless people other than what the FBO's provide, which is a very limited and selective service. For major health conditions these FBO's refer patients to state services. It is uncertain how many homeless patients take up these referrals.

The findings demonstrate that homeless participants do access healthcare facilities for various communicable diseases. Collecting treatment from the TB clinic, accessing a STI clinic and seeking aid for HIV/ AIDS are examples of homeless people accessing healthcare.

All but one homeless participant had used healthcare facilities, either in rural or urban settings.

Despite suffering from higher levels of ill-health, it is heartening to hear that from the responses obtained from this study, homeless people have access to healthcare facilities, even though these findings are not generalisable as the study sample is too small. The afore-mentioned responses from homeless participants are in direct contrast with the literature. Riley et al (2003:475) state that due to barriers preventing access to primary health care facilities, many homeless people are inappropriately using Accident and Emergency services.

The responses from participants were divided as to what stage of illness homeless clients sought healthcare. Some participants mentioned that homeless clients sought care for minor ailments, whilst some participants mentioned that homeless clients sought healthcare when the illness was at an advanced stage. A reason for leaving their illness until it reaches a later stage is suggested by Shiner (1995:527) who asserts that homeless people do not consider health issues to be a priority, thus claiming low expectations of their health. Thaddeus and Maine (1994:1097) and Olufemi (1999:491) are of the opinion that those suffering from an illness may feel too ashamed of being stigmatised, so that they do not seek health care, thus contributing to the severity of the illness.

The previous mentioned suggestions might also explain reasons for non-compliance amongst homeless people. Several authors (Van der Heyden et al (2003:154), Hwang et al (2005:313), Riley et al (2003:475) and Wright & Tompkins (2006:287) caution that homeless people present with multiple

morbidity and that premature mortality and lowered life expectancy are amongst the problems known to exist in homeless populations.

5.5 The factors facilitating access to healthcare by homeless people in South Central Durban.

The majority of the homeless participants mentioned that the time spent travelling to a healthcare facility ranged from twenty minutes to two hours. Thaddeus and Maine (1994:1092) state that the further the distance, the greater the impact on the severity of the condition in which the patients arrive. Thus distance can be a disincentive which can delay an individual's choice to seek health care.

Homeless participants mentioned that the cost of catching a taxi to healthcare facilities was on average R2.50. However the majority of the homeless participants walked to the healthcare facility. The healthcare facility was on average twenty to thirty minutes walk, thus facilitating access to healthcare.

Costs incurred, either cost for receiving healthcare, cost for transport, doctor's fees, cost of medication and loss of salary whilst one is away from work seeking health care are further obstacles described by Thaddeus and Maine (1994:1094). These hidden costs could impact on the individuals' decision to seek health care. Healthcare workers stated that all healthcare facilities are free. If the homeless client needed referral to another healthcare facility, then a referral letter would ensure that the homeless client would not have to pay.

The majority of the homeless participants stated that they had received good service from the healthcare facilities that they had attended. These findings concur with Thaddeus & Maine (1994:1095) that the quality of care is an important consideration in the decision to seek care.

How did homeless participants know which healthcare facilities to use? One of Anderson's (2007) enabling factors of the Health Care Utilisation model is that of a social network. The formation of a social network amongst homeless people is supported by Smith (2008:756). The use of a social network along with togetherness can be seen in homeless participants' responses when searching for food, healthcare and in protecting each other. The homeless participants responded that they were all told by someone else. In the third level of Maslow's hierarchy, this social network could be seen as having a supportive homeless family. One homeless participant responded that it was food being served that enticed him to come and join the queue.

5.6 The factors hindering access to healthcare by homeless people in South Central Durban.

Literature suggests that homeless people are subjected to discrimination and marginalisation (Wright & Tompkins, 2006:289, Seager & Tamasane, 2008:24). A minority of homeless participants did describe negative experiences of long waiting time and bad service received. Responses from healthcare workers and homeless participants suggested that discrimination towards homeless people could also be a factor which could prevent homeless clients seeking health care. This is supported by Thaddeus and Maine (1994:1096) who make mention of negative experiences due to staff attitudes.

Both of the above suggestions are reiterated by The World Health Report (2000) Health Systems: Improving Performance (WHO, 2000: xii) which among the many discrepancies in healthcare available for the poor has also identified less prompt attention and being treated with less respect for homeless peoples' dignity.

A problem voiced by homeless participants is that of lack of medication. This is supported by Thaddeus and Maine (1994:1102) who describe in the third phase of the three delays model, delays in receiving adequate treatment at

the healthcare facility, namely lack of medication which could further delay the clients' recovery.

Another problem encountered by the healthcare worker participants is that of homeless clients not having a fixed address, thus hindering healthcare workers in following up of compliance in medication, especially TB medication. Sleeping and shelter are two of the needs identified in the physiological level of Maslow's hierarchy (1943).

A healthcare worker challenged what healthcare facilities are available for non-South African citizens. Manfellotto (2002:70) describes that Italy has introduced a very pro-active approach towards health care for the homeless. In 1999 a Presidential decree 394/ 1999 was promulgated that all foreign citizens whether legally in Italy or not, have unrestricted access to preventive, curative and rehabilitative health care under the National Health System.

5.7 Recommendations of respondents regarding care for homeless people in South Central Durban.

5.7.1 Recommendations by Homeless people

The majority of the homeless participants stated that they would like employment. Homeless participants recommended that there should be additional facilities for homeless people to access ID documents. With such documentation homeless people can apply for grants and pensions. With access to grants, homeless people will be able to meet their basic needs. This is supported by the WHO European Report (2002: 50) that stresses that one main important point in improving health is to reduce socio-economic inequalities.

Provision of accommodation, food parcels, shoes and clothing is another recommendation proposed by homeless participants. The above are all examples of the physiological needs described in Maslow's hierarchy (1943).

All homeless participants from Dalton hostel requested a permanent health care facility / healthcare worker to be situated at the hostel. The notion of providing healthcare workers for consistent daily healthcare is supported by Riley et al (2003:476). The same participants also confirmed that they were concerned about the overcrowding at the hostel.

5.7.2 Healthcare worker recommendations

Healthcare workers recommended that there should be additional facilities for homeless people to access ID documents following which homeless people can apply for grants and pensions. One healthcare worker however cautioned that “we” do not want to develop a dependent society. This is a controversial discussion; however there must be provision of basic needs.

Provision of accommodation is another recommendation proposed by healthcare workers, along with food parcels.

A suggestion from one healthcare worker was to have many health services available at the healthcare facility, to prevent clients having to go to other facilities for health care. This opinion is confirmed by the National Health Care for Homeless Council in America (2008:1-3) who strongly advocates for the creation of a single health system that provides the homeless access to a high quality comprehensive health care.

The researcher has divided recommendations from healthcare workers according to some of the principles of Primary Health Care (Denhill, King & Swanepoel, 1999:6).

Equity

A register with all homeless people found in the area be compiled. Once we know how small or big the problem of homelessness is, then plans can be put in place to provide promotive, preventive and curative and rehabilitative health

care for homeless people. A register can also aid in monitoring health problems experienced by homeless people. This suggestion is already implemented by the DPMM who have a database which shows health problems that homeless present with (Manfellotto, 2002:77).

Accessibility

The provision of ARV treatment for HIV/ AIDS for homeless people appears to be problematic. Suggestions from healthcare worker participants include government intervention regarding the provision of ARV's to homeless people. Hwang et al (2005:411) strongly emphasize the formation of available coordinated treatment and support programmes for homeless people, especially for the prevention and treatment of HIV/ AIDS. These programmes must be devised to meet the specific health needs of homeless people.

Affordability

Despite fees at government healthcare facilities being free, there is still the issue of hidden costs. For example, if a homeless client is referred to another healthcare facility, does the client have enough money for transportation to the referred healthcare facility? Thaddeus and Maine (1994:1092) explain in phase two delay, that cost could be a factor that hinders an individual's ability to reach a healthcare facility.

Availability

In the research setting responses from both homeless and healthcare workers reiterated that in order to access a healthcare facility, one had to go early or one might not be seen. A suggestion from a healthcare worker participant was that of clinics being open 24 hrs/ day. Manfellotto (2002:74) describes how DPMM is open at night for the homeless to access healthcare.

Another recommendation from healthcare worker participants was to empower homeless people. Provision of education classes to enable homeless people to finish their basic education was suggested, as none of the

homeless participants interviewed had obtained their Matric. Training in Skills development and empowerment programmes to help homeless people become economically viable and also allow them to gain some dignity and self respect. This would allow them to progress to Maslow's fourth level of esteem needs. Another positive factor of employment is an improvement of health, this is supported by Van der Heyden et al, (2002:153) who state that with decreasing socioeconomic levels health expectancy also decreases.

This research study shows the self supportive networks formed by homeless people. Also shown are the various ingenious/ opportunistic measures that homeless employ in order to obtain money. McNulty (2005:11) states that traditionally efforts to improve the living conditions of the poor have adopted an approach that focuses on the communities' problems rather than the communities' strengths and assets. By harnessing these networks and ingenious ideas, the homeless community encouraged to become active participants in designing and implementing strategies to improve their living conditions and well-being. Using an asset-based approach "instils a sense of empowerment" which facilitates the community to "assume a sense of responsibility" (McNulty, 2005:13). When all the members of a community, have had a stake in the formulation and implementation of community development, the greater the likelihood that the development is sustained (McNulty, 2005:1).

Another recommendation is the provision of preventative health programmes for homeless people. In this study healthcare services appear to be curative not preventive or promotive. One healthcare worker participant suggested that by installing preventive and promotive health programmes one may see an increase in homeless people coming to seek health care at an earlier stage of illness. Manfellotto (2002:78), Hwang et al (2005:411), Riley et al (2005: 476) and Wright & Tompkins (2006:289) discuss the provision of preventive and promotive screening services in order to limit disease and to detect disease at an earlier stage before the disease progresses to a severe late stage.

In conclusion a healthcare worker participant emphatically stated that “We don’t have enough information and hopefully this study will facilitate this information.” (HCW 2). The need for research into healthcare provision for homeless people is reiterated by Wright & Tompkins (2006:291), Hwang et al (2005:412), Riley et al (2003:476) and Shiner (1995: 546).

5.8 Summary of Chapter

This chapter presented discussion from the findings of the research study. The major categories were predetermined and formulated as objectives. The sub-categories arose from responses from homeless participants and healthcare workers. Discussion from the responses of homeless and healthcare worker participants revealed basic, health, safety and security needs. Responses also described health seeking behaviours experienced by homeless people and those perceived by healthcare workers. The factors accessing and hindering access to healthcare by homeless people were also discussed. In conclusion of this chapter respondents offered recommendations to improve the care for homeless people.

CHAPTER SIX RECOMMENDATIONS AND CONCLUSION

The research generated many recommendations for policy makers, healthcare service providers, for homeless people and for future research.

6.1 Policy makers

- By having a database of homeless people the government would then see the extent of the problem of homelessness i.e. gender, race, age and urban or rural. This database can be kept jointly by the Departments of Social Services and Health.
- Using the database, government could promulgate the provision of basic resources for homeless people. Together with NGO's and FBO's government could organise the provision of basic resources for homeless people. Safe, overnight, not overcrowded, free accommodation with good, ablution facilities, together with three nutritious meals. Also the provision of family accommodation so that families would not have to be separated.
- By having a database of homeless people NGO's and FBO's could initiate basic education/ skills programmes. After attaining education and skills, NGO's and FBO's would then be able to help in attaining employment. This database could also indicate to government where social services can be provided, especially in the application and provision of grants and pensions.
- The database could also include statistics of the health of homeless people obtained from other healthcare facilities. This would aid in determining health conditions that homeless people suffer from. These statistics could then be utilised by policy makers and healthcare providers to provide medical treatment for these health conditions. The formulation and implementation of health promotion and health prevention programmes would be facilitated.
- Are we aware of the effects of the HIV/ AIDS epidemic on homeless people? Is there government policy on promotion, prevention and medical management for homeless people e.g. VCT, Blood tests CD4 and viral loads, provision of ARV's, fixed accommodation/ address so that homeless can access ARV's and follow up, identity documents/ birth certificates so that homeless people can access ARV medication, access to nutritious meals to aid in the management of HIV/ AIDS.

6.2 Healthcare providers

- By having a stable place for homeless people, health promotion and prevention programmes could be delivered and follow up appointments monitored, to help in compliance in treatment and medication.
- The researcher proposes that in the curriculum of the training of healthcare workers, inclusion of healthcare needs specific to homeless people.
- All health facilities to provide a “one stop shop” where all services are provided, from minor ailments to medical treatment for HIV/ AIDS. Due to extended waiting times, some facilities should be open for extended hours.
- By having a database of homeless patients accessing healthcare facilities, one could determine if patients referred to state facilities are utilising these referrals.

6.3 Homeless people

- During data collection the researcher “uncovered” social networks formed by homeless people. These social networks function by providing a safety/ security net with which, homeless people form in order to protect themselves. This collaborative action demonstrated by homeless people could be harnessed as a strength by which to empower homeless people. These social networks could be improved upon to strengthen opportunities for homeless people (asset based approach to development). Homeless people could then be part of a committee with government and NGO’s and FBO’s to aid/oversee aid to homeless people.

6.4 For future research

- The impact of HIV/ AIDS on homeless people and whether homeless people do have access to ARV treatment.

- The findings of this qualitative study could be used as the basis for a longer quantitative study. This research was conducted with a small sample of homeless participants. The researcher hopes that further research using a larger sample will be conducted, so as to greater evidence that will support or not support the findings found in this study.

6.5 Conclusion

Healthcare provision for homeless people in Durban South Africa appears to be a hit and miss effort between the state and NGO's. Emphasis is placed on curative health services whilst little emphasis is placed on health promotion and prevention. This small study describes health seeking behaviours of homeless people and their perceptions of access to healthcare services.

A number of recommendations have been suggested by the participants as well as the researcher and one hopes that these may indeed be implemented so as to provide better access to healthcare for homeless people.

REFERENCES

Biswas-Diener, R., & Diener E,D. 2006. The subjective well-being of the homeless and lessons for happiness. *Social Indicators Research* 76:185-205 [Online]. Available: <http://www.porquest.umlcom/pqdweb?index=o&did=1049420151&Srchmode> [11 August 2008].

Brink, P,J., & Wood, M, J. (1998). *Advanced design in nursing research*. 2nd ed. California: SAGE Publishers.

Burns, N., & Grove S, K. 2001. *The practice of nursing research conduct, critique and utilization*. 4th ed. Philadelphia: WB Saunders Company.

Creswell, J,W. 1998. *Qualitative inquiry and research design choosing amid five traditions*. United States of America: SAGE publications.

Dennill, K., King, L., & Swanepoel, T. 1999. *Aspects of primary health care: community health care in Southern Africa*. 2nd ed. Halfway House: International Thomson Publishing Southern Africa (Pty) Ltd.

Department of Health. White Paper for the transformation of the health system in South Africa. 1997. [Online] Available:<http://www.gov.docs.za> [21 may 2001].

Dictionary. 2009. [Online] Available www.ask.com. [13 July].

De Vos, A.S., Strydom, H., Fouche, C, B., & Delport, C.S.L. 2005. *Research at grassroots for the social sciences and human service professionals*. 3rd ed. Pretoria: Van Schaik Publishers.

Engelbrecht, C. 2005. Trustworthiness Qualitative research module. Durban: University of KwaZulu-Natal. [Course notes].

eThekwini Municipality. 2009. Homelessness. [Online] Available: <http://www.duridan.gov.za/durban/government/abms/sdb/partnerships/housing-sector.html>. [12 Jun 2009].

Green, A. 1997. *An introduction to health planning in developing countries*. 2nd ed. New York: Oxford University Press.

Hwang, S.W., Orav, J., O'Connell, J., Lebow, J.M., & Brennan, M.D. 1997. Causes of death in homeless adults in Boston. *Annals of Internal Medicine*, [Online]. 126 (8). Available: <http://www.annals.highwire.org/cgi/content/full/126/8/625> [5 May 2008].

Hwang, S.W., Tolomiczenko, G., Kouyoumdjian, F.G., & Garner, R. 2005. Interventions to improve the health of the homeless a systematic review. *American Journal of Preventive Medicine*, [Online] 29 (4). Available: <http://www.sciencedirectcom/science?-ob=ArticleURL&udi=B6VHT-4HC72VR> [24 January 2008].

Katzenellenbogen, J.M., Joubert, G., & Abdool Karim S.S. 2001. *Epidemiology a manual for South Africa*. South Africa: Oxford University Press.

Laurenson, P., & Collins, D. 2007. *Beyond punitive regulation? New Zealand local governments' responses to homelessness*. Journal compilation editorial board of Antipode, [Online] 2007. Available: <http://www.blackwell-synergy.com/doi/pdf/10.1111/j.1467-8330.2007.00545>. [1 June 2008].

Manfellotto, D. 2002. *From misinformation and ignorance to recognition and care: immigrants and homeless in Rome, Italy*. [Online] Available: <http://www.who.dk/documents/sed/10case5.pdf> [1 Apr 2004].

Martins, D. C. 2008. *Experiences of homeless people in the health care delivery system: A descriptive phenomenological study*. [Online] Available: <http://www3.interspace.wiley.com/cgi-bin/fulltext/121384882/pdf>. [12 June 2009].

McMurray-Avila, M. 2001. *Organizing health services for homeless people a practical guide*. 2nd ed. [Online] Available: <http://www.nhchc.org/publications/pagesfrom2ndedition-101901.pdf> [15 Nov 2007].

McNulty, R, H., 2005. *Using an asset-based community development approach globally beyond the developed world*. Asia-Pacific Creative Communities: a Strategy for the 21st century. [Online] Available: http://www.unescobkk.org/fileadmin/user_upload/culture/Culture_Industries/presentations/session_Two_-Robert_McNulty.pdf. [3 Nov 2008].

Musgrave Methodist Church. 2007. *Kathleen Voysey primary health care clinic*. 2nd ed. [Brochure].

National health care for the homeless council. 2008. [Online] Available:: <http://www.nhchc.org/Publications/basics-of-homelessness.html> [2 Feb 2008].

Olufemi, O. 1997. *Health of the homeless street women in South Africa*. Habitat International 23 (4) [Online] Available: <http://www.sciencedirect.com/science?ob.html> [12 Jun 2009].

Patton, M.Q. 2002. *Qualitative research & evaluation methods*. 3rd ed. United States of America: Sage Publications INC.

Potter, P.A., & Perry, A.G. 2005. *Fundamental of Nursing*. 6th ed. St Louis: Mosby.

Riley, A.J., Harding, G., Underwood, M.R., & Carter, Y. 2003. Homelessness :a problem for primary care? *Br J Gen Practice* 53 (491).

Roberts, T.M. 2003. *The objective and subjective conditions of poverty amongst the destitute and homeless population of central Durban*. Master Dissertation, University of Natal.

Seager, J., & Tamasane, T. 2008. Health and wellbeing of people living on the streets in South Africa. Conference of Health and Homeless, Oxford, 16 Sept

2008. [Online] Available: <http://www.hsrc.ac.za/Research-Publication-7565.phtml>. [12 Jun 2009].

South African Social Investment Exchange (SASIX). 2008. Basic healthcare projects. [Online] Available: <http://www.sasix.co.za/projects/index/?sector=BH>. [21 August 2008].

Shiner, M. 1995. Adding insult to injury homelessness and health service use. *Sociology of Health and Illness*, [Online] 17 (4). Available: <http://www.blackwell-synergy.com/production/shill/1995/17/6.html> [21 Mar 2006].

Sim, J. & Wright, C. 2002. *Research in health care concepts, designs and methods*. United Kingdom: Nelson Thornes.

Smith, H. 2008. Searching for kinship: The creation of street families among homeless youth. *American Behavioural Scientist* 51;756 [Online]. Available: <http://www.abs.sagepub.com/cgi/content/abstracts/51/6/756>. [29 May 2008].

Stein, J. A., Andersen, R., & Gelberg, L. 2007. Applying the Gelberg-Andersen behavioural model for vulnerable populations to health service utilization in homeless women. *J Health Psychol*, [Online]. 12, 791. Available: <http://www.sagepublications.com> [1 Apr 2008].

Tabibzadeh, I. & Liisberg, E. 1997. Response of health systems to urbanization in developing countries. *World Health Forum* (16).

Thaddeus, S. & Maine, D. 1994. Too far too walk: Maternal mortality in context. *Soc. Sci Med* 38 (8).

Turner, S. 2001. Primary health care in homeless shelters in Poland.
Available:<http://www.euro.who.int/SocioEconomicDeterminants/case/20030212-7> [1 Apr 2004].

Ulin, P.R., Robinson, E.T., Tolley, E.E., & McNeill, E.T. 2002. *Qualitative methods a field guide for applied research in sexual and reproductive health*. USA: Family Health International.

Van den Heyden, J.H.A, Demarest, S. Tafforeau, J. & Van Oyen, H. 2003. Socio-economic differences in the utilization of health services in Belgium. *Health Policy* 65 (2), p.153 -165.

World Health Organization. 2000. *The world health report: Health systems: Improving performance*. Geneva: World Health Organization

World Health Organisation Region for Europe. 2001. *Poverty and health evidence in WHO's European region*. [Online] Available: <http://www.euro.who.int/SocioEconomicDeterminants/poverty/20030128-8> [1 Apr 2004].

World Health Organisation European report links poverty to widening gaps in health. 2002. [Online] Available: <http://www.euro.who.int/eprise/main/WHO/mediacentre.html>. [18 May 2004].

World Health Organisation. 1994. Article 25 Universal declaration of human rights. [Online] Available: <http://www.hrweb.org/legal/udhr.html>. [21 August 2008].

Wiecha, J., Dwyer, J.T. & Dunn-Strohecker, M. 1991. *Nutrition and health services needs among the homeless*. [Online] Available:<http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1580272&blobtype=pdf>. [1 June 2008].

Wright, N., & Tompkins, C. 2005. *How can health care systems effectively deal with the major health needs of homeless people?* [Online] Available: <http://www.euro.who.int/Document/E85482.pdf> [29 July 2008]

Wright, N., & Tompkins, C. 2006. How can health services effectively meet the health needs of homeless people? *British Journal of General Practice*, Apr, p.286-293.

Wright, T. 2000. *Resisting homelessness: global, national and local solutions*. [Online] Available: <http://www.jstor.org/stable/2654929>. [22 May 2008].

CHAPTER ONE: INTRODUCTION

1.5 Background to the problem

Homelessness is a multifaceted and complex problem that has profound socio-economic and socio-political consequences for society. Homeless people frequently delay seeking healthcare as they are primarily concerned with meeting their own needs for shelter, food, clothing and safety.

The state of homelessness has a significant influence on the health of homeless people. Due to circumstances of inadequate shelter, poor access to food, susceptibility to communicable diseases, vulnerability to violence and injuries, homeless people suffer from a higher rate of serious morbidity and premature mortality (Wright & Tompkins, 2006:287, Olufemi, 1999:483). Homelessness is a dual-edged sword as health problems may contribute to homelessness, whilst at the same time, the condition of homelessness may

cause and exacerbate health problems (McMurray-Avila, 2001:11). Furthermore homelessness presents serious challenges to healthcare providers.

One important need of homeless people is access to healthcare. A controversial issue is whose responsibility is it to provide healthcare to homeless people? In the United States of America and the United Kingdom this responsibility is partnered between central and local governments and non-governmental organisations. In providing healthcare for homeless people, numerous targeted programmes have been implemented (Wright & Tompkins, 2005:6, Shiner, 1995:527, Hwang, Tolomiczenko and Kouyoumdjian, 2005:321, National Health Care for the Homeless Council, 2008:3, Manfellotto, 2002:73). Whilst these crucial programmes do provide some relief to homeless peoples' needs, these programmes do not prevent homelessness nor provide solutions to end homelessness (National Health Care for the Homeless Council, 2008:1).

Despite substantial international evidence which documents multiple morbidity and mortality, homeless people do have problems in obtaining adequate healthcare (Wright & Tompkins, 2006:286, Manfellotto, 2002:76, National Health Care for the Homeless Council, 2008:3, Riley, Harding, Underwood & Carter, 2003:474, Hwang et al, 2005:314, Van der Heyden et al, 2003:155, Wiecha, Dwyer & Dunn-Strohecker, 1991:368). Are the healthcare services provided adequate for homeless people? The inverse care law proposed by Tudor Hart (1965), cited in Riley et al (2003:473) refers to the least health utilisation by people with the greatest need. What factors hamper homeless people in accessing healthcare?

Homelessness is a broad and complex term that affects many people in South Africa. Homelessness inevitably causes serious health problems, leading to conditions that are closely associated with poverty. Homeless people have a higher morbidity rate, mortality rate and a lower life expectancy (Hwang et al, 2005:311). As a result of their complex health issues and lack of stable

housing, homeless people present with serious challenges for healthcare providers (Hwang et al, 2005:313, Van der Heyden et al, 2003:154). Thus homeless people are in desperate need for basic needs and healthcare services. Provision for these needs is promulgated in the declaration of human rights (Article 25 UN Declaration of Human Rights, 1994:4), “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family”.

There are different models of healthcare provision for homeless people. Not all public health services can meet the challenges of providing healthcare for homeless people. South Africa is one such an example. Non- profit organisations and faith based organisations play a partnering role in providing these services (Sasix, 2007:1).

The care of homeless peoples’ health is of utmost importance especially to preserving health of all citizens, for example limiting the spread of communicable diseases (Manfellotto, 2002:78, Martins, 2008:421). Communicable diseases can quickly spread to become deadly public health emergencies (National Health Care for the Homeless Council, 2008:1). Besides the costs incurred for the provision of health and the provision of basic needs, the greatest costs are “the moral and social results of the needs” of the most vulnerable people –the homeless (National Health Care for the Homeless Council, 2008:1).

As homelessness is a very broad and complex topic the researcher has narrowed the focus for the aim of the study. In the international literature it is shown that homeless people have a high incidence of drug and alcohol abuse and mental illness and that homelessness then results from serious addiction to substances and from untreated mental illness. In the South African context, homelessness results from severe socio-economic conditions, including general poverty, rural to urban migration and inadequate provision of housing. It is in this context that homeless people seek access to healthcare.

1.6 Problem statement

Homeless people encounter barriers in accessing healthcare which can impact in a delay in receiving healthcare. These multiple barriers include lack of finances, cultural barriers due to marginalisation and barriers due to a lack of comprehensive healthcare provision (Wright & Tompkins, 2005:4). These barriers could result in a delay in deciding to seek healthcare, a delay in reaching a healthcare facility or a delay in receiving adequate healthcare (Thaddeaus & Maine, 1994:1092).

In South Africa, healthcare for homeless people is provided by governmental health services and non-governmental organisations (Seager & Tamasane 2008: 24, Olufemi, 1999:488). However homeless people are just part of the general clinic population and if there are special needs related to being homeless these are not necessarily catered for. Due to a number of homeless people seen in the Berea/ Musgrave suburbs in Durban, a soup kitchen was formed at the Berea Presbyterian Church, a central accessible venue, to provide a morning meal. Currently between one hundred to one hundred and fifty homeless people are given soup on a daily basis. At observing the health needs of homeless people who came to the soup kitchen, the ministers of the churches involved in the feeding scheme suggested a free primary health clinic should be established. The Kathleen Voysey Primary Health Care clinic (KVC) was started in 1997 as an outreach programme of the Musgrave Methodist Church, Durban. The clinic is open one morning a week and comprises doctors and nurses. The medical team provides promotive and curative primary healthcare. It was envisaged by the ministers of the participating churches that the time span of the clinic would not last long, as public health services were offering health services for the homeless for free. Over the ten years that the clinic has been operational, the number of attendees (the majority homeless people) has been increasing from fifteen clients per morning to seventy clients per morning (Kathleen Voysey primary health care clinic brochure, 2007: ii).

The researcher queried as to why the increased need for the services as provided by the KVC? It is for this reason that the researcher decided to explore the health seeking behaviours and experiences of homeless people.

1.7 Purpose of the study

This study aims to describe the experiences relating to the healthcare seeking behaviours of homeless people in South Central Durban. The researcher aims to increase awareness about the health, and access to healthcare, of homeless people.

1.8 Specific objectives of the research

- 6) To describe the health care needs of homeless people in South Central Durban.
- 7) To describe the experiences relating to the health seeking behaviours of homeless people in South Central Durban.
- 8) To describe factors facilitating access to health care by homeless people in South Central Durban.
- 9) To describe factors influencing access to health care by homeless people in South Central Durban.
- 10) To make recommendations to the Kathleen Voysey Primary Health Clinic and other health services regarding health care services for the homeless in South Central Durban.

Based on the above research objectives, the following questions formed the basis of this study:

1.5 Research Questions

What are the healthcare needs of homeless people?

- 6) What are the perceived health care needs of homeless people?
- 7) What are the felt needs of homeless people?
- 8) What are the observed needs of homeless people?

What are the health seeking behaviours of homeless people?

- 4) What influences the decision by homeless people to seek health care? i.e. Why do they seek care?
- 5) What influences the decision by homeless people of when to seek health care?
- 6) What influences the decision by homeless people of where to seek health care?

What are the factors influencing access by homeless people?

- 10) What are the factors that facilitate the seeking of health care by homeless people?
- 11) What are the factors that hinder the seeking of health care by homeless people?

1.6 The significance of the study

For this research the researcher primarily used a qualitative methodology with a small quantitative component. The qualitative component comprised one on one in-depth interviews. The quantitative component comprised a record review showing frequency distribution of health problems experienced by homeless people presenting at the Kathleen Voysey clinic.

One of the main reasons that the researcher chose this area to research is that she could not obtain information on the provision of healthcare for the homeless in South Africa, particularly Durban. The researcher was of the considered opinion that the research produced will be of benefit, not only by highlighting the plight of the homeless, but also by providing information and statistics for the eThekweni Health Department for the provision of healthcare to this hitherto neglected segment of the population.

The research will identify areas of further investigation and will propose different models and policy changes required to improve healthcare provision for homeless people.

1.8 Operational concepts / Definition of terms

These definitions have been included so as to define some of the core concepts under investigation in this study.

Homeless

A complex concept embracing states of rooflessness, houselessness, living in insecure accommodation, or living in inadequate accommodation (Wright & Tompkins, 2006:5).

Need

A condition or situation in which something is required or wanted by someone (www.ask.com).

Felt Need

These conditions/ needs are experienced and verbalised by homeless participants.

Observed Need

These conditions/ needs are seen/ witnessed by healthcare workers

Perceived Need

These conditions/ needs are assumptions made by healthcare workers after observing needs of homeless people. The perceived needs by healthcare workers may or may not be felt by homeless people.

Experience

An event or series of events that one has lived through or participated.

Faith Based Organisation

A voluntary group sponsored by a church/ religious organisation which provides free charity work. These organisations are also non-profit organisations.

Health

Health as defined by WHO “ a state of complete mental, physical and social well being and not merely the absence of disease or infirmity” (Green, 1997:44).

Healthcare worker

A professional person either a doctor or a registered nurse working in a primary healthcare setting.

Health seeking behaviour

This is the behaviour that a person displays in the conscious effort to promotes one’s optimum wellness, medical treatment for an ailment / illness and rehabilitation (www.ask.com –medical dictionary).

Access to health

This is when a person actively seeks for a healthcare service.

South Central Durban

This area is south of central Durban and includes the suburbs Congella (Berea South), Berea, Mayville (Bellair) and Cato Manor (Bellair).

1.8 Overview of how research report is structured

Chapter one introduces the background to the problem; this is then followed by the problem statement, purpose of the study, objectives and research questions and significance of the study. The operational concepts describe the terms used in this study. In chapter two, literature concerning the definition and causes of homelessness is discussed. The needs of homeless people together with health problems that homeless people encounter are highlighted. The provision and utilisation of healthcare services is then described together with the conceptual framework underpinning the research. Chapter three describes the methodology used

in the research process. Chapter four presents the findings of the study. Chapter five presents a discussion of the results. Chapter six offers recommendations that have arisen from the study.

CHAPTER TWO: LITERATURE REVIEW

2.2 Purpose of the literature review

This chapter explores issues around the needs of homeless people, with special reference to their health needs. This chapter also looks at poverty, the triple burden of disease that homeless people suffer as well as the provision of health care for homeless people.

2.2 Scope of literature review

Five sources were used in the literature search. These were:

- 6) Printed materials such as journals and books. This entailed a hand search of the Lancet, World Health Forum and Health Policy journals at the Medical School and the Howard College libraries at the University of KwaZulu-Natal.
 - 7) References obtained from the reference list at the end of journal articles.
 - 8) Electronic databases: Pub Med, Google-scholar, CINAHL.
 - 9) International health related websites such as that of the World Health Organisation.
 - 10) Policy document: Department of Health 'The white paper for the transformation of the health system in South Africa' (1997)
- The search words used in retrieving relevant material include: homeless, healthcare for homeless, health services for homeless.

The Harvard referencing system has been used throughout this document.

2.2.1 Definition of Homelessness

The World Health Organisation (2005) defines homelessness as “a complex concept embracing states of rooflessness, houselessness, living in insecure accommodation, or living in inadequate accommodation” (Wright & Tompkins, 2005:5). Seager & Tamasane (2008:4) define people who sleep in the open, one or more nights per week as absolute homelessness. Shiner (1995:526) further describes different living conditions as constituting homelessness; some homeless people live on the road and are known as “rough sleepers”, other homeless people live in shelters which provide short term accommodation. At these shelters the facilities provided are minimal.

Homelessness is not confined to a total lack of shelter. For many children and young people it signifies a state of detachment from the family and results in vulnerability to potential dangers, including exploitation and abuse, from which the family normally insulates the child (Smith, 2008:756).

2.2.3 Factors contributing to Homelessness

There is no single cause of homelessness. Wright & Tompkins (2006:286-293) have identified risk factors which may lead to one becoming homeless. These factors include: breakdown of relationships, physical or sexual abuse, lack of qualifications, unemployment, alcohol and /or drug misuse, mental health problems, contact with the criminal justice system, debt, lack of a social support network, institutionalisation as children and death of a parent during childhood. For many of these, it is difficult to identify the cause versus the consequence of homelessness. For example, Biswas-Diener & Diener (2006:186) question whether depression and alcohol abuse are causes or effects of homelessness. Laurenson & Collins (2007:654) suggest that deinstitutionalisation of mentally ill people in the United Kingdom and the United States of America has also contributed to homelessness. Wiecha, et al (1991:365) also state this as a cause and suggest that homelessness is

exacerbated by not providing those deinstitutionalised with adequate community-based care. Homelessness would also exacerbate mental illness.

Additional causes of homelessness include an inadequate supply of affordable housing, lack of social support systems and job losses to disabilities (Wiecha et al 1991:365; Wright 2000:29; Olufemi 1999:484). Olufemi (1999: 485) further elaborates that the 1997 study on the health of homeless women in South Africa, indicated that poverty and unemployment constitute the major causes of homelessness.

Tabibzadeh & Liisberg (1997:298) and eThekweni Municipality (2009) discuss urbanisation as a factor contributing to homelessness. Tabibzadeh & Liisberg (1997:298) describe the push and pull dynamics which lead to urban migration. Once rural migrants and illegal immigrants have arrived in the “asphalt jungle” they find that the prevailing conditions are far from favourable. “Poor, unemployed, illiterate and malnourished”, the migrants of necessity are forced to squat in makeshift shacks built on “land unsuitable for human settlements” which lack any access to essential services. These unfavourable conditions lead to disease and hopelessness (Tabibzadeh & Liisberg, 1997:267). This is evidenced in Italy and Poland as Manfellotto (2002:70) and Turner (2001:96) describe, with illegal immigrants to Italy and Poland using both countries as stepping-stones into Europe.

2.2.3 Needs of Homeless People

What specific needs do homeless people have? Potter & Perry (2005:50-51) define the very basic needs of all people as food, shelter and clothing and water. Maslow (1943) in Potter & Perry (2005) further divided these and other needs into five levels. The lowest level, physiological needs consist of eating, drinking, sleeping shelter and warmth. The next level, safety needs, comprise of a certain acceptable level of personal security from crime, health and well being. The third level, love/belonging/social needs, embraces such personal aspects as friendship and having a supportive and communicative family. The

fourth level comprises of esteem needs and possessing self esteem, self respect and respect for others. The fifth level, self actualisation refers to the state where humans are able to make the “most of their abilities and strive to be the best that they can be” (Potter & Perry, 2005:66). Maslow (1943) proposed that once the more basic needs are met, the individual can progress to higher levels.

How do homeless people fit into Maslow’s (1943) theory of needs? In the first level, the majority of homeless people do not have their physiological needs met. Wright (2007:28) states that one of the main causes of homelessness is the lack of accommodation. Seager & Tamasane (2008: 3) state that of the homeless people that participated in the study 56.4% mentioned that they slept on the streets (Sager & Tamasane, 2008:4). A number of studies have attributed lack of shelter and warmth to the increase and/ or the exacerbation of illnesses amongst homeless people (Shiner, 1997:526). Do homeless people source enough food? Wiecha et al (1991:365) state that homeless people do not have enough income to source food. Food is sourced either from soup kitchens or rummaging in rubbish. The result is that homeless people “sometimes or often consume inadequate amounts of food” (Wiecha et al, 1991:367).

For homeless people, safety is threatened. Hwang, Orav, O’Connell, Lebow & Brennan (1997:625) state that homicide was the leading cause of death amongst homeless people aged 25 to 44 years of age. Wright & Tompkins (2006:287) state that homeless men have high rates of committing offences and imprisonment as well as being victims of crime. Due to social and economic differences homeless women are more vulnerable to domestic violence, rape and muggings, which sometimes results in loss of life (Olufemi, 1999: 482).

Wright (2000:27) reinforces that homeless people do not have an adequate income or employment. Biswas-Diener & Diener (2006:186) refer to a larger body of literature that suggests that higher income is directly related to increased longevity, better health and greater life satisfaction. Stein,

Andersen & Gelsberg (2007:792) reiterate that homeless people severely lack the “financial and non-financial resources” needed to meet their personal and healthcare needs. Wright (2000:30) emphatically states that there is a lack of proper health and social services which can “provide the solution to homelessness”.

Loss of the family support structure hinders homeless people from achieving the third level of needs (Wright 2000:30). Wright (2000:30) refers to homeless people being hindered by “personal limitations”. These limitations include mental illness, substance abuse along with the inability to sustain relationships, which affects homeless peoples’ self esteem. This is further compounded by the negative social perceptions of homeless people as they often are referred as “hobos, tramps or bums” (Wright, 2000:30). Biswas-Diener & Diener (2006:202) reinforce the ability to form good social relationships. These relationships are essential for well-being and may forestall “the psychological costs of material deprivation”.

Wright (2000:27) emphatically states that the increase in homelessness “reflects the deep neglect of basic human needs”.

2.2.4 Health problems related to being Homeless

The World Health Organization (WHO) European Health Report (WHO, 2002:50) identifies the following as the consequences of poverty: material deprivation, low educational achievement, poor health, vulnerability and exposure to environmental and occupational risks, along with both powerlessness and voicelessness. The report further explains that poverty deprives individuals of the freedom to satisfy hunger, to achieve sufficient nutrition, to obtain remedies for treatable illnesses or to enjoy clean water or sanitary facilities.

In her definition of homelessness, McMurray-Avila (2001:11) describes the relationship between socioeconomic factors and health. On one level, health problems very uncommonly lead to homelessness. However, the condition of

homelessness can both cause and exacerbate health problems. Stein et al (2007:792) elaborate that homeless people are “severely lacking in financial and non-financial resources” that are essential in order to meet their daily personal and health needs.

The homeless consume such sustenance as whatever is obtainable, resulting in a poor diet which easily leads to nutritional deficiencies, thereby lowering the immune system, and increasing the risk of morbidity. In its conclusion the WHO reiterates the vicious circle prevailing as regards poverty i.e. ill health and unemployment (WHO, 2002:49).

The condition of homelessness and the concomitant poverty lie at the root of many of the health problems experienced by homeless people. Such health problems that have been documented include tuberculosis, HIV/AIDS, malnutrition, severe dental disease, alcoholism, mental illnesses, diabetes mellitus and hypertension. This reflects only partially the dimensions thereof. People without shelter are also prone to parasitic infestation, frostbite, infections and violence (National Health Care for the Homeless Council, 2008:1).

Homelessness also severely complicates delivery of health services. Shiner (1995:526) and Riley et al (2003:473) describe the inverse care law as proposed by Tudor Hart (1971), which states that “the availability of good medical care tends to vary inversely with the need for it in the population served”. Due to lack of access to healthcare, both acute and chronic health problems may go undetected and untreated. This may lead to severe medical complications (McMurray-Avila, 2001:1).

Homeless people are confronted with the reality of poverty; one of the consequences of poverty is poor nutrition. Homeless people lack the financial means to purchase nutritious food, a safe storage place for foodstuffs, along with inadequate facilities for preparing meals (Wiecha et al, 1991:365). The aforementioned factors together further compound health related problems relating to nutritional deficiencies experienced by homeless people. One of

the main modalities in the management of chronic diseases is the control of the diet consumed; due to poor nutrition, homeless people are not able to access the necessary diet in order to control the chronic disease (Wiecha et al, 1991:365, Martins, 2008:426). Health problems commonly prevailing amongst homeless people possessing a nutritional component either in the etiology or management of the health problem include the following; alcoholism, anaemia, dental problems, gastric ulcers, cardiovascular disease, hypertension, tuberculosis, acute and chronic infections, malnutrition and acquired immunodeficiency syndrome (Wiecha et al, 1991:368).

Tabibzadeh and Liisberg (1997:287) describe the “triple burden of disease” that homeless clients suffer from. The first burden of disease relates to poverty, lack of water and sanitation, sub standard housing, overcrowding and the resulting increase in communicable diseases. This is affirmed in the European Health Report 2002 (WHO, 2002:33) which states that the biggest factor associated with communicable diseases remains poverty. The report advocates for the reduction of poverty by European countries as a public health priority. The second burden includes ill health due to changes in living conditions. Examples hereof include diseases due to air pollution, smoking, mental and psychosomatic disorders related to stress. The third burden looks at social instability and cultural and social alienation. These factors can lead to a sense of helplessness developing, which in turn may result in crime, violence, drug abuse, sexual promiscuity and prostitution. This triple burden of disease, together with scarcity of means to promote health and prevent illness, amounts to the “drama which is known as the urban health crisis” (Tabibzadeh & Liisberg, 1997:269).

Wright & Tompkins (2006:291) state that multiple morbidity and premature mortality are more prevalent amongst homeless populations. Research conducted on autopsy and post mortem findings, performed on homeless people in Germany, indicate that the average age of death was 45 years. The major causes of death were unnatural, due to factors including intoxications.

Van der Heyden et al (2002:2) reiterate that with decreasing socioeconomic levels, health expectancy also reveals a decline.

In their discussion, of a study conducted on the causes of death in homeless adults, Hwang et al (1997:3) emphasised that the research depicted the “enormous effect” of the AIDS epidemic on the homeless population.

Due to inability to source adequate nutrition, exposure to various environmental factors, unsafe sanitary practices, social problems together with sporadic contact with providers of food, shelter or healthcare, “homelessness may cause or exacerbate health problems” (Wiecha et al, 1991:372).

2.2.5 Health seeking behaviours of, healthcare provision to and healthcare utilisation by homeless people.

2.2.5.1 Health seeking behaviours

Health as defined by WHO “is a state of complete mental, physical and social well being and not merely the absence of disease or infirmity” (Green, 1997:44).

McMurray-Avila (2002:12) extends this definition further: “health is one of the fundamental rights of every human being and is dependent upon the fullest cooperation of individuals and states”.

Health seeking behaviours are dependant on how people perceive their own state of health. The questions arise: “How do homeless people perceive their own health? When do homeless people access healthcare services?” Shiner (1995:529), Olumfemi (1999: 488), and Martins (2008:426) address these issues and argue that homeless people do not consider health matters to be a priority, thus allocating a low expectation to their health requirements. Many homeless people are more concerned with meeting their basic needs for food,

shelter, clothing and safety, than seeking healthcare (National Health Care for the Homeless Council, 2008).

2.2.5.2 Healthcare provision

Healthcare provision is a fundamental right as in the United Nations Universal Declaration of Human Rights (Universal Declaration of Human Rights, 1994:4). Governments possess an inherent responsibility for the health of their population, which can be fulfilled only by the provision of adequate health and social measures (McMurray-Avila, 2001:11). It was this premise that spurred the development of Primary Health Care at the International Conference held in Alma Ata in 1978, where accountability for health was further extended to social and economic sectors in “addition to the health sector” (Mc Murray-Avila, 2001:12).

Seager & Tamasane (2008:24) emphasise that a homeless lifestyle exposes one to numerous health risks, risks which are preventable with basic public interventions. Government policies need to look at the provision of health care for homeless people. Hwang, Tolomiczenko, Kououmdjian and Garner (2005:311) assert that the provision of coordinated health care programmes consisting of treatment and support interventions for homeless adults, as compared with current “sporadic and substandard care”, would yield improved health outcomes for homeless adults.

Poland and Italy are two countries who have showed their obligation to provide healthcare for homeless people.

In Italy in 1995 urgent regulations were implemented to allow the right to health care for all illegal and clandestine people. In 1998, Act 49 stated “no one can be excluded from access to health care”. This was followed up in 1999 with a Presidential decree 394/ 1999 that “all foreign citizens whether legally in Italy or not are allowed unrestricted access to preventive, curative

and rehabilitative health care under the National Health System” (Manfellotto, 2002:70).

Manfellotto (2002:74) observes that Italy has introduced a very pro-active approach towards healthcare for the homeless. In Italy, the Department of Preventive Medicine for Migration, Tourism and Tropical Dermatology (DPMM) have been offering healthcare services for homeless people. Furthermore, in order to cater for the health needs of the homeless, these services are also offered at night. The DPMM also actively provides preventive and screening measures, thereby promoting prevention, prophylaxis, detection and treatment of diseases at an early stage, thereby limiting and controlling the “progression to more severe conditions that would be expensive to treat” (Manfellotto, 2002:78). In addition to offering healthcare services to homeless people, the DPMM also studies and monitors health problems thereby collecting important data on homeless people and their health problems which require medical attention (Manfellotto, 2002:78).

Turner (2001:93) explains that in Poland shelters for the homeless are financed by the Provincial Administration. Palma Hospital started the Palma Initiative, whereby health care professionals visit these shelters and provide primary health care.

In America the National Health Care for Homeless Council (2008:1) strongly advocates for the creation of a single health system that provides the homeless with access to high quality comprehensive health care.

All South Africans have a constitutional right to access health care. In South Africa, The White Paper for the Transformation of the Health System (1997) identifies as one of its goals in Chapter 1.1. “To promote equity, accessibility and utilization of health services: increase access to integrated health care services for all South Africans focusing on the rural, peri-urban and urban poor and the aged with emphasis on the vulnerable groups”. In order to achieve the above goals, a primary health care philosophy has been

implemented in South Africa. The South African Social Investment Exchange (Sasix, 2008:1) describes challenges that South Africa faces, including health care interventions to meet the needs of vulnerable children, people with HIV/AIDS, people living in informal settlements and homeless people. The public health system currently unable to meet the aforementioned challenges, therefore relies on intersectoral partnerships between government, non-profit organisations and business, to assist in providing these needs (Sasix, 2007:1).

In order to form and promulgate policies for homeless people, we need to know the precise scope and dimension of the problem of homelessness, the health problems with which homeless people present and at what stage of illness.

Hwang et al (1997:628-629) expressed their concern over increasing deaths amongst homeless people due to AIDS. Hwang states that the findings “have serious implications for clinicians and policy makers”.

Potter & Perry (2008:50-51) reiterate that due to the scarcity of research conducted into healthcare provision for homeless people, inadequate data is available in order to guide decision making.

2.2.5.3 Healthcare utilisation

Barriers to accessing healthcare services

The World Health Report (WHO 2000: ix) ‘Health Systems: Improving Performance’ identifies many discrepancies existing in relation to healthcare available for the poor. These arise owing to the fact that since the poor are being identified as the main disadvantaged group, they are subsequently treated with less respect for their dignity, have access to a more circumscribed choice of health providers, are offered poorer quality amenities, and less prompt attention. Seager & Tamasane (2008:11) reiterate that homeless people suffer from verbal abuse when accessing health services.

Martins (2008:427) describes that homeless people were often treated differently and with disrespect when accessing healthcare.

The Polish Department of Public Health states that people in the shelters remain ineligible for primary health care. Their status of unemployment does not allow access to health care, except in an emergency situation (Turner, 2001:94).

Homeless people experience higher rates of illnesses and injuries than people who live in secure housing. McMurray-Avila (2001:11) explains that these factors can further complicate the satisfactory provision of healthcare. The author elaborates that problems with access to healthcare services, as experienced by homeless people, can effect a delay in health problems being diagnosed and treated. This can further lead to additional medical complications and “impede the individual’s’ ability to overcome homelessness” (2001:11).

In their article ‘Homelessness: a problem for primary care?’ Riley et al (2003:475) discuss the subjects’ impact on health services in the United Kingdom. Riley et al allude to the fact that many homeless people have been inappropriately utilising local accident and emergency departments as a result of barriers preventing access to primary care.

As a result of the influx to accident and emergency departments by homeless individuals, primary care services have been successfully implemented to enable the homeless better access to appropriate medical care. It appears that, due to the lack of consistency in the level of services provided, these services have not been well utilised by the homeless.

Hwang et al (2005:320) strongly propose the development of programmes to improve the health of homeless people. Hwang et al comment that no rigorous survey has been undertaken to assess whether health programmes have resulted in noticeably improved health outcomes for homeless people. In the

systematic review undertaken by Hwang et al (2005:320), there is further mention of the need for the provision of coordinated health programmes that have been specifically designed for the needs of homeless people.

2.3 Conceptual framework underpinning the study

For this study the researcher adopted the Three Delays Model first described by Thaddeus and Maine (1994) to identify barriers in accessing healthcare by pregnant women, from the onset of an obstetric complication to receiving care in a health facility. Many of the delays described would apply to those experiences by homeless people.

The three phases of delays identified in the model are:

Phase I delay: Delay in deciding to seek care on the part of the individual, the family, or both.

This stage includes the decision on the part of the individual to seek care. Factors that could hinder the decision making process of homeless people include perceptions of illness, distance from a health care facility, financial costs, previous experience with health care systems, staff attitudes and the perceived quality of care.

Phase II delay: Delay in reaching an adequate health care facility.

Having made the decision to seek healthcare, factors may be present that hinder homeless people from reaching the health facility. These could include distance from a health care facility, financial barriers, for example availability and cost of transport.

Phase III delay: Delay in receiving adequate care at the facility.

This stage looks at the factors which could hinder receiving adequate health care once a healthcare facility has been reached. Such factors affecting homeless people would include shortages of supplies and

medications, shortages of staff, inadequate management and attitudinal barriers.

Phase one describes the barriers to seeking healthcare and subsequent utilisation of the healthcare service. As previously mentioned in this literature review, homeless people do not consider health matters to be a priority. This complicates the matter as homeless people often seek healthcare late when their condition is serious and has become an urgent medical emergency (National Health Care for the Homeless Council, 2008:1-3). Travelling to a healthcare facility can prove problematic as homeless people do not have the financial means to travel to a facility. The distance to be travelled can constitute a disincentive which can delay a client's choice to seek healthcare (Thaddeus & Maine, 1994:1094).

Another obstacle that could influence the decision to seeking healthcare is cost. Cost, as in payment of the healthcare, cost of transportation, doctor's fees, and the cost of medication. Economic status is an important factor when considering health seeking behaviours, especially for the poor. The literature presents evidence that the lower the socioeconomic status the greater the mortality and morbidity.

Homeless people do not have health insurance, which limits homeless people as to which healthcare facilities they can use. Wright & Tompkins (2005:289) discuss the discrimination homeless people experience at healthcare facilities; these represent attitudinal barriers and in turn this may be perceived as a lower quality of care rendered. The National Health Care for the Homeless Council (2008:1-3) reiterates that for some homeless people past ill experiences with the healthcare system will cause homeless clients to avoid seeking healthcare.

Thaddeus & Maine (1994:1096) suggest that people may have had previous experiences with healthcare facilities, which may impact in delaying their decision to seek healthcare. Factors identified that may lead to dissatisfaction in the quality of care provided include; "staff attitudes, hospital procedures,

availability of supplies, long waiting times, lack of emotional support, lack of privacy” (Thaddeus & Maine, 1994:1095). A homeless client may feel too ashamed and fear being stigmatised, that they do not seek healthcare, a decision that may further compound the severity of the illness.

Once a homeless client has decided to seek healthcare, obstacles are encountered in making the decision of where to seek care and how to get to the facility. Phase two describes the factors involved in reaching a healthcare facility. As not all healthcare facilities offer services to homeless people, travelling to a healthcare facility that does provide free services for homeless people may be far. This reason mentioned along with other mitigating factors may explain the increased use of accident and emergency departments by homeless people. Once homeless people have accessed a healthcare facility, lack of finances could further complicate access to healthcare, as homeless people may be unable to purchase medications or afford other medical expenses e.g. dressings. Lack of finances could also hinder homeless people from joining programmes for substance abuse (Stein, Andersen & Gelberg, 2007:792).

When a homeless client has reached a healthcare facility, the client could encounter a delay in receiving adequate care at the facility. Factors affecting adequate care could include shortages of supplies and medications, shortages of staff, inadequate management and attitudinal barriers.

As homeless people commonly present with multiple morbidities, this puts further stress on the healthcare system as additional medications and interventions are needed to treat and manage homeless clients.

2.4 Summary of Chapter

The review of the literature discusses definitions and causes of homelessness. The specific needs of homeless people are compared to Maslow’s (1943) theory of needs. The review then describes health problems, health seeking behaviours, healthcare provision and healthcare utilisation by

homeless people. Thus, the Three Delays Model serves as a suitable framework to underpin this research, since it is most relevant to the barriers that homeless people may encounter when seeking healthcare.

CHAPTER THREE: METHODOLOGY

3.3 Introduction

This chapter describes the methodology adopted in this study on describing the health care seeking behaviours of homeless people in South Central Durban. The research objectives, research questions, study design, study location, study population, sampling strategy and size, data collection, data management, data analysis, mechanisms to assure quality of the study, ethical considerations and limitations of the study are described.

3.4 Objectives

The objectives of the study were to:

- 1) Describe the health care needs of homeless people in South Central Durban.
- 2) Describe the experiences relating to the health seeking behaviours of homeless people in South Central Durban.
- 3) Describe factors facilitating access to health care by homeless people in South Central Durban.
- 9) Describe factors influencing access to health care by homeless people in South Central Durban.
- 10) Make recommendations to the Kathleen Voysey Primary Health Clinic (KVC) and other health services regarding health care services for the homeless in South Central Durban.

The research questions were developed to explore the above objectives:

Health Care Needs

- 1) What are the perceived health care needs of homeless people?
- 2) What are the felt needs of homeless people?
- 3) What are the observed needs of homeless people?

Health Seeking behaviours

- 4) What influences the decision by homeless people to seek health care? i.e. Why do they seek care?

- 5) What influences the decision by homeless people as to when to seek health care?
- 6) What influences the decision by homeless people concerning where to seek health care?

Factors facilitating/hindering access

- 7) What are the factors that facilitate the seeking of health care by homeless people?
- 12) What are the factors that hinder the seeking of health care by homeless people?

3.3 Methodology

For this research the researcher primarily used a qualitative methodology with a small quantitative component. The qualitative component comprised of one on one in-depth interviews. The quantitative component comprised of a record review showing the frequency distribution of health problems experienced by homeless people.

3.3.1 Qualitative methodology

Qualitative research is descriptive and constitutes an excellent way of obtaining information and exploring a particular phenomenon (Brink & Wood 1998:336). Patton (2002:5) describes qualitative research as research whose primary focus is on people and the “meanings they attach to or derive from their experiences”. Creswell (1998:15) explains that qualitative research involves research undertaken in a natural setting, thus creating a “holistic picture” of the research study.

Burns & Grove (2001:38) describe applied research as a scientific investigation conducted in order to generate knowledge that will improve or influence clinical practice. Sim & Wright (2002:50) reinforce this definition and state that, by conducting applied research, practical solutions can be offered

in order to address specific problems and issues. Patton (2002:217) discusses the ability of applied researchers “to bring their own personal insights and experiences into any recommendations that may emerge”, due to the researchers’ ability to understand the problems whilst conducting the fieldwork.

The rationale behind the choice of a qualitative methodology for the current study was to try to understand health seeking behaviours both from the perspective of homeless people as well as from that of health care workers.

The researcher aimed to increase knowledge regarding health seeking behaviours of homeless people that would result in improved health care provision to this marginalised segment of society in Durban.

3.3.2 Quantitative component

Katzenellebogen, Joubert & Abdool Karim (2001:66) describe a descriptive study as a survey “which sets out to quantify the extent of a problem”. By determining the extent of a problem, service providers and planners gain the essential information necessary in order to plan services and provide the resources needed. The researcher used quantitative cross-sectional descriptive summaries of data contained in service registers, in order to complete the findings for study objective one, which calls for a description of the observed health needs of homeless people.

Table 3.1 Research questions and methods used per research question.

Research Questions	Methods used
Health Care Needs	
1) What are the perceived health care needs of homeless people?	One on one in-depth interview with homeless people and healthcare workers
2) What are the felt needs of homeless people?	One on one in-depth interview with homeless people and healthcare workers
3) What are the observed needs of homeless people?	Record review - Quantitative frequency distribution of health

	problems treated at KVC from January 2006 to December 2006. In-depth interviews
Health Seeking Behaviours	
4) What influences the decision by homeless people to seek health care? I.e. why do they seek care?	In-depth interview with homeless people and healthcare workers
Research questions	Methods used
5) What influences the decision by homeless people of when to seek health care?	In-depth interview with homeless people and healthcare workers
6) What influences the decision by homeless people of where to seek health care?	In-depth interview with homeless people and healthcare workers
Factors Facilitating/Hindering access	
7) What are the factors that facilitate the seeking of health care by homeless people?	In-depth interview with homeless people and healthcare workers
8) What are the factors that hinder the seeking of health care by homeless people?	In-depth interview with homeless people and healthcare workers

3.4 Study location

The study location is an area in which homeless people are known to reside i.e. within the boundaries of Congella (Berea South), Berea, Mayville (Bellair) and Cato Manor (Bellair), which is zoned as South Central Durban. In the map provided on the next page, this area is indicated in blue. The study area is an urban area which consists of small businesses, residential homes and flats.

Healthcare workers were interviewed from all clinics within the study location namely: Lancer Road Primary Health Care Clinic, Cato Crest Primary Health Care Clinic, Communicable Disease Clinic, Hope Clinic and Kathleen Voysey Primary Health Care Clinic (KVC). These clinics all function independently.



Figure 1. Map of Durban showing study location – South Central Durban

3.5 Study Population

Homeless people aged 18 years and above and healthcare workers in health services in South Central Durban which provide health care to homeless people.

3.6 Sampling

3.6.1 Sampling strategy

For gathering data from healthcare workers all the clinics in the study location were included in the study. From each of these clinics (three municipal clinics and two NGO based clinics) one healthcare worker was interviewed.

A total of six interviews were held with healthcare workers. For gathering data from homeless people, homeless people were approached from the soup kitchen queue at the Berea Presbyterian Church and Dalton Hostel. A total of twelve interviews were held with homeless people.

For the qualitative component of the study a purposive heterogeneous sampling method was used. The aim of purposive sampling was to recruit participants who possess the most knowledge or information regarding the phenomenon of interest. In using both homeless people and health care workers the researcher used heterogeneous sampling. By using heterogeneous sampling the researcher was able to obtain similarities and different views from the two sample groups (Ulin, Robinsin, Tolley & McNeill, 2002:60).

For the quantitative component of the study, information was collected in relation to what diagnoses/ health needs homeless clients were presenting with at the healthcare facilities. This data were contained in service registers, kept at healthcare facilities. However, only one healthcare facility (KVC) kept a specific record of attendance by homeless people, together with the conditions that they presented with. Thus the researcher could only present a record of such data from one health care facility.

3.6.2 Sample size

Patton (2002:246) suggests stating a minimum expected sample size “based on expected reasonable coverage of the phenomenon to be studied”. By stating a minimum size one may change the size of the sample as data is collected from the interviews. The principles in determining the ultimate sample size in qualitative data collection include redundancy and saturation.

When collecting data for any research, a common problem is the adequacy and sufficiency of necessary data. Ulin et al (2002:58) cite Glaser and Strauss (1967) who suggest that “when little new information is coming from your

observations and interviews you can be reasonably confident that you have saturated that source of information to the point of redundancy”.

New participants were approached until the researcher felt that theoretical saturation had been obtained, in that “no new data or new inputs were obtained” (de Vos, Strydom, Fouche & Delport 2005: 329).

Twelve homeless people were interviewed and six healthcare workers. The healthcare workers interviewed were either in charge of the clinic or deputies.

3.7 Recruiting Participants

3.7.1 The Homeless

Participants were approached from the soup kitchen queue at the Berea Presbyterian church which is the location from which the Kathleen Voysey Primary Health Clinic operates. The research assistant approached and enquired in English and isiZulu, of those in the soup kitchen queue as to their willingness to participate in the research. In total eight interviews were conducted at this site.

Dalton Hostel in Congella constitutes a hostel operated by the eThekweni Municipality offering sheltered accommodation. Together, the researcher and the research assistant visited Dalton Hostel, whereupon the research assistant approached and enquired of those at Dalton Hostel as to their willingness to participate in the research. In total four interviews were conducted at this site.

3.7.2 The Healthcare workers

Healthcare workers were recruited from clinics in South Central Durban. Three healthcare workers interviewed were from municipal clinics and the remaining three healthcare workers came from clinics run by Faith Based Organisations (FBO's).

Permission to conduct interviews was obtained from the eThekweni Municipality and FBO's. After permission was granted, the researcher then contacted the clinics directly and spoke to the Doctor or the Chief Professional Nurse Manager, the clinic manager then decided who was to be interviewed and a convenient time to conduct the interview.

3.9 Data collection, management and analysis

3.9.1 Data collection techniques

In order to access the information for the quantitative data, the researcher collected and analysed the daily statistics chart at KVC which supplied a brief overview of:

- Clinic attendance
- Diagnosis
- Level of health care professional was consulted
- Medication prescribed and dispensed
- Referrals and the facility where referred

From this information the researcher then compiled a list of:

- The total number of attendances at the clinic
- The associated conditions

Information relating to the above factors were counted and recorded over the period of one year preceding the study (January to December 2006). The researcher entered the data in Microsoft Office Excel and then developed frequency distributions indicating the ten most frequent conditions/ attendances over a period of twelve months.

The researcher was unable to collect similar information at the other clinics participating in this study. At the other health facilities similar information is kept, however, there is no indication as to which clients are homeless or not

homeless. At one clinic, the professional nurse interviewed mentioned that she did not know if clients attending the clinic were homeless or not. The professional nurse further elaborated that all clients provided an address, but she did not know if the client actually lived there. Another professional nurse further suggested that clients give an address (any) so that they will neither be victimised nor refused treatment. (Reflective diary 4th June 2007)

All interviews were conducted at the interviewees' place of work by the research assistant. Due to the researcher's involvement in a Faith Based Organisation that provides healthcare for homeless people in the research setting, all interviews with healthcare workers were conducted by the research assistant. The interviews with homeless participants were also conducted by the research assistant as the majority of homeless participants spoke isiZulu.

Interviews were conducted with both homeless people and healthcare workers, using a general interview approach. Data were obtained by conducting in- depth interviews, thereby allowing an individual to reflect experiences and events pertaining to the focus of the research (de Vos et al, 2005:287). Roberts (2003:23) describes how "during the interview he tried to talk as little as possible so as to try to maintain as natural a conversation as possible, jotting down key words, phrases and imagery". As soon as Roberts left the field he would then compile the field report. After each interview the researcher also compiled field notes.

3.9.2 Data collection instruments

For quantitative data, data was obtained from the daily statistics charts at KVC. For qualitative data in-depth interviews were held. In order to perform the interviews an interview guide (Annexure H for healthcare workers, Annexure K/L for homeless participants) was compiled by the researcher. The interview guide contained main and probing questions.

The research assistant was trained in use of the interview guide and thereafter conducted interviews using the interview guide.

3.9.2.1 From Healthcare workers

Prior to each interview with healthcare workers, the researcher telephoned each participant to arrange an appointment at a time suitable and venue accessible to the participant. Once this had been arranged, both the researcher and the research assistant proceeded to the venue. Interviews were conducted in a private room. After explaining the reason for the interview and showing the relevant ethical clearance documents and obtaining informed consent, the researcher then excused herself from the interview. The researcher is known to some of the healthcare workers, therefore so as not to influence the interview, it was decided that the research assistant should conduct the interviews. The research assistant conducted the interviews using the interview guide, all such being tape recorded. Interviews conducted with healthcare workers took between 45-60 minutes. All interviews were conducted in English.

3.8.2.2 From Homeless Participants

The interview guide employed in the research was available in both English and isiZulu. The guide used in the interviews was developed by the researcher in English. The guide subsequently was submitted to a colleague who translated the questionnaire into “street” isiZulu. Thereafter it was forwarded to a colleague who translated the guide into English again. Further modifications were undertaken, thereby ensuring its reliability in translation by another colleague. The research assistant conducted the interviews utilizing the interview guide.

Interviews with homeless participants were conducted at the Berea Presbyterian Church, and at the Dalton hostel. At both venues separate offices were provided, thus providing privacy during the interview process.

Once homeless participants agreed to be interviewed, the research assistant took the participant to a private room. Here the research assistant explained in detail what the interview entailed, reviewed the guidelines (as discussed) and then obtained informed consent. All interviews were tape recorded, thus enabling the recording of rich and valuable data.

Initially, homeless participants were hesitant about allowing the recording of the interview and two participants asked if they could have the interview played back so that they could hear their voices. Once the interview had started homeless participants grew comfortable with the tape recorder operating. After the interview had finished, some homeless participants still wanted to talk. However, as regards certain information, they requested that the tape recorder be switched off. The research assistant asked questions as per the interview guide and also probed with a view to elicit more information. Interviews with homeless participants ranged from between 30-40 minutes. Of the twelve interviews, eleven were conducted in isiZulu and one interview was conducted in English.

The individual interviews were conducted until the researcher had reached theoretical saturation, as the data collected contained no new information. After each interview had been conducted the researcher and the research assistant met and compiled field notes (reflective diary). These field notes were used in the discussion of the study. All interviews conducted in isiZulu were translated by the research assistant. All interviews, both English and isiZulu, were transcribed together by the research assistant and the researcher. All silences and pauses were recorded as '...'.

3.9.3 Training the research assistant

An African female assistant was identified who was fully conversant in both isiZulu and English. In addition, she was also familiar with health care

terminology as she was a current nursing student. The assistant was not connected to the KVC or any of the healthcare facilities in the study location. The researcher conducted a training session with her. The training session was held in the researcher's office, thus providing a quiet and private venue, and all precautions were undertaken to prevent interruptions during the session. The researcher discussed the purpose of the research and its methodology. The assistant was provided with a copy of general guidelines for conducting interviews and, as she would be conducting the interviews, these were discussed with her. Points that were covered included:

- The location of interviews with homeless people. These included the Berea Presbyterian Church, where the KVC clinic is held, and Dalton Hostel. Both facilities have separate offices which provided privacy during the interview.
- Aim of research: obtaining informed consent and maintaining confidentiality/ ethical concerns, content of interview, establishing rapport and trust, language, cultural norms, ensuring comfort of the participant and acquiring the ability to listen.
- Guidelines before conducting an interview were discussed and these included: a quiet venue with no distractions, explanation of the purpose of the interview, explanation of the format and length of the interview, how to locate and access the researcher later if so required and the research and bioethics committee.
- All interviews would be tape recorded, thus facilitating the recording of rich data obtained during the interview. The assistant was instructed as to the use of the tape recorder.

A colleague was invited to the training session in order to role play an interview, so that the assistant could practice her interview skills. The researcher vacated the room to allow the assistant and colleague time alone to practice. Informed consent was obtained from the colleague and the tape

recorder was switched on. In this initial practice, the colleague assumed the role of a healthcare worker and then assumed the role of a homeless person. Feedback elicited from the research assistant included that she appreciated this opportunity to practice both interviewing skills and the use of the tape recorder.

During this role play, both the assistant and colleague expressed concern over the wording “health seeking behaviours” (in the healthcare workers interview guide), and whether healthcare workers would be capable of understanding the exact meaning. The assistant also expressed concern over the wording “health aid” (in the interview guide for homeless people) and suggested that the words ‘health assistance’ be used. Both the colleague and the research assistant felt that the session had been extremely useful. The assistant requested another session, which was subsequently held the following day.

The following day involved only the researcher and the assistant, both reviewing the two interview guides. After obtaining informed consent, the assistant interviewed the researcher as a healthcare worker and subsequently as a homeless person. Both interviews were recorded. In playing back the recorded interviews the assistant noted that her voice was too loud whilst the researcher’s voice was quieter and sometimes too faint to hear. The assistant then noted that for future interviews the tape recorder needed to be placed nearer the person being interviewed. The assistant expressed the opinion that this session had proved beneficial and that she had gained more confidence in conducting interviews.

3.8.4 Pilot study

Two pilot interviews were conducted, one with a healthcare worker and the other with a homeless person.

The first pilot interview was conducted with the former. Due to time constraints, as the health care facility was extremely busy the researcher and the assistant visited the healthcare worker at home. To obviate the introduction of bias, the researcher vacated the room whilst the interview was being conducted. After informed consent was obtained, the interview was conducted and recorded. The interview was approximately 30 minutes long.

Comments from the research assistant included that the interviewee was both extremely helpful and easy to converse with. Comments from the interviewee included:

- For question two: “Can you describe the health seeking behaviours of homeless people coming to your clinic?”

The interviewee queried as to what exactly did the researcher want to know? Did the researcher want to know the frequency with which homeless people came to the clinics? The interviewee then queried as to whether question two is not similar to question one, which asked “Can you describe the healthcare needs of homeless people?”

- For question five: “Can you describe factors that hinder access to health care by homeless people?”

The interviewee suggested that, instead of the word ‘hinder’, perhaps another word could be used e.g. delay, hamper, obstruct.

The research assistant provided the following reflections regarding the pilot interview with the homeless. “Interview went well, no difficult questions”. “Interviewee appeared confused at times: early in the interview, clarification was needed. Information received was interesting.” “Initially client not relaxed, but he became relaxed and gave the information”. After the interview was conducted and the tape recorder was switched off, the client continued talking and giving information.

Based on the information with the two interviewees, the researcher arranged a meeting with the research supervisor. Revisions were suggested for the questionnaire for healthcare workers. The revisions in the questions consisted of probes, to aid in eliciting richer responses.

- For question one: “Can you describe the health care needs of homeless people coming to your clinic?”
- Suggestions included the possibility that, in order to obtain a baseline/ initial response, an introductory probe could elicit the person’s basic needs in order to maintain well being. Thereafter problems that the homeless encounter e.g. health, social, and economic problems could be probed.
- For question two: Can you describe the health seeking behaviours of homeless people coming to your clinic?
- Suggestions included dividing this question into three sections. For the first section, this involved probing at what stage of illness they attend the clinic e.g. little minor aches or late serious problems. The second section investigated whether the homeless come for follow up appointments... are they compliant with their medication? The final section sought to elicit a response as to whether the homeless came for health problems or other concerns e.g. disability grants?
- For question five: “Can you describe factors that hinder access to health care by the homeless?”
- It was suggested that this question includes barriers/ hinder.

3.8.5 **Data Management**

After the interviews were conducted, each interviewee was furnished with a number, thus ensuring anonymity. After the interview the researcher immediately monitored all notes obtained from the interviews and no problem areas were identified.

The taped recordings of all interviews were stored in a lock up cabinet. The researcher and the research assistant transcribed the data from the interviews verbatim onto the researcher's computer. The researcher maintained two copies of the data: one serving as a back-up to be safely stored in an appropriate location and the other copy was employed for the researcher to work on. The access to the computer was limited by installing passwords therefore the researcher would serve as the only individual who would have access to the researcher's computer. In the writing up of the data the researcher did not use names of the clients, thus not subjecting anyone to any victimization or embarrassment. All data obtained from the research will be stored securely until the research had been published. Data will be destroyed after five years.

3.8.6 Data Analysis

The researcher employed a manual method to analyze the data obtained. All information obtained was collated e.g. interviews, field notes and memos to form a data base.

Initially, the researcher read, re-read and immersed herself in the detail of the transcripts from the interviews and the field notes, "trying to get a sense of the interview before breaking it into parts" (Ulin et al, 2002:144).

As the researcher read the data, patterns/ categories of themes and sub-themes were identified, which represented the "central core of the data collected" e.g. relationships with health care workers (Patton, 2002:453). Whilst reading homeless people's transcripts, the researcher used different colour highlighters for the different themes that the researcher identified,

carefully recording a key indicating the particular pattern represented by each colour.

Once the researcher had read the data, checked for inaccuracies in transcription, identified patterns and coded them; it was necessary for the researcher to answer two questions, namely

- “How to arrive at the essential meanings of the qualitative data?
- How to ensure that the interpretation offered is trustworthy?”(Ulin et al, 2002:160).

A deductive approach was used whereby the data were analysed according to predetermined categories that was guided by the research questions and research objectives. An independent researcher agreed with the coding (analyst triangulation). Findings from the data were reported in the narrative form. Negative cases were reported in the results.

3.9 Study Period –Actual

Table 3.9 Study Period

Write Research Proposal	March/ April 2006
Higher Degrees and Ethical Clearance	Dec 2006
Data Collection	June –Sept 2007
Data Analysis	Oct 2007– Apr 2008
Complete Research Report	October 2008

3.10 Research Team

The research team comprised of the following personnel:

- Three isiZulu interpreters assisted in the translation of the interview guide.
- One English/ Zulu speaking assistant, who was not connected to the KVC or any of the other health services in any way, aided in

conducting interviews and translation of the questionnaires to both the clients and the healthcare workers.

- Researcher

3.11 **Mechanisms to assure the quality of the study**

Patton (2002:544) identifies five groups of criteria which are utilised for judging the “quality of qualitative inquiry”. Within the paradigm of this study social construction and constructivist criteria were used.

3.11.1 **Credibility (truth value)**

Patton (2002:552-553) identifies three points which need to be considered when assessing the credibility of research, viz:

- Rigorous methods must be used for the collection of data during fieldwork. An important source of data is the compiling of field notes, which the researcher and assistant completed immediately after the interview process was finished, while the interview remained both clear and fresh. Field notes contained a description of what was observed during the interview process, inter alia the “physical setting, what activities took place, direct quotations, non-verbal communication, assistant’s own feelings and reactions whilst conducting field work” (Patton, 2002:303). By using field notes, together with transcribed verbatim interviews, it is possible to acquire a better and complete overview of the subject being researched. A thick description includes more than a mere recording of what transpired during the interview process. Thick description describes the emotions and feelings and “establishes the significance of events for the person in question” (Patton, 2002:503).

- Credibility of the researcher: the researcher is currently a MPH (Master of Public Health) student and has studied two modules in research. The researcher's strengths (bracketing) lie in that the researcher has been personally involved in the KVC clinic for nine years, which satisfies the criteria of prolonged engagement. The researcher's weakness is that she is a novice researcher with limited experience. To overcome the researcher's inadequacies, a research supervisor both oversees the process and is available for advice. In addition, the services of two colleagues as peer reviewers have been utilised in order to obtain the maximum input possible in order to achieve credibility.
- Philosophical belief in the value of qualitative research. The research design employed is that of applied, qualitative research. Applied research was used so as to produce knowledge and information regarding the health seeking behaviours of homeless people that will assist in improving health services for homeless people. The applied researchers "bring their own personal insights and experiences into any recommendations that may emerge" (Patton, 2002:217). This is further augmented due to the ability of the researchers to understand the problems whilst conducting fieldwork.

3.11.2 Triangulation

By performing triangulation during the research process, one can ensure to the maximum reasonable extent that the results and conclusions obtained by the research are credible. Patton (2002:247) suggests four triangulation methods which will "contribute to verification and validation of qualitative analysis".

These methods are:

Methods triangulation: this involves checking the consistency of data that has been collected by using different data collection methods. In the research, the researcher used data from the daily statistics sheet, interviews and observations (Patton, 2002:556).

Triangulation of sources: This refers to the process whereby the consistency of data is checked when different data sources are utilised (Patton, 2002:556). By conducting interviews with homeless people and with healthcare workers who provide health care services to homeless people, the researcher triangulated views from different sources. Once the transcripts were completed, the researcher then contacted the healthcare workers (either by telephone or email) and requested that they check whether the transcript provided a true reflection of what had been said during the interview (member check). All healthcare worker participants replied in the affirmative. The researcher was not able to trace the homeless participants to query whether the transcripts were a true reflection of information they had provided.

Analyst triangulation: The researcher read and re-read the data, and analysed the data according to five broad themes which were predetermined as the research objectives. By re-reading the data sub themes were inductively identified. An independent researcher, expert in qualitative data analysis, independently read the data and formulated sub themes. The independent researcher was in general agreement with the coding and emerging themes, thus rendering the research more credible. This researcher verbally agreed to maintain confidentiality regarding the findings of the research study.

3.11.3 Attention to Negative cases

Whilst data was being collected, it is important to identify any negative cases, which consists of data that fails to agree with the bulk of that collected, including exceptions to the rule (Patton, 2002:554). Negative case analysis can provide alternative “dissenting voices” and thus challenge the researcher to continue the process of searching until all possible alternatives can be ascertained and accounted for.

3.11.4 Reflexivity

The process of assessing and making explicit the researcher's own subjective experience and how it may have influenced the research process is very important in qualitative analysis. Person (s) reading this study will understand and appreciate the researcher's world view and then conduct their own personal judgement as to whether the researcher has in any way influenced this research. By "bracketing" the researcher's own experiences in undertaking voluntary work, it will then be possible to check the data collected along with the findings of this research.

The researcher is a white female, in her forties, who has been a professional nurse for twenty-six years. The researcher has been involved with the KVC since 1997. These nine years of working at the clinic have influenced the researcher in that she is sympathetic to the health needs of the homeless. This could potentially influence the research results.

The researcher kept a reflective research diary, in which the researcher reflected on-going self evaluation and critique throughout the research process. The researcher recorded her sentiments experienced during the data collecting process. The researcher also recorded biases and experiences and the manner whereby they may have influenced the research process, the results and interpretation of the research.

3.11.5 Transferability

The study should be described in such a manner that it will facilitate the transfer of the research process to another setting (Engelbrecht, 2005). Someone may read the research report and thereafter conduct similar research in a different geographical setting, thus identifying the problems of the homeless population and allowing comparison of findings.

3.11.6 Dependability

In order to ensure dependability in qualitative research, the researcher needs to meticulously represent, explain and logically motivate all steps and study decisions taken (Engelbrecht, 2005). All data collected were stored in a safe place, as well as decisions about coding and is available so that the researcher can provide evidence of the research findings (audit trail).

3.13 **Ethical considerations**

Subsequent to obtaining ethical clearance from the Bioethics Committee at the University of Kwa-Zulu Natal, permission was obtained from all Dalton Hostel and all the clinics i.e. eThekweni Municipality (Lancer Road Primary HealthCare Clinic, Cato Crest Primary Health Care Clinic and Communicable Disease Clinic) Hope Clinic and KVC Primary Health Care Clinic.

The researcher has attempted to meet the ethical requirements for research as proposed by Patton (2002:408-409), by:

- Explaining the purpose of the study to the respondents: As the majority of the homeless people in South Central Durban are isiZulu speaking, the researcher used an isiZulu speaking research assistant to assist in developing the interview guides and in conducting the interviews. Prior to obtaining informed consent, the research assistant furnished information to the potential participants regarding the researcher, as well as providing an overview of the research according to the educational level of the participants.
- Risk assessment: The researcher did not place any of the participants at any risk of psychological stress, legal liabilities, ostracism by peers or even political repercussions. The researcher was not accused of exploiting a vulnerable population by increasing their social stigmatization and employing bribery and coercion to attain or even influence research results, thus not adhering to the principle of justice. One aspect wherein the researcher promised confidentiality lies in the

area of illegal activities e.g. illegal drugs, illegal squatting and prostitution. Working with homeless people, entails being aware of such antisocial activities, as the abuse of alcohol and the frequent prevalence of the “sweet” smell of dagga being smoked.

- Confidentiality: All interview guides were numbered and the names of participants did not appear in any aspect of the research material. All data collected was retained on the researcher's computer and locked in a cabinet. Access to the computer was limited as the researcher was the sole individual who had access thereto. In the formal compiling of the data the researcher did not use names of the clients, and thus has not subjected the latter to any victimization or embarrassment.

Informed consent: which entailed a rational free decision to participants was made by all participants in this research. Firstly, the research assistant disclosed to the participants a covering letter which explained the identity of the researcher, the purpose of the research, potential benefits/ risks of the research, provision of anonymity and confidentiality (Letter of consent Annexure I and J). In the letter the issues of voluntary consent and the option to withdraw were included. The researcher ensured that the translator signed a contract of confidentiality. At all times privacy was maintained, thereby an atmosphere of honesty and trust was promoted. Before the interview was conducted, the interviewer obtained written permission from the participant and then only proceeded with the interview. Signing informed consent proved to be problematic, as two of the homeless participants were illiterate and one homeless participant refused to sign consent as she was afraid that this information would be forwarded to the authorities. The researcher approached her supervisor who contacted the BioMedical Ethics Committee at UKZN and requested their advice in this regard. The question arose: If a client is illiterate and wishes to participate in research study, does one need another witness to sign that the client has given his/ her consent?

- The reply from the BioMedical Research Ethics Administrator was:
“As long as the witness is independent of the study and well known to the participant, not the nurse or anyone involved in the project”.
Thereafter the permission documents were adapted to incorporate a witness’s signature and date.

The research assistant recruited volunteers from the soup kitchen queue, when people were already on the premises. Thus, provisions were not provided for potential inducements, including bus fare. For interviews conducted at Dalton Hostel, a small private room was provided.

3.13 Data access and ownership.

Since this research project is self funded the researcher does not owe any obligations to sponsors or donors. Upon request the researcher has furnished three-monthly reports to the KVC Committee regarding the research development.

3.14 Interviewer’s mental health.

A possibility existed that both the assistant and the researcher could be affected by conducting the interviews and processing the data obtained there-from. In the event that this should materialise, the researcher enlisted the assistance and expertise of a minister of religion who would conduct a debriefing process, should the need arise. This anticipated service was not needed.

3.15 Data collection boundaries.

As the researcher collected data from twelve homeless people and six health care workers. If, during the interview, the assistant discovered that the participants failed to supply sufficient information for the research, the researcher would forgo the interview as opposed to “pushing” for information.

3.16 Limitations to the study

- The study was limited to homeless people, the majority of whom are black and residing in South Central Durban. Therefore the results from the research cannot be generalized to the entire homeless population in South Africa. The methodology chosen for the research study does not lend itself to the generalisation of results.
- The homeless are by nature suspicious. Thus, in order to persuade the homeless to answer questions, both trust and confidentiality were essential. The researcher was very conscious of finding an assistant who could develop a good rapport with interviewees without the interviewee feeling intimidated and victimised.
- For this study homeless participants identified their place of “residence” as being in the suburbs of Congella (Berea South), Berea, Mayville (Bellair) and Cato Manor (Bellair), which is zoned as South Central Durban. However homeless people are known to be migratory, and sleep anywhere that might prove safe and dry. Therefore, the researcher can not assume 100% accuracy in stating that those homeless people who participated in the research originate from South Central Durban.
- As other health care facilities used in this study did not keep a specific record of attendance by homeless people and the conditions that they presented with, the researcher could only present a record of such data from one health care facility (KVC).
- In the translation of the questionnaire for homeless participants from English to isiZulu, and in the translation of verbal responses of homeless participants, there could have been loss of meaning.

3.17 Summary of Chapter

This chapter described the methodology used in this qualitative study. Interviews were conducted with homeless participants and healthcare workers. Training of the research assistant and recommendations from the

pilot study has been discussed. Methods to ensure credibility, ethical considerations and data management and data analysis have also been described. In conclusion of the chapter limitations of this study are presented.

CHAPTER FOUR: PRESENTATION OF FINDINGS

4.1 Introduction

This chapter presents the findings of the study. The introductory section provides an overview of the participants in the study. In the subsequent sections the findings are reported according to the major categories and sub-categories for this study, which were predetermined and arose from the study objectives and research questions.

4.2 The Participants

4.2.1 Homeless participants

The homeless participants comprised of six males and six females. All the female participants were black; five of the male participants were black and one was white.

As an introductory question the homeless were asked about their geographical origin. Three came from rural areas within the Eastern Cape, six came from rural KwaZulu-Natal, one from Mpumalanga and two from Durban. Participants were asked how long they had been homeless in Durban. Responses varied from 6 months to three years to “*all my life*.” (HL 2)

With regard to their reasons for migrating to Durban, nine participants responded that they came to Durban to seek employment, while one responded “*because of HIV positive, to get better care*.” (HL 6) The remaining two participants were born and grew up in Durban.

4.2.2 Healthcare worker participants

The six healthcare worker participants interviewed were all women. Two of the participants were registered doctors; the remaining participants were professional nurses. Two healthcare worker participants were black (n=2), The remaining were white (n=2), coloured (n=1) and Indian (n=1). The

healthcare workers fell into the following age groups: 30's (n=2), 40's (n=2) and 50's (n=2).

4.3 The healthcare needs of homeless people in South Central Durban.

The health care needs of homeless people were determined by:

- Analysing the clinic statistics of the Kathleen Voysey Primary Health Clinic, to obtain the observed healthcare needs of homeless people attending this clinic.
- Eliciting responses from homeless people themselves about what they felt were their healthcare needs.
- Eliciting responses from healthcare workers about what they perceived were the healthcare needs of homeless people in South Central Durban.

4.3.1 Observed healthcare needs

The Kathleen Voysey Primary Health Care Clinic is only open on a Thursday morning. The analysis of the clinic statistics for the period January to December 2006 revealed that during this time there were a total of 2493 attendances. Of these 47% (n=1170) were male attendees and 53% (n=1323) female attendees. Over the period of the year 284 new clients were seen, which indicates that out of the total number of consultations (n=2493), 87% (n=2209) were to existing clients.

The conditions that clients presented with are reported in Table 4.1. The results depict that the majority of client attendances related to diabetes, hypertension/ cardiac conditions, respiratory problems and retroviral conditions.

A total of 621 attendances were treated for respiratory conditions during the year. On average 15 to 65 attendances were seen on a monthly basis, with

the highest number thereof being treated for respiratory problems during the month of June (n=115). This also coincides with the month with the highest frequency of attendances.

Regarding diabetes, attendance numbers ranged from 8-32 per month, the total number for 2006 (being 264). The month with the greatest number of diabetic attendances (n=32) was during the month of June. Hypertensive/ Cardiac attendances ranged from 7-33 attendances per month, the total number for 2006 (being 275). Regarding dressings, attendance numbers ranged from 6-32 per month, with a total number of 220 attendances for 2006. Attendances where healthcare workers were querying Retroviral conditions numbers varied from 2-12 per month, the total number for 2006 being 64. Retroviral attendance ranged from 16-49 per month, with most of this category attending the clinic in March (n=49), with a total for 2006 (of 423).

During 2006, 59 attendances were referred to the Durban Communicable Disease clinic for TB follow up and treatment; 16 attendances were referred for treatment of sexually transmitted infections. During 2006, 140 attendances were referred to hospitals for further management; 25 attendances were referred for dental management; 4 were assigned to the district surgeon, and 25 attendances received direction for assistance in obtaining grants.

Table 4.1 Clinic attendances at KVC during 2006 (see overleaf)

	January	February	March	April	May	June	July	August	September	October	November	December	% case load	TOTAL
Total Patients seen	68	183	290	112	245	293	229	273	189	193	290	128		2493
Total Female Patients	27	81	113	49	100	142	124	128	90	84	157	75	46.8	1170
Total Male Patients	41	102	177	63	145	151	105	145	99	109	133	53	53	1323
New Patients	10	26	38	9	31	44	28	25	19	29	20	5	11.4	284
Old Patients	58	157	252	103	214	249	201	248	170	164	270	123	88.6	2209
Asthma/Chest	17	49	65	29	57	115	53	65	56	46	54	15	24.9	621
Diabetes	8	18	21	20	27	32	24	24	25	14	34	17	10.6	264
Hypertension/Cardiac	7	21	32	15	27	25	24	33	25	19	27	20	11	275
Dressings	6	16	31	10	15	22	14	32	20	20	25	9	8.8	220
?Retroviral	2	6	11	1	12	5	6	5	1	4	7	4	2.5	64
Retroviral Positive	16	32	49	16	42	52	35	39	33	36	46	27	17	423
Referral DCC ?TB	2	6	7	1	2	6	7	5	5	7	7	4	2.4	59
Referral DCC ?STI	1	/	4	1	1	2	/	2	/	/	/	/	0.6	16
Referral Hospital	1	5	7	6	37	15	11	15	5	11	21	6	5.6	140
Referral Dental	/	2	4	/	3	/	3	4	2	4	2	1	1	25
Referral District Surgeon	/	1	/	/	1	/	/	/	1	1	/	/	0.2	4
Referral Grants	2	2	2	2	1	3	/	1	1	4	6	1	1	25

4.3.2 Felt healthcare needs

Homeless people reported health, social and welfare problems.

4.3.2.1 Health Needs

Homeless participants reported suffering from minor ailments, communicable and non-communicable diseases and trauma.

The minor ailments reported included body pains and wounds.

“My whole body is paining [he indicates his chest]. ...And when I’m sleeping at night I find it difficult to turn, inside my body there is pain and I sometimes feel my tummy windy and when I cough I feel pain inside my body.” (HL P)

“For my legs ... I have these sores on my legs because I have not been looking well after myself properly.” (HL 3)

Another homeless participant lamented that his wound was taking a long time to heal. He also offered a reason for why the wound was not getting better.

“ Today I came because I am having a sore in my left leg ... I have had it sometime, it was better but now it is coming back...the wound is not getting better...I think it is because of the tight shoes that I am wearing” [he points to the old shoes he is wearing]. ” (HL 7)

Homeless participants revealed that they suffered from various communicable diseases including TB, STI, scabies and HIV/ AIDS.

“As of now I am taking TB treatment from the TB chest clinic.” (HL P)

“...but what I remember I went to clinic for STI. For the first time my left testicle was swollen and I developed swollen glands... and then they helped me at the clinic.” (HL 1)

“I came today because my body is itching, the itching of the body... that has been happening quite a long time. The pain is not on the skin but it is inside. The pain comes and goes as if it never existed, sometimes it starts as if something is tickling me and it gets worse.” (HL P)

“I’m not well... I went for testing and I was told that I am HIV+ ...sick person. I’m having a running stomach.” (HL 4)

“I’m not well...I’m HIV positive.” (HL 6)

The non-communicable diseases that the homeless participants reported included high blood pressure, diabetes, and gynaecological problems.

“I have diabetes... I came for BP treatment because it has been going up and down ... for BP they gave me Metformin.... For my sugar I am on injection. Today I came for meds for BP.” (HL 5)

“I’m feeling dizzy, I’m having nausea and I haven’t had my periods since 27 June, I only had periods for one day. So I even feel that my womb is sore. I’m not sure it is because I haven’t has periods.” (HL 6)

Participants at the Dalton Hostel described that on the weekends when drunkenness occurs, fights ensue, which result in traumatic injuries.

“I was beaten by people with a crate.” (HL 1) This participant sustained injuries to his arm, which was swollen and which he could not straighten.

“I was run over by a food trolley.” (HL 7) This participant had a painful left leg and ankle along with wounds which had become septic.

4.3.2.3. Social Needs

The social needs that were identified by homeless participants were shelter, food, safety/security, work, family life and community networks.

Homeless participants reported on their places of shelter.

"I sleep at the verandas at the shops and at the hostel...Its not one fixed place, but not exactly on the road. Sometimes I stay on the verandas. People at Dalton Hostel, citizens of Dalton know about us." (HL P)

Homeless participants elaborated on sleeping anywhere that is safe where one can avoid being disturbed.

"We don't sleep in one place because today we will sleep here and then someone will chase us away." (HL P)

"I'm sleeping outside; I can't say exactly where I sleep because the policeman keeps chasing us away...I just sleep where I can't be bothered." (HL 1)

Some homeless participants stated that they sleep at Dalton Hostel. Dalton Hostel is a hostel run by the eThekweni municipality and caters for monthly and longer, cheap accommodation. Currently the hostel is running at a 100% capacity, and a long waiting list exists for future occupants. At the hostel, men and women stay in separate blocks. Family units had, in the past, been available. However, they were,

"phased out due to shortage of accommodation." (HL 10)

The price the participants pay for monthly accommodation at Dalton Hostel varies from R25 to R45, depending on the number of occupants sharing a room. The number of occupants per room varies from four to thirty-two people. A four bedded room costs R45 and includes access to water and electricity. In this room, occupants can also cook their own food.

“Each and every one of us has his own stove and pots.” (HL 8)

One homeless participant described the double burden of unemployment and yearly rent increases (R10.00) at the Dalton Hostel. This can result in,

“people leaving the hostel, and forces people to stay in the streets and verandas.” (HL 9)

Healthcare worker participants emphasised the urgent necessity of providing hygiene facilities, showers and toilets for homeless people.

“We use the toilets at the train station, sometimes the hostel toilets or sometimes an open space. It is difficult at the station when there are cleaners around as they chase us away.” (HL P)

“If I need to shower I need to go down to the beachfront ... and use the showers there ... you know if I leave it too long I break out into sores. ... they normally ask for R5... R5 to use the showers... they have an office there for the showers... and you go and pay at the office... and then you can go and shower... very organized, run by the municipality.” (HL 3)

One homeless participant provided a description of her own personal hygiene.

“and here at the clinic they give us soap and sometimes food...so with the soap you can wash, and your clothes in the sun and get clean [showing how clean she was] and when you get R2 you buy a roll-on and apply it on your armpit... and again with that money from the boxes [homeless participant collected cardboard boxes and then sold same to paper waste] you can buy the body lotion.” (HL 2)

“In all fairness staying in the road does not mean you have to be dirty... if you are dirty, people will take you as otherwise and that you are poor, does not mean that you don’t have to take care of yourself... even coming here to the

clinic ... we need not to come daily... just wake up in the morning clean yourself and see what else you can do... I don't usually bath myself in the morning. I wait until the sun is up and then I nicely wash myself." (HL 2)

Homeless participants agreed that food is a very important need. A few of the homeless participants identified that a reason for coming to one of the Primary Health Care clinics was that there is a soup kitchen before the clinic opens.

"Yes for only for food.... It's the first time [coming to the clinic] and I'm very very hungry... then I decided to come." (HL 1)

Homeless participants described other sources where they obtained food:

"People staying at the hostel whenever they are having a braai [buy meat together] they give us as well. Whenever people that stay at the hostel go home, any left over food is given to us." (HL P)

"When we get temporal [temporary] jobs from people living in the flats, when they are moving their goods, we don't often get paid and sometimes, are given rotten food." (HL 1)

Additional social problems experienced by homeless people include sexual abuse, fear of exposure, fear for life and criminals.

As a result of little sheltered accommodation for homeless people, they are at risk of physical and sexual abuse. One homeless participant described in detail the threat of abuse from young boys, and taxi drivers:

"You see whenever someone wants to touch me and I don't want that I have to fight because I am old... I'm not of their age...they must go to their age group." (HL 2)

"I am scared of getting HIV/ AIDS. When the taxi drivers come [for sex] to the homeless all I see is HIV/ AIDS on their foreheads and I stay away." (HL 2)

One way of attempting to protect oneself is not to sleep in the same place.

"So you see now we have to go and sleep there, we don't stay in one place. I will be lying if I say that I stay in one place." (HL 2)

A homeless participant elaborated another way of protecting herself,

"I have two pairs of tights/ leggings, I always wear a tight legging in case of gang rape, the leggings protect me at night." (HL 2)

She further described how homeless people protect each other,

"Ja, remember that its not only me that lives here, there we are many, there are many people... we protect each other, even yesterday we did not sleep well because of these young boys..." (HL 2)

Another illustration of the threat to safety and security was when a participant was asked to sign the informed consent for this research. She did not want to sign for fear of exposure. She was scared that,

"my name would be forwarded to SAPS as they are informed that it is illegal to stay on the road." (HL 2)

The quote below further reinforces the vulnerability felt by homeless people.

"The only thing that we are scared of, are people rather than animals, because we have heard that the sangomas want body parts to make muti."
(HL P)

There is a preconception that homeless people are involved in criminal activities. A homeless participant explained,

“Being homeless does not mean that we are criminals, I don’t do smash and grab. Criminals steal our possessions... but I fight for my belongings.”

(HL 1)

Despite not having many possessions, homeless people are proud and possessive of their belongings, as described by one homeless participant,

“Yes I carry everything with me... My blankets here...” [he tried to take them out to show the research assistant who told him that he does not have to take them out]. (HL 3)

All the homeless participants emphasized the need for employment. At the time the interviews were held, four homeless participants had some form of temporary employment and the remaining eight homeless participants did not have employment.

One homeless participant who resided at Dalton hostel stated that:

“For life to go on perfectly, one must have a steady job, be able to maintain your family. As I am unable to work, life is really difficult for me, and in order to get better things in life, one must have some money for things for health care.”

(HL 10)

Many homeless participants described the psycho-social importance of being employed. Besides getting remuneration, employment also increases self-worth and the sense of belonging. A homeless participant described his experiences:

“I’d like to have money one day so that I go back home, because at home they would not like seeing me like this...and I’ve never disappointed them.” (HL 1)

“Because I am homeless “other people” don’t take me seriously because I do not have a job.” (HL1)

Responses from homeless participants show that participants have resourcefully tried to find temporary employment ranging from selling vegetables, fruit, peanuts, cigarettes and boxes to sewing clothes. In desperation some homeless turn to prostitution.

“Some of the homeless females turn to prostitution, but I say they are good females.” (HL 2)

When the researcher and the assistant went to Dalton Hostel, they noticed that there were only a few residents at the hostel. When they enquired about possible respondents for the research, the supervisor of Dalton Hostel explained that during the day residents are often out looking for work.

A concern from homeless participants is that when they are able to get employment, they are often exploited as they do not receive an adequate wage. A homeless participant described her job of distributing flyers, advertising sangoma services. If a client used the service then the homeless person received a meagre commission. She further elaborated,

“There are so many people that are going for the consultation, but we are paid peanuts at the end of the day.” (HL 6)

Another homeless participant described his disappointment.

“When we get temporal [temporary] jobs from people living in the flats, when the people are moving their goods, we don’t often get paid.” (HL 1)

Homeless people are opportunistic in attempting to get money. After the interview was over one homeless participant asked for R10.00 from the research assistant. The research assistant did not give any money. This action was reiterated by a healthcare worker participant, who described,

“some homeless ask for money.” (HCW 5)

A social problem identified by a homeless participant who resides at the Dalton Hostel is that of separation of families. The participant stated that males and females are accommodated in separate blocks, and that children stay with their mothers in the female block. The homeless participant further elaborated that,

“we have children here but it is not conducive for them because there are no crèches and for those who attend school; it costs money to transport them to school.” (HL 9)

In the descriptions of accommodation, food and sexual abuse, homeless participants reinforce the concept of a social network that also provides a sense of community.

4.3.2.3 Welfare Needs

Homeless participants were asked whether they received pensions. One participant received an old age pension. Another participant used her child's grant. A homeless participant described her problems in accessing a pension.

“They organized for my pension but it was unsuccessful...I don't know they just told me that.” (HL 4)

Homeless participants describe the means by which they obtain money for accommodation.

“my grandmother helps me out of her pension money.” (HL 10)

Whilst, *“my brother sometimes pays for me.”* (HL 9)

4.5.3 Perceived healthcare needs.

When asked what they perceived were the healthcare needs of homeless people, healthcare workers reported on health, social and welfare problems.

4.3.3.1 Health Needs

Healthcare workers reported that homeless people suffer from minor ailments, communicable diseases, non-communicable diseases and trauma.

The minor ailments reported included colds/flu, aches and pains, sore bones, boils, ear, nose and throat problems and chest infections.

“Health problems diabetes, hypertension, aches and pains, sore bones is the favourite and we give out more Brufen [anti-inflammatory] for sore bones than anything. Skin conditions, scabies +++, boils, all these sort of things, ear, nose and throat problems and chest problems.” (HCW 3)

“People in Cato Crest like coming to the clinic for minor things, others come when they see no change in home treatments e.g certain herbs boiled with lemon for a cough.” (HCW 1)

The communicable diseases reported include scabies, TB and HIV and AIDS.

“We see the odd child...Streetwise bring them. And they are normally full of scabies and we have to treat them.” (HCW P).

“TB, they do get follow up due to the community health workers and clients coming to the clinic for medication.” (HCW 1)

Another healthcare worker who works at a Communicable Disease Clinic stated:

“We do have homeless people.” (HCW 2)

Another communicable disease identified is HIV and AIDS.

“We get patients coming in with AIDS. We are not an AIDS testing centre but if we suspect they have got AIDS we send them for testing.” (HCW 3)

“Most of the time we see people if they get sick, like some of them will get TB or a skin infection etc...they go to another facility and that facility says that they should have an HIV test... and they come. So a lot come with health related problems that could be related to HIV.” (HCW 4)

When asked what non-communicable conditions homeless people present with, one healthcare worker replied:

“Health problems e.g. diabetes, hypertension.” (HCW 3)

There were no responses regarding trauma from the KVC clinic. However a response was offered from a municipal clinic:

“There are a lot of shebeens in Cato Crest. They drink and they have a fight and then when they are hurt they come to the clinic, especially in the evenings and the weekends.” (HCW 1)

4.3.3.2 Social Needs

The social needs of homeless people identified by healthcare workers were shelter, ablution facilities, food and social problems. The needs were summed up by one healthcare worker participant from the KVC clinic:

“They need food, they need shelter, they need medical care, and very often they also need tender loving care, basically. I think it goes like the Maslow theory of needs, where you need warmth, shelter, food and sociable.” (HCW P)

“The needs of homeless people is the same as other people, because they are also people as well, so all the needs that a human being needs to survive they also need the same thing.” (HCW 5)

Regarding the provision of food, a response from a healthcare worker at KVC:
“They get soup every day Monday to Friday. Yes they need food. The soup kitchen queue is much longer than the clinic queue.” (HCW 3)

The need for the provision of food is reiterated by a healthcare worker from another clinic:

“The added bonus is that there is a feeding scheme that’s run here every day.” (HCW 4)

A healthcare worker from another clinic recounts:

“Or they come and say that they are hungry. We give them food parcels, whenever they are available.” (HCW 5)

All healthcare worker respondents agreed on the need for the provision of shelter:

“They need shelter; if they are not living in hostels then they are living under the bushes/ trees, near the railway line.” (HCW 3)

One KVC healthcare worker suggested that due to the lack of shelter, health has deteriorated:

“We have had HIV folk who have already gone into the AIDS state who are sleeping down at Maydon Wharf and they have nowhere to go.” (HCW P)

Healthcare worker participants reinforced the need for hygiene facilities, showers and toilets. One healthcare worker described:

“They need hygiene facilities, showers and some way in the form of a loo.” (HCW 3)

Healthcare worker respondents emphasized that homeless people encounter various types of social problems, for example unemployment, which could lead to alcohol abuse. This was described by a healthcare worker:

“Social problems, some of them have got big social problems. Do you know they have been thrown out of homes or they have been retrenched for some reason or other, so therefore this is why they are on the streets a lot of them. A lot have been retrenched and have taken to drunkenness and so they get thrown out and live on the streets. They have got family problems all the usual sort of social problems that people have.” (HCW 3)

Another healthcare worker reflected on her experiences encountered whilst counselling homeless people:

“Because we offer counselling, which is general counselling, so sometimes they will come for spiritual needs and social problems, because they may want us to pray for them to get a job etc.” (HCW 4)

The above responses show a range of social problems from rejection of homeless people to social problems which are the same as anybody else's. The responses also highlight that homeless people also encounter emotional and spiritual problems.

4.3.3.3. Welfare Needs

Healthcare workers unanimously agreed that homeless people needed access to money. One healthcare worker from KVC clinic stated that there is a demand from homeless people for grants.

“Well a lot of them ask, especially the 45 to 50 year old, asking for grants. The street people don't have homes, they don't have money, they haven't even got a pension half of them, and we do try and send them down to get pensions, welfare.” (HCW 3)

4.6 The health seeking behaviours of homeless people in South Central Durban.

The process for eliciting the health seeking behaviours of homeless people was influenced by the 3-delays conceptual framework. Thus the health seeking behaviours of homeless were determined by:

- Establishing what prompted homeless people to seek health care. This included establishing what homeless people perceived their health status to be and why they sought health care.
- Eliciting responses from homeless people about the factors influencing when they sought care. This included comments from health workers in their observations about when homeless people sought care in relation to the severity of the presenting problem.
- Eliciting responses from homeless people about the factors influencing where they sought care.

4.4.1 Why homeless seek care?

As an introductory question homeless participants were asked what their perceptions of health were. There was a mixed response to perceptions of health, with some perceiving themselves as healthy and others as not healthy.

Reasons for not being healthy included that they did not have a permanent job and therefore they could not buy food or “*better things*” (HL 10) to enable a healthier lifestyle. Other contributing factors included:

“I would say that I have managed to keep myself in good health...but my legs, I have not been able to shower properly, and I have picked up these sores on my legs ...that’s why I came here to get them fixed up.” (HL 3)

One participant stated the need to keep well, as his family would not like to see him unhealthy.

“Yes, I see myself as a healthy person but only if I can get some few cents then I will live a normal life in my mind and in my heart. But now my problem is

that I am not working. I'd like to have money one day so that I go back home, because at home they would not like seeing me like this... and I've never disappointed them..." (HL 1)

One homeless participant from Dalton hostel stated that he was not healthy. Only one homeless participant expressed that she had:

"never been to the clinics or hospitals." (HL 11)

The participant went on to explain that,

"I have never been sick",

The participant went on to explain that she keeps herself healthy by using traditional herbs and *"by sticking to good foods."* (HL 11)

A contributing factor as to why homeless people seek health care is that of compliance.

One homeless participant explained:

"Today I'm here to collect my medication, it is my date... and today what is the date today [talking to herself] so it means I must come back next month on the 10th." (HL 2)

Healthcare workers who responded regarding non-compliance to medication and follow up visits, gave the following reasons: stopping medication when symptoms have improved, medication stolen and no money to pay for transport to hospitals. Another factor is that of having no fixed address which further compounds the problem of non-compliance, as healthcare workers are unable to follow up care of homeless clients.

"What we have found is that a lot of times when they would not take their medication, was when other homeless friends or whatever would steal their medication... then they would not have taken their medication." (HCW 4)

One healthcare worker further explained the choice in medication as they anticipate non-compliance,

“... so that is why sometimes you use your opinion and use your judgment that this person is not really going to take the medication but rather opt for injection rather than tablets. We do this because they do not come for the follow up. They do default.” (HCW 5)

4.4.2 When homeless people seek healthcare

In answering the question; When do homeless come to seek health care? Responses from healthcare workers ranged from homeless clients presenting with minor ailments to homeless clients presenting with major ailments.

“At what stage they come, yes they come with lots of minor aches and pains, cough, cold or a headache.” (HCW 3)

“From those we have seen a lot of them will tend to come when they are late in their illnesses...they are actually very sick ...and sick for quite some time”. (HCW 4)

4.4.2 Where homeless people seek care.

Of the homeless participants, only one expressed that she had *“never been to the clinics or hospitals.” (HL 11)*

The remaining homeless participants stated that they had previously used a clinic and/or hospital. Responses from participants varied as to which clinics/hospitals they had attended. These ranged from accessing primary health care clinics for minor ailments to a TB clinic for treatment, and being referred to a government hospital for further treatment. These responses were confirmed by responses from healthcare workers.

“If they do come with other problems we refer them to the PHC clinic (Lancer’s Road) here by the taxi rank. The other point is that the clinic is convenient. If you look at where it is situated, it is situated right in the centre of all the taxis

and transport. Everything is close by. There are a lot of clinics that are run by NGO's." (HCW 2)

The findings show that if the clinic is unable to deal with the health problem, there is a good referral network that health workers use.

There was a mixed response to whether homeless clients prefer urban or rural healthcare facilities. One homeless participant and one healthcare worker mentioned that clients are coming to urban clinics from rural areas:

"because there is care this side. In the farm the person with HIV positive is not taken care of." (HL 6)

Whilst one participant described his reasons for accessing a rural clinic:

"In the clinic they are the ones who said I must go to the Dududu Clinic because that is where I come from...when I am sick I see it better to go home so that I'll die next to my wife." (HL 9)

4.7 Factors influencing access of healthcare by homeless people in South Central Durban.

4.5.1 Factors facilitating access

The factors facilitating access to health care identified by both homeless and healthcare workers, included: incentives to seek care, financial implications of seeking care, quality of care and accessibility of healthcare facilities.

Both healthcare workers and homeless participants responded that offering food could be an incentive for homeless clients to access healthcare facilities.

"They (those I stay with on the street) brought me to the clinic because they also come to the clinic, due to the food that is offered. So they come Monday

to Friday and there is a free clinic on Thursday.” (HL P)

The healthcare workers from the Faith Based Organizations stated that a soup kitchen was run in conjunction with the healthcare facility.

“Secondly the added bonus is that there is a feeding scheme that’s run here every day. We don’t run it. The church [Durban Christian Centre] here actually runs it.” (HCW 4)

The idea of the provision of food is further reiterated by a healthcare worker from a municipal clinic:

“We used to provide them with food parcels. I think that is what attracted them to come to this clinic. But we don’t give them any more.” (HCW 5)

Another factor that could facilitate access to healthcare facilities relates to the financial implications of seeking care. How much does it cost to travel to access healthcare facilities? On reaching healthcare facilities what sum of money did the homeless need to pay for the services?

Homeless participants responded that travelling to the healthcare service did not cost them anything, as the majority walked.

“We didn’t come with money; we just walked with our feet.” (HL 1)

The amount paid to access a healthcare facility varied from R3.50 to R25.00.

One participant declared *“today I don’t have money so I will walk.” (HL 4)*

Another homeless participant was able to reach the healthcare service by taxi, *“It cost me R3.50.” (HL 5)*

Another homeless respondent explained, *“It depends on my health whether I decide to walk or take a taxi.” (HL 9)*

Healthcare workers elaborated further that a major reason that homeless people access their clinics, is that services offered are free. Clients attend such clinics for this very reason.

“The main thing is that we are free. I know that cost is a major factor in terms of coming here. They get a meal a day and they can come to the clinic for free. I think for us those are two things that really facilitate accessing healthcare. The second thing is that they get medication for free. Some of them live around here, some in Albert Park and so there’s no transport costs involved, so they just walk, those that are living in the area...” (HCW 4)

To obviate payment being demanded, KVC healthcare workers supply homeless clients with a referral letter.

“No, no there’s no problem especially with a referral letter from here, it open’s doors for me ... and the letter states that I don’t pay.” (HL 2)

Residents at Dalton Hostel are also furnished with a letter stating that they stay at the residence, which facilitates access to healthcare facilities.

Another factor that could facilitate access to healthcare facilities relates to the quality of care that homeless people received. Homeless participants provided positive responses concerning the service that they had received, both from clinics and from government hospitals.

“Well there’s nothing that I can say, but when I was beaten by people with a crate, I went to the hospital by the beach. They gave me the tablets. Down by the hospital they wanted R20... but I didn’t have. They said when I come back I must pay next time.” (HL 1)

[KVC] I found it very good ... I have always had good attention.” (HL 3)

Reasons why healthcare workers thought respondents reported positively about the treatment they had received at healthcare facilities:

“I think that they get a lot more tender loving care from us, and I think they become aware by word of mouth that we are very happy to talk to them and be open about their HIV status. I think that’s the big plus. The other is with the chronics. We try and stress compliancy and we hope that they do. With reinforcement we seem to get clients coming back to us. A lot of new ones come for HIV testing. We then refer, but they are happy to bring us their results.” (HCW P)

Another reason could relate to the greater resources available to health care facilities in the urban areas vis-à-vis rural areas.

“Sometimes people came from Eastern Cape, visiting their relatives in Cato Crest, and these people when they come, come with long term sicknesses, hoping to get better assistance from the urban clinic. The clinic offers many resources. This could be a reason as to why clients are coming.” (HCW 1)

Homeless participants also gave negative responses concerning the services encountered.

“I have to wait. I know that they are very busy here and I sit and wait...” (HL 3)

“This clinic [KVC] is much better than Cato Crest.... They are treating us bad there... I got a better treatment.” (HL 4)

Another factor that could facilitate access to healthcare facilities is how geographically accessible healthcare facilities are.

Half of the homeless participants described the distance travelled to healthcare facilities as “near” and that the time taken to travel was between 20-30 minutes.

"It's not that far, but it takes half an hour to get there [clinic]." (HL P)

The distance travelled was reinforced by a healthcare worker:

"The clinic is easily accessible to Cato Crest, as clients walk." (HCW 1)

The remaining half of the homeless participants stated that walking to healthcare facilities could take up to an hour. Two homeless respondents also mentioned that it also depended on their health as to how far and fast they could walk. A homeless participant mentioned:

"It is far... you see as I will leave now I will get there about 12 [approximately 2 hours]." (HL 4)

To ascertain the process followed by homeless clients in choosing KVC healthcare facility the question was posed to them about how they came to use the health facility (KVC).

Homeless participants' responses ranged from, being told by a friend, to a sister, to *"a certain lady that I attend church with."* (HL 5)

"Those I stay with on the streets told me about this clinic. I didn't know about it." (HL P)

A homeless participant responded that it was the food being served that enticed him to come and join the queue.

"Well me and my friends were passing by then we saw that people were given food, then we entered. When we were in we find out that there is a clinic." (HL 7)

4.5.2 Factors hindering access

The categories of factors identified by both homeless and healthcare worker participants were: types of healthcare services available at facilities, problems encountered at healthcare facilities, problems with money and identification documentations and discrimination.

A healthcare worker participant mentioned that the ideal healthcare facility would contain all services available:

“... the facility, they would have everything at one place...which is where we have a bit of a drawback because we don’t provide ARV’s...but if I can get everything I need at one place it saves me having to go from x to y to z.”
(HCW 4)

Homeless participants lamented the long waiting time at healthcare facilities. One homeless participant described such an experience, despite his earnest effort to arrive early (five o’clock) to ensure his priority status in the queue.

“I’ve been to Addington Hospital I find that I have to wait, wait, wait sometimes the whole day and they can’t see me because they are too busy...I have to wait to see a doctor/ sister and sometimes they are just so busy that I do not get seen that day....” (HL 3)

Another homeless participant described her experience when she arrived at lunch time (approx 12.00):

“I went to the clinic next to Chesterville rank, but I could not be attended as I was told I came late. The nurse told me to be early if I want to be attended.”
(HL 7)

Another problem encountered at healthcare facilities concerned the receiving of medication. A participant commented:

“Sometimes if I go there they do not give me the tablets ... they say that they are finished.” (HL 4)

Another problem identified by healthcare worker participants concerned the lack of money:

“Money...half the time they can’t get to wherever we want to send them.... for instance at one stage Wentworth would give ARV’s, but they can’t afford to get to Wentworth. If you haven’t got any money how are you going to get to Wentworth?”(HCW 3)

Healthcare workers reiterated that besides the need of money for transport to other healthcare facilities that provide ARV’s, clients also require identification and a fixed permanent address.

“This is a great problem for us referring for ARV, is that the clients have to have an ID [identity document], they have to have a buddy to go with them...this is a big factor... they have to have a permanent address. As most of our clients don’t have a permanent address, they are sleeping under the bushes.” (HCW P)

Possession of an identification document also poses problems in obtaining grants and pensions, as illustrated by one healthcare worker:

“Many of them don’t have IDs and then this presents a problem. If they haven’t got IDs... if they haven’t got an ID book they usually don’t have a birth certificate either... they have to access a birth certificate and that sometimes is a problem when they are at death’s door...”(HCW 3)

The issue of healthcare for non-South African citizens was raised by one healthcare worker participant:

“If they are from another country like Malawi, they are not considered South African residents and they will not attend to them. So they are chased away.” (HCW P)

One healthcare worker offered a possible reason hindering access to healthcare by homeless people as that of discrimination against homeless clients by healthcare workers.

“Just depends on the staff that you have... because a lot of the time people don’t want to go to other facilities because the staff are unfriendly, or the staff don’t provide an atmosphere that is non- discriminating.” (HCW 4)

The problem of discrimination was reiterated by a few homeless participants,

“... They [KVC] giving me a better service, I wish that they can always be like this.... Well it can sometimes happen that there are those individuals on a bad mood but its not like us (black)...people say hey hey hey... these things that live on the road...hey they are so full of nonsense....how would you feel if people say that to you?” (HL 2)

4.6 Recommendations of respondents regarding care for homeless people in South Central Durban.

Recommendations identified by both homeless and healthcare worker participants included: assistance with obtaining identity documents, accommodation, food parcels, clothing and shoes, employment and grants. There were further recommendations proposed on the management of health problems experienced by homeless people.

There were suggestions from both healthcare workers and homeless participants that there should be assistance in obtaining identification documents:

“And also if they don’t have ID then they can’t even access their disability grant, poor grants or even their old age pension.” (HCW P)

Another recommendation from both homeless participants and healthcare workers was that shelter for the homeless should be available.

“We had HIV folk who have already gone into the AIDS state who are sleeping down at Maydon Wharf and they have no where to go. And we have had people dying on the streets. And that is so unacceptable...it really is. We need somewhere where we can refer people, especially in their last days, so that they can be comfortable.” (HCW P)

When the researcher and assistant went to Dalton Hostel it was noted that the hostel was full and that there was a long waiting list for potential residents.

Homeless participants and healthcare workers were unanimous in the suggestion for the provision of food parcels. One healthcare worker suggested:

“Food parcels are given to TB patients when available... I feel that these parcels should also be given to HIV + and those who are really hungry and malnourished.” (HCW 2)

Homeless and healthcare workers also suggested:

“Clothing to make them look as human beings. This clinic receives clothing for children and they give to the vulnerable ones. Soap so that they’ll look after their personal hygiene, to be accepted by society.” (HCW 5)

Homeless participants suggested employment so that *“I’ll keep on and survive”* (HL 7). This suggestion is confirmed by a healthcare worker, however she cautioned:

“... We must be careful that we don’t want to develop a dependent society – people need employment. Even the government grants are not enough, how can you feed a family on a government grant?” (HCW 2)

The research assistant wrote in her field notes reflections of the same interview:

“The healthcare worker feels that young ones are purposely defaulting on their TB treatment, for government grant purposes. This has been picked up on her statistics looking at the age of defaulting clients. The young ones ask about the social grant and can they get a letter to take to social welfare” (20th August 2007).

Suggestions from residents at Dalton Hostel included the provision of a health service at the hostel and to attend to the overcrowding. All participants requested a clinic at the hostel or for a permanent healthcare worker to be appointed, to be able to deal with emergencies.

“There are a lot of women that get ill, and others are seriously ill.” (HL 9)

“Because sometimes people get sick at night or injured and the need for first aid.” (HL 8)

The same participant further explained that when an ambulance is called for a sickness or an injury, residents often have a long wait. One participant reinforced the need for a clinic as her concern is for the newborn babies that:

“get sick and mother do not have money, and then the babies get seriously ill.” (HL 11)

Homeless hostel dweller participants mentioned that overcrowding is a big problem. They were concerned regarding the lack of hygiene, and the risk of contracting communicable diseases.

The category of managing health problems of homeless people was further divided into sub-categories, as identified by both homeless and healthcare

worker participants. The sub-categories identified were equity, accessibility, affordability and empowerment.

Equity

During the time period of data collection for this research, healthcare worker participants were not able to state how many homeless people were to be found in the research setting. One of the suggestions from a healthcare worker participant is that there:

“should be a register of homeless people.” (HCW 2)

By keeping a register one can know how many homeless people there are and make plans for providing health care. The healthcare worker participant further elaborated:

“I think that there is a major gap in managing the homeless, if you compare with other parts of the world, obviously the homeless need to be monitored on a regular basis for TB, drug abuse.” (HCW 2)

Accessibility

Healthcare worker participants and one homeless participant suggested better access for ARV's for homeless people. One healthcare worker participant suggested:

“I think that it would be good if we had some government intervention regarding ARV treatment.” (HCW P)

A suggestion from a healthcare worker that one way of providing healthcare and ARV's for homeless people could be by providing:

“a mobile clinic providing health services for homeless people.” (HCW 5)

Affordability

Currently, if you are homeless, healthcare at government health services is free/ reduced. However homeless clients still have to produce identification documents and proof of unemployment. There are also the hidden costs e.g. transport. One healthcare worker participant described:

“limitations/ barriers for people to access healthcare, whilst most government clinics don’t charge, if you go to hospital there is a minimal fee that you have to pay ...do we have the facilities to be able to say, that people who are homeless, that we waiver that.” (HCW 4)

Availability

A healthcare worker explained the factors which do not make these services available:

“A lot of the time, the government clinics if you are not there by a certain time... you just don’t get seen. Like here at the Chest clinic you have to be here by eight o’clock or else you will not be seen for that day.” (HCW 4)

“.... Is it possible for us to have 24-hr clinics? You can look and see are there enough clinics in the area? If there are clinics, are the clinics big enough to accommodate the population of the area, and do they have the staff?” (HCW 4)

Empowerment

A healthcare worker participant asked the question:

“What is government doing to get homeless people off the streets?” (HCW 4)

The participant then went on to make some strong suggestions to empower the homeless. The first suggestion involves that of education, as none of the homeless participants interviewed had completed their Matric. ABET should be involved to allow people to finish their education. This suggestion was also

made by a homeless participant. The healthcare worker participant further elaborated that education will empower homeless people and

“get people economically viable.” (HCW 4)

“a better environment will improve health.” (HCW 4)

Further suggestions included empowerment programmes on becoming economically sustainable for homeless people, and preventative health education programmes.

“There is not a lot of initiative in terms of health seeking behaviour, therefore they come and see you later rather than earlier...not much in terms of preventative work for the homeless e.g. HIV, TB. Preventative programmes are available on the TV, radio and newspapers which does not reach the homeless.” (HCW 4)

The suggestion was reiterated by a homeless participant who requested for health education programmes, as this participant shares a thirty two bedded room and is very concerned about contracting TB.

“Other people when they come to stay with us, you see a person being healthy but as time goes on she loses weight and gets seriously ill.” (HL 10)

In conclusion a healthcare worker participant emphatically stated that:

“We don’t have enough information and hopefully this study will facilitate this information.” (HCW 2)

4.7. Summary of Chapter

This chapter describes the findings which have answered the five objectives of the study. In order to obtain a clearer understanding of the relationship between health seeking behaviours of homeless people and access to healthcare facilities, these results need to be put into the wider context of the existing literature, and subjected to further discussion and interpretation.

CHAPTER FIVE

DISCUSSION OF THE RESULTS

5.2 Introduction

The results in Chapter Four are discussed according to the objectives of the study and compared against previous research and literature, in the context of the conceptual framework. New areas of exploration are identified and presented.

5.2 The participants

The sample used in this study was heterogeneous. Responses were obtained from both homeless participants and healthcare workers. Amongst the homeless participants the different demographic factors identified included: sex, race, geographical origin and reasons for migration. The study included homeless participants from equal numbers of both sexes and included a range of ages. The findings seemed to suggest that older homeless females were more vulnerable to sexual abuse and assault. Older homeless people may have better access to social grants particularly the state pension. The generalisability of these findings would need to be tested through a larger, representative quantitative study.

All healthcare workers were female. Due to the nature of the questions posed to the healthcare workers, the researcher is of the opinion that the same responses would have been generated by male healthcare workers and thus a gender perspective did not seem to be an important analytical consideration.

5.3 The healthcare needs of homeless people in South Central Durban.

The findings presented common observed health problems which were experienced globally by homeless people. From the data obtained from the 2006 register at KVC it was observed that the percentage attendances of male and female homeless were the same. A large majority of these attendances were repeat attendances. This demonstrated relatively good treatment compliance of patients that attend the KVC. By homeless participants demonstrating good follow up attendances, this in turn shows a good level of awareness of health and health problems. The data also shows that homeless attendances are referred for further management. The scope of the study did not extend to verify whether referrals actually took place.

The researcher was unable to access treatment compliance and continuity of care at municipal and provincial health facilities as these facilities did not keep a record of which patients were homeless. From the findings, a healthcare service that is user friendly for homeless people, such as the services offered by the FBO's, can promote continuity of care and reduce non-compliance with treatment, especially given that the incentives provided by the clinic attract patients.

The findings indicated that a common complaint described by homeless participants was that of general malaise. Homeless participants described suffering from non-communicable diseases, communicable diseases and injuries due to trauma. Non-communicable diseases included diabetes, hypertension and gynaecological conditions. Communicable diseases included TB, HIV/AIDS and STI's. Conditions due to trauma included foot

trauma and violence. These conditions are also reported in Turner (2001:99), Wright & Tompkins (2006:286-269), Wiecha et al (1991:368), Roberts (2003:37), National Health Care for the Homeless Council (2008:1), Hwang et al (2005:313), Riley (2003:475), Manfellotto (2002:77) and Shiner (1999:526). For example the prevalence of foot trauma is supported by Wright & Tompkins (2006:268) who ascribe foot trauma experienced by homeless people to wearing inappropriate shoes together with walking long distances. Perry & Potter (2005:50-51), Olufemi (1999:484) concur that the lack of resources available to homeless people exacerbate chronic health problems.

Homeless participants described accessing specific healthcare facilities for the treatment of TB and STI's. One of the homeless participants mentioned the names of the medication that she was taking, demonstrating awareness of the health problem and the required treatment.

The findings showed that a minority of homeless participants acknowledge that they are suffering from HIV/ AIDS. This finding is of important value as it shows that some of the homeless participants are aware of the clinical manifestations of HIV/ AIDS and shows acknowledgement that they have this infection. Furthermore the participants who were HIV infected talked to the research assistant about their illness, without the fear of stigmatisation.

All homeless participants in the study, when asked about their health problems, also stated their basic needs e.g. shelter, ablution facilities and food for survival. This finding supports the WHO definition of health, as being a "state of physical, mental and social well-being not merely the absence of disease or infirmity" (Green, 1999:7).

Homeless participants in this study revealed a lack of security and safety, as they are not always able to find a safe place to sleep. They attributed their "nomadic" lifestyle to ongoing threats to safety and security, in that, if they sleep in the same place night after night, they are vulnerable to attacks, exploitation and victimisation, including from the police. This is supported in research conducted by the National Health Care for the Homeless Council

(2008:1-3) that asserts that people who do not have shelter are prone to attacks of violence. The National Health Care for the Homeless Council (2008:1-3) further asserts the vulnerability of homeless people and that homeless people are in danger of being exploited and abused. Homeless participants vividly described the traumatic injuries to which they have subjected. Homeless participants reinforced their vulnerability of being exposed by refusing to sign informed consent for this study and by acknowledging that they are frightened of people.

Homeless participants described their fears and the measures that they took in order to attempt to allay these fears. A homeless participant described wearing two pairs of tights/ leggings at night to try and protect herself from being sexually abused. In her response the same participant described how homeless people sleep together so as to protect themselves. This response provides evidence to support the formation of a social network by homeless people. This finding is supported by Smith (2008:756) who described the “self-supportive networks, commonly called street families” that homeless people form.

In their description of the triple burden of disease that homeless people experience, Tabibzadeh and Lissberg (1997:288) commented that with the third burden, homeless people experience social alienation which can in turn leads to crime, alcohol abuse and prostitution. Responses from homeless participants demonstrated that not all homeless turn to crime and prostitution. By fighting for their belongings and carrying their belongings with them, the homeless demonstrate self preservation and pride in the little that they own.

In contrast to the situation faced by ‘rough sleepers’, homeless participants at Dalton Hostel experienced a degree of safety and security. The problem experienced in the Hostel is that of overcrowding. Both situations carry health risks, as described by Shiner (1995:526) “inadequate shelter and warmth, exacerbates respiratory, musculo-skeletal and skin-related conditions”. These conditions were observed in the 2006 KVC data.

Another basic need emphasised by both the homeless people and the healthcare workers, is the provision of ablution facilities that would assist homeless people to maintain basic hygiene. The inability to find secure ablution facilities distressed homeless people, as they were fully aware of the need to keep clean, both for health reasons and in order to preserve self-pride and dignity. Homeless participants revealed themselves to be resourceful in finding ways and places to attempt to keep themselves clean. Any health intervention to improve basic hygiene in homeless people needs to take cognisance of this awareness and resourcefulness.

Access to food was a major concern for the homeless people. They are often dependant on the 'alms' of others to have this need met. This need drew them to the FBO health facilities which provided soup. They often offered their labour in exchange for food. They were dependant on other residents at the Dalton Hostel to share any left over food with them. Although in the way that this was spoken about by Respondent HL P, there may be elements of a supportive social network in place. There is doubt however, that the food obtained is sufficient to meet daily caloric and nutritional needs. Wiecha et al (1991:372) call for food assistance programmes and nutritional services for homeless people in order to "meet their dietary and nutrition-related needs".

There is consensus among homeless participants that employment is seen as a means of not only being able to provide basic needs and furthering one's life, but also to improve self esteem and sense of belonging. All the homeless participants wished for employment. Many participants had attempted some form of job in order to access some money. Seager & Tamasane (2008:24), Martins (2008:428) describe the resourcefulness of homeless people despite being homeless. In order to obtain money one homeless participant mentioned prostitution, the participant then defended women that they are still 'good' despite resorting to prostitution. By asking for money, the homeless could be seen as being dependent or, seeking a means to survive.

Responses from the homeless participants regarding welfare needs, show that there appears to be a lack of knowledge regarding accessing pensions/

grants. Riley et al (2003:476) state that homeless people commonly encounter problems in registering for social assistance and healthcare. The findings could suggest that due to unemployment, the homeless are dependent on pension/ grants as a means of obtaining money.

Healthcare workers stated that homeless participants suffered from minor ailments, non-communicable diseases, communicable diseases and injuries due to trauma. Minor ailments included colds/ flu and aches and pains. Non-communicable diseases included diabetes, hypertension and skin conditions. Communicable diseases included scabies, TB, HIV/AIDS and STI's. Traumatic injuries occurred due to fights in shebeens.

With regard to HIV/ AIDS, a healthcare worker, explained the problems that homeless people encountered. In order to receive ARV's, patients' need to have a form of identification, need to have a fixed address and a person who will act as their support. Not all homeless people have the afore-mentioned requirements, which are imperative for acceptance into the treatment programme. The findings pose reflection concerning the care of homeless HIV positive clients. Has the client had blood samples taken for CD4 counts or viral loads? Has the client been offered access to anti-retroviral therapy? Hwang et al (1997:3) stress the "enormous effect of the AIDS epidemic on the homeless population" and further propose that the findings have serious implications both for policy makers and clinicians.

Healthcare workers reiterated similar perceived social problems as stated by the homeless participants. These needs included shelter, ablution facilities, food and unemployment. A healthcare worker offered a vivid description of homeless people who are in the terminal stages of HIV/ AIDS, sleeping outside by the harbour, as they have no where to go and die with dignity. Healthcare workers mentioned that soup kitchens are available. However do these soup kitchens provide three nutritious meals a day? Weicha et al (1997:364) stress that homeless people need improved access to nutritional food, especially in certain health problems which have a nutritional component in the treatment or cause.

Healthcare workers described similar perceived welfare problems as mentioned by the homeless participants, namely that of obtaining grants and pensions.

5.4 The health seeking behaviours of homeless people in South Central Durban.

There were mixed responses from the homeless participants regarding whether they perceived themselves as healthy. The findings showed that when asked for a definition of health, homeless participants were able to offer a holistic definition that included not only health aspects but also social and economic concerns. The findings also showed that homeless participants knew when they were not healthy. Thaddeus & Maine (1994:1096) affirm that before deciding to seek medical treatment, people need to recognise that they have a condition requiring medical attention. All participants agreed that if their circumstances were improved, then this would better their health.

Riley et al (2003:473) and Shiner (1995:526) quote the inverse care law (Mares, 1985) which states that medical care is inversely available to the need of the population. Faith Based Organisations provide special health services for homeless people, but state health facilities do not especially cater for the needs of homeless people. Wright (2000:42) stresses that the responsibility for the health of the homeless people lies firmly at global, national, state and local government's doors. These authorities need to provide adequate facilities to combat health and social problems. This study describes that there is no special provision of healthcare services for homeless people other than what the FBO's provide, which is a very limited and selective service. For major health conditions these FBO's refer patients to state services. It is uncertain how many homeless patients take up these referrals.

The findings demonstrate that homeless participants do access healthcare facilities for various communicable diseases. Collecting treatment from the TB clinic, accessing a STI clinic and seeking aid for HIV/ AIDS are examples of homeless people accessing healthcare.

All but one homeless participant had used healthcare facilities, either in rural or urban settings.

Despite suffering from higher levels of ill-health, it is heartening to hear that from the responses obtained from this study, homeless people have access to healthcare facilities, even though these findings are not generalisable as the study sample is too small. The afore-mentioned responses from homeless participants are in direct contrast with the literature. Riley et al (2003:475) state that due to barriers preventing access to primary health care facilities, many homeless people are inappropriately using Accident and Emergency services.

The responses from participants were divided as to what stage of illness homeless clients sought healthcare. Some participants mentioned that homeless clients sought care for minor ailments, whilst some participants mentioned that homeless clients sought healthcare when the illness was at an advanced stage. A reason for leaving their illness until it reaches a later stage is suggested by Shiner (1995:527) who asserts that homeless people do not consider health issues to be a priority, thus claiming low expectations of their health. Thaddeus and Maine (1994:1097) and Olufemi (1999:491) are of the opinion that those suffering from an illness may feel too ashamed of being stigmatised, so that they do not seek health care, thus contributing to the severity of the illness.

The previous mentioned suggestions might also explain reasons for non-compliance amongst homeless people. Several authors (Van der Heyden et al (2003:154), Hwang et al (2005:313), Riley et al (2003:475) and Wright & Tompkins (2006:287) caution that homeless people present with multiple

morbidity and that premature mortality and lowered life expectancy are amongst the problems known to exist in homeless populations.

5.5 The factors facilitating access to healthcare by homeless people in South Central Durban.

The majority of the homeless participants mentioned that the time spent travelling to a healthcare facility ranged from twenty minutes to two hours. Thaddeus and Maine (1994:1092) state that the further the distance, the greater the impact on the severity of the condition in which the patients arrive. Thus distance can be a disincentive which can delay an individual's choice to seek health care.

Homeless participants mentioned that the cost of catching a taxi to healthcare facilities was on average R2.50. However the majority of the homeless participants walked to the healthcare facility. The healthcare facility was on average twenty to thirty minutes walk, thus facilitating access to healthcare.

Costs incurred, either cost for receiving healthcare, cost for transport, doctor's fees, cost of medication and loss of salary whilst one is away from work seeking health care are further obstacles described by Thaddeus and Maine (1994:1094). These hidden costs could impact on the individuals' decision to seek health care. Healthcare workers stated that all healthcare facilities are free. If the homeless client needed referral to another healthcare facility, then a referral letter would ensure that the homeless client would not have to pay.

The majority of the homeless participants stated that they had received good service from the healthcare facilities that they had attended. These findings concur with Thaddeus & Maine (1994:1095) that the quality of care is an important consideration in the decision to seek care.

How did homeless participants know which healthcare facilities to use? One of Anderson's (2007) enabling factors of the Health Care Utilisation model is

that of a social network. The formation of a social network amongst homeless people is supported by Smith (2008:756). The use of a social network along with togetherness can be seen in homeless participants' responses when searching for food, healthcare and in protecting each other. The homeless participants responded that they were all told by someone else. In the third level of Maslow's hierarchy, this social network could be seen as having a supportive homeless family. One homeless participant responded that it was food being served that enticed him to come and join the queue.

5.6 The factors hindering access to healthcare by homeless people in South Central Durban.

Literature suggests that homeless people are subjected to discrimination and marginalisation (Wright & Tompkins, 2006:289, Seager & Tamasane, 2008:24). A minority of homeless participants did describe negative experiences of long waiting time and bad service received. Responses from healthcare workers and homeless participants suggested that discrimination towards homeless people could also be a factor which could prevent homeless clients seeking health care. This is supported by Thaddeus and Maine (1994:1096) who make mention of negative experiences due to staff attitudes.

Both of the above suggestions are reiterated by The World Health Report (2000) Health Systems: Improving Performance (WHO, 2000: xii) which among the many discrepancies in healthcare available for the poor has also identified less prompt attention and being treated with less respect for homeless peoples' dignity.

A problem voiced by homeless participants is that of lack of medication. This is supported by Thaddeus and Maine (1994:1102) who describe in the third phase of the three delays model, delays in receiving adequate treatment at the healthcare facility, namely lack of medication which could further delay the clients' recovery.

Another problem encountered by the healthcare worker participants is that of homeless clients not having a fixed address, thus hindering healthcare workers in following up of compliance in medication, especially TB medication. Sleeping and shelter are two of the needs identified in the physiological level of Maslow's hierarchy (1943).

A healthcare worker challenged what healthcare facilities are available for non-South African citizens. Manfellotto (2002:70) describes that Italy has introduced a very pro-active approach towards health care for the homeless. In 1999 a Presidential decree 394/ 1999 was promulgated that all foreign citizens whether legally in Italy or not, have unrestricted access to preventive, curative and rehabilitative health care under the National Health System.

5.7 Recommendations of respondents regarding care for homeless people in South Central Durban.

5.7.1 Recommendations by Homeless people

The majority of the homeless participants stated that they would like employment. Homeless participants recommended that there should be additional facilities for homeless people to access ID documents. With such documentation homeless people can apply for grants and pensions. With access to grants, homeless people will be able to meet their basic needs. This is supported by the WHO European Report (2002: 50) that stresses that one main important point in improving health is to reduce socio-economic inequalities.

Provision of accommodation, food parcels, shoes and clothing is another recommendation proposed by homeless participants. The above are all examples of the physiological needs described in Maslow's hierarchy (1943).

All homeless participants from Dalton hostel requested a permanent health care facility / healthcare worker to be situated at the hostel. The notion of providing healthcare workers for consistent daily healthcare is supported by

Riley et al (2003:476). The same participants also confirmed that they were concerned about the overcrowding at the hostel.

5.7.2 Healthcare worker recommendations

Healthcare workers recommended that there should be additional facilities for homeless people to access ID documents following which homeless people can apply for grants and pensions. One healthcare worker however cautioned that “we” do not want to develop a dependent society. This is a controversial discussion; however there must be provision of basic needs.

Provision of accommodation is another recommendation proposed by healthcare workers, along with food parcels.

A suggestion from one healthcare worker was to have many health services available at the healthcare facility, to prevent clients having to go to other facilities for health care. This opinion is confirmed by the National Health Care for Homeless Council in America (2008:1-3) who strongly advocates for the creation of a single health system that provides the homeless access to a high quality comprehensive health care.

The researcher has divided recommendations from healthcare workers according to some of the principles of Primary Health Care (Denhill, King & Swanepoel, 1999:6).

Equity

A register with all homeless people found in the area be compiled. Once we know how small or big the problem of homelessness is, then plans can be put in place to provide promotive, preventive and curative and rehabilitative health care for homeless people. A register can also aid in monitoring health problems experienced by homeless people. This suggestion is already implemented by the DPMM who have a database which shows health problems that homeless present with (Manfellotto, 2002:77).

Accessibility

The provision of ARV treatment for HIV/ AIDS for homeless people appears to be problematic. Suggestions from healthcare worker participants include government intervention regarding the provision of ARV's to homeless people. Hwang et al (2005:411) strongly emphasize the formation of available coordinated treatment and support programmes for homeless people, especially for the prevention and treatment of HIV/ AIDS. These programmes must be devised to meet the specific health needs of homeless people.

Affordability

Despite fees at government healthcare facilities being free, there is still the issue of hidden costs. For example, if a homeless client is referred to another healthcare facility, does the client have enough money for transportation to the referred healthcare facility? Thaddeus and Maine (1994:1092) explain in phase two delay, that cost could be a factor that hinders an individual's ability to reach a healthcare facility.

Availability

In the research setting responses from both homeless and healthcare workers reiterated that in order to access a healthcare facility, one had to go early or one might not be seen. A suggestion from a healthcare worker participant was that of clinics being open 24 hrs/ day. Manfellotto (2002:74) describes how DPMM is open at night for the homeless to access healthcare.

Another recommendation from healthcare worker participants was to empower homeless people. Provision of education classes to enable homeless people to finish their basic education was suggested, as none of the homeless participants interviewed had obtained their Matric. Training in Skills development and empowerment programmes to help homeless people become economically viable and also allow them to gain some dignity and self respect. This would allow them to progress to Maslow's fourth level of esteem

needs. Another positive factor of employment is an improvement of health, this is supported by Van der Heyden et al, (2002:153) who state that with decreasing socioeconomic levels health expectancy also decreases.

This research study shows the self supportive networks formed by homeless people. Also shown are the various ingenious/ opportunistic measures that homeless employ in order to obtain money. McNulty (2005:11) states that traditionally efforts to improve the living conditions of the poor have adopted an approach that focuses on the communities' problems rather than the communities' strengths and assets. By harnessing these networks and ingenious ideas, the homeless community encouraged to become active participants in designing and implementing strategies to improve their living conditions and well-being. Using an asset-based approach "instils a sense of empowerment" which facilitates the community to "assume a sense of responsibility" (McNulty, 2005:13). When all the members of a community, have had a stake in the formulation and implementation of community development, the greater the likelihood that the development is sustained (McNulty, 2005:1).

Another recommendation is the provision of preventative health programmes for homeless people. In this study healthcare services appear to be curative not preventive or promotive. One healthcare worker participant suggested that by installing preventive and promotive health programmes one may see an increase in homeless people coming to seek health care at an earlier stage of illness. Manfellotto (2002:78), Hwang et al (2005:411), Riley et al (2005: 476) and Wright & Tompkins (2006:289) discuss the provision of preventive and promotive screening services in order to limit disease and to detect disease at an earlier stage before the disease progresses to a severe late stage.

In conclusion a healthcare worker participant emphatically stated that "We don't have enough information and hopefully this study will facilitate this information." (HCW 2). The need for research into healthcare provision for homeless people is reiterated by Wright & Tompkins (2006:291), Hwang et al (2005:412), Riley et al (2003:476) and Shiner (1995: 546).

5.8 Summary of Chapter

This chapter presented discussion from the findings of the research study. The major categories were predetermined and formulated as objectives. The sub-categories arose from responses from homeless participants and healthcare workers. Discussion from the responses of homeless and healthcare worker participants revealed basic, health, safety and security needs. Responses also described health seeking behaviours experienced by homeless people and those perceived by healthcare workers. The factors accessing and hindering access to healthcare by homeless people were also discussed. In conclusion of this chapter respondents offered recommendations to improve the care for homeless people.

CHAPTER SIX RECOMMENDATIONS AND CONCLUSION

The research generated many recommendations for policy makers, healthcare service providers, for homeless people and for future research.

6.1 Policy makers

- By having a database of homeless people the government would then see the extent of the problem of homelessness i.e. gender, race, age and urban or rural. This database can be kept jointly by the Departments of Social Services and Health.
- Using the database, government could promulgate the provision of basic resources for homeless people. Together with NGO's and FBO's

government could organise the provision of basic resources for homeless people. Safe, overnight, not overcrowded, free accommodation with good, ablution facilities, together with three nutritious meals. Also the provision of family accommodation so that families would not have to be separated.

- By having a database of homeless people NGO's and FBO's could initiate basic education/ skills programmes. After attaining education and skills, NGO's and FBO's would then be able to help in attaining employment. This database could also indicate to government where social services can be provided, especially in the application and provision of grants and pensions.
- The database could also include statistics of the health of homeless people obtained from other healthcare facilities. This would aid in determining health conditions that homeless people suffer from. These statistics could then be utilised by policy makers and healthcare providers to provide medical treatment for these health conditions. The formulation and implementation of health promotion and health prevention programmes would be facilitated.
- Are we aware of the effects of the HIV/ AIDS epidemic on homeless people? Is there government policy on promotion, prevention and medical management for homeless people e.g. VCT, Blood tests CD4 and viral loads, provision of ARV's, fixed accommodation/ address so that homeless can access ARV's and follow up, identity documents/ birth certificates so that homeless people can access ARV medication, access to nutritious meals to aid in the management of HIV/ AIDS.

6.2 Healthcare providers

- By having a stable place for homeless people, health promotion and prevention programmes could be delivered and follow up appointments monitored, to help in compliance in treatment and medication.
- The researcher proposes that in the curriculum of the training of healthcare workers, inclusion of healthcare needs specific to homeless people.

- All health facilities to provide a “one stop shop” where all services are provided, from minor ailments to medical treatment for HIV/ AIDS. Due to extended waiting times, some facilities should be open for extended hours.
- By having a database of homeless patients accessing healthcare facilities, one could determine if patients referred to state facilities are utilising these referrals.

6.3 Homeless people

- During data collection the researcher “uncovered” social networks formed by homeless people. These social networks function by providing a safety/ security net with which, homeless people form in order to protect themselves. This collaborative action demonstrated by homeless people could be harnessed as a strength by which to empower homeless people. These social networks could be improved upon to strengthen opportunities for homeless people (asset based approach to development). Homeless people could then be part of a committee with government and NGO’s and FBO’s to aid/oversee aid to homeless people.

6.4 For future research

- The impact of HIV/ AIDS on homeless people and whether homeless people do have access to ARV treatment.
- The findings of this qualitative study could be used as the basis for a longer quantitative study. This research was conducted with a small sample of homeless participants. The researcher hopes that further research using a larger sample will be conducted, so as to greater evidence that will support or not support the findings found in this study.

6.5 Conclusion

Healthcare provision for homeless people in Durban South Africa appears to be a hit and miss effort between the state and NGO's. Emphasis is placed on curative health services whilst little emphasis is placed on health promotion and prevention. This small study describes health seeking behaviours of homeless people and their perceptions of access to healthcare services.

A number of recommendations have been suggested by the participants as well as the researcher and one hopes that these may indeed be implemented so as to provide better access to healthcare for homeless people.

REFERENCES

- Biswas-Diener, R., & Diener E,D. 2006. The subjective well-being of the homeless and lessons for happiness. *Social Indicators Research* 76:185-205 [Online]. Available: <http://www.porquest.umlcom/pqdweb?index=o&did=1049420151&Srchmode> [11 August 2008].
- Brink, P,J., & Wood, M, J. (1998). *Advanced design in nursing research*. 2nd ed. California: SAGE Publishers.
- Burns, N., & Grove S, K. 2001. *The practice of nursing research conduct, critique and utilization*. 4th ed. Philadelphia: WB Saunders Company.
- Creswell, J,W. 1998. *Qualitative inquiry and research design choosing amid five traditions*. United States of America: SAGE publications.
- Dennill, K., King, L., & Swanepoel, T. 1999. *Aspects of primary health care: community health care in Southern Africa*. 2nd ed. Halfway House: International Thomson Publishing Southern Africa (Pty) Ltd.
- Department of Health. White Paper for the transformation of the health system in South Africa. 1997. [Online] Available:<http://www.gov.docs.za> [21 may 2001].
- Dictionary. 2009. [Online] Available www.ask.com. [13 July].
- De Vos, A.S., Strydom, H., Fouche, C, B., & Delport, C.S.L. 2005. *Research at grassroots for the social sciences and human service professionals*. 3rd ed. Pretoria: Van Schaik Publishers.
- Engelbrecht, C. 2005. Trustworthiness Qualitative research module. Durban: University of KwaZulu-Natal. [Course notes].

eThekwini Municipality. 2009. Homelessness. [Online] Available: <http://www.durban.gov.za/durban/government/abms/sdb/partnerships/housing-sector.html>. [12 Jun 2009].

Green, A. 1997. *An introduction to health planning in developing countries*. 2nd ed. New York: Oxford University Press.

Hwang, S.W., Orav, J., O'Connell, J., Lebow, J.M., & Brennan, M.D. 1997. Causes of death in homeless adults in Boston. *Annals of Internal Medicine*, [Online]. 126 (8). Available: <http://www.annals.highwire.org/cgi/content/full/126/8/625> [5 May 2008].

Hwang, S.W., Tolomiczenko, G., Kouyoumdjian, F.G., & Garner, R. 2005. Interventions to improve the health of the homeless a systematic review. *American Journal of Preventive Medicine*, [Online] 29 (4). Available: <http://www.sciencedirectcom/science?-ob=ArticleURL&udi=B6VHT-4HC72VR> [24 January 2008].

Katzenellenbogen, J.M., Joubert, G., & Abdool Karim S.S. 2001. *Epidemiology a manual for South Africa*. South Africa: Oxford University Press.

Laurenson, P., & Collins, D. 2007. *Beyond punitive regulation? New Zealand local governments' responses to homelessness*. Journal compilation editorial board of Antipode, [Online] 2007. Available: <http://www.blackwell-synergy.com/doi/pdf/10.1111/j.1467-8330.2007.00545>. [1 June 2008].

Manfellotto, D. 2002. *From misinformation and ignorance to recognition and care: immigrants and homeless in Rome, Italy*. [Online] Available: <http://www.who.who.dk/documents/sed/10case5.pdf> [1 Apr 2004].

Martins, D. C. 2008. *Experiences of homeless people in the health care delivery system: A descriptive phenomenological study*. [Online] Available:

<http://www3.interspace.wiley.com/cgi-bin/fulltext/121384882/pdf>. [12 June 2009].

McMurray-Avila, M. 2001. *Organizing health services for homeless people a practical guide*. 2nd ed. [Online] Available:
<http://www.nhchc.org/publications/pagesfrom2ndedition-101901.pdf> [15 Nov 2007].

McNulty, R, H., 2005. *Using an asset-based community development approach globally beyond the developed world*. Asia-Pacific Creative Communities: a Strategy for the 21st century. [Online] Available:
http://www.unescobkk.org/fileadmin/user_upload/culture/Culture_Industries/presentations/session_Two_-Robert_McNulty.pdf. [3 Nov 2008].

Musgrave Methodist Church. 2007. *Kathleen Voysey primary health care clinic*. 2nd ed. [Brochure].

National health care for the homeless council. 2008. [Online] Available::
<http://www.nhchc.org/Publications/basics-of-homelessness.html> [2 Feb 2008].

Olufemi, O. 1997. *Health of the homeless street women in South Africa*. Habitat International 23 (4) [Online] Available:
<http://www.sciencedirect.com/science?ob.html> [12 Jun 2009].

Patton, M.Q. 2002. *Qualitative research & evaluation methods*. 3rd ed. United States of America: Sage Publications INC.

Potter, P.A., & Perry, A.G. 2005. *Fundamental of Nursing*. 6th ed. St Louis: Mosby.

Riley, A.J., Harding, G., Underwood, M.R., & Carter, Y. 2003. Homelessness :a problem for primary care? *Br J Gen Practice* 53 (491).

Roberts, T.M. 2003. *The objective and subjective conditions of poverty amongst the destitute and homeless population of central Durban*. Master Dissertation, University of Natal.

Seager, J., & Tamasane, T. 2008. Health and wellbeing of people living on the streets in South Africa. Conference of Health and Homeless, Oxford, 16 Sept 2008. [Online] Available: <http://www.hsrc.ac.za/Research-Publication-7565.phtml>. [12 Jun 2009].

South African Social Investment Exchange (SASIX). 2008. Basic healthcare projects. [Online] Available: <http://www.sasix.co.za/projects/index/?sector=BH>. [21 August 2008].

Shiner, M. 1995. Adding insult to injury homelessness and health service use. *Sociology of Health and Illness*, [Online] 17 (4). Available: <http://www.blackwell-synergy.com/production/shill/1995/17/6.html> [21 Mar 2006].

Sim, J. & Wright, C. 2002. *Research in health care concepts, designs and methods*. United Kingdom: Nelson Thornes.

Smith, H. 2008. Searching for kinship: The creation of street families among homeless youth. *American Behavioural Scientist* 51;756 [Online]. Available: <http://www.abs.sagepub.com/cgi/content/abstracts/51/6/756>. [29 May 2008].

Stein, J. A., Andersen, R., & Gelberg, L. 2007. Applying the Gelberg-Andersen behavioural model for vulnerable populations to health service utilization in homeless women. *J Health Psycholol*, [Online]. 12, 791. Available: <http://www.sagepublications.com> [1 Apr 2008].

Tabibzadeh, I. & Liisberg, E. 1997. Response of health systems to urbanization in developing countries. *World Health Forum* (16).

Thaddeus, S. & Maine, D. 1994. Too far too walk: Maternal mortality in context. *Soc. Sci Med* 38 (8).

Turner, S. 2001. Primary health care in homeless shelters in Poland. Available:<http://www.euro.who.int/SocioEconomicDeterminants/case/20030212-7> [1 Apr 2004].

Ulin, P.R., Robinson, E.T., Tolley, E.E., & McNeill, E.T. 2002. *Qualitative methods a field guide for applied research in sexual and reproductive health*. USA: Family Health International.

Van den Heyden, J.H.A, Demarest, S. Tafforeau, J. & Van Oyen, H. 2003. Socio-economic differences in the utilization of health services in Belgium. *Health Policy* 65 (2), p.153 -165.

World Health Organization. 2000. *The world health report: Health systems: Improving performance*. Geneva: World Health Organization

World Health Organisation Region for Europe. 2001. *Poverty and health evidence in WHO's European region*. [Online] Available: <http://www.euro.who.int/SocioEconomicDeterminants/poverty/20030128-8> [1 Apr 2004].

World Health Organisation European report links poverty to widening gaps in health. 2002. [Online] Available: <http://www.euro.who.int/eprise/main/WHO/mediacentre.html>. [18 May 2004].

World Health Organisation. 1994. Article 25 Universal declaration of human rights. [Online] Available: <http://www.hrweb.org/legal/udhr.html>. [21 August 2008].

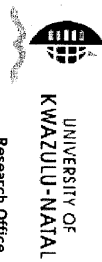
Wiecha, J., Dwyer, J.T. & Dunn-Strohecker, M. 1991. *Nutrition and health services needs among the homeless*. [Online]

Available:<http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1580272&blobtype=pdf>. [1 June 2008].

Wright, N., & Tompkins, C. 2005. *How can health care systems effectively deal with the major health needs of homeless people?* [Online] Available: <http://www.euro.who.int/Document/E85482.pdf> [29 July 2008]

Wright, N., & Tompkins, C. 2006. How can health services effectively meet the health needs of homeless people? *British Journal of General Practice*, Apr, p.286-293.

Wright, T. 2000. *Resisting homelessness: global, national and local solutions*. [Online] Available: <http://www.jstor.org/stable/2654929>. [22 May 2008].



UNIVERSITY OF
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24 November 2006

Mrs D Wentzel
School of Nursing
Desmond Clarence Building
Howard College
University of KwaZulu-Natal

Dear Mrs Wentzel

PROTOCOL: To describe the health care seeking behaviours and experiences of homeless people in South Central, Durban. Mrs D Wentzel, Community Health. Ref: H083/06

We acknowledge receipt of the permission letter granting provisional approval for the above study from Ethekwini Municipality as per our request of 30 October 2006.

The Biomedical Research Ethics Committee considered the abovementioned application and the protocol was approved at its meeting held on 13 June 2006 pending appropriate responses to queries raised. These conditions have now been met and the study is given full ethics approval and may begin as at 24 November 2006.

The following documents have been approved:

Consent Letter to Health Care Workers
English Consent Letter to Homeless People
Interview guide for Health Care Workers
Isizulu version of the Information Document and questionnaire

This approval is valid for one year from 24 November 2006. To ensure continuous approval, an application for recertification should be submitted a couple of months before the expiry date. In addition, when consent is a requirement, the consent process will need to be repeated annually.

I take this opportunity to wish you everything of the best with your study. Please send the Biomedical Research Ethics Committee a copy of your report once completed.

Yours sincerely


DR. MKHOUL
Chair, Biomedical Research Ethics Committee

ANNEXURE A
110

ETHEKWINI MUNICIPALITY
Health, Safety and Social Services Cluster
Health Unit

9 Old Fort Place
Durban 4001
P O Box 2443
Durban 4000
Tel: (031) 311 1111
Fax: (031) 311 3530
Website: <http://www.durban.org.za>



Our Ref:

Your Ref:

Enquiries:

Dr R Gajee
Telephone: 311-3679

2006-11-17

Dorian Wentzel
340 Nicholson Road
GLENWOOD
4001

Dear Ms Wentzel

RE: RESEARCH REQUEST : TO DESCRIBE THE HEALTHCARE SEEKING BEHAVIOURS AND EXPERIENCES OF HOMELESS PEOPLE IN SOUTH CENTRAL DURBAN

Provisional approval is granted for the above study to be conducted at the South Central Durban Clinics.

Please note that you will be required to contact Ms Sibahle Maphumulo (Tel: 3113580) to make appointments with Clinic Managers before visiting any clinic to conduct interviews.

Final approval will only be granted after full ethics approval and appropriate indemnities are received.

Yours faithfully


U. Simba
HEAD : HEALTH

Original letter forwarded to the Head : Health



ANNEXURE B
11



*Together,
Making Christ Known,
Sharing His Love,
Growing in His Grace*

Rev. Peter Buttenworth
P O Box 51125, Musgrave, 4062, South Africa
Telephone 201 2005 Fax 2021 080
E-mail: contact@musgravemethodist.co.za
Web Page: www.musgravemethodist.co.za

15 June 2004

To whom this May Concern

On behalf of the Kathleen Voysey Primary Health Care Clinic, a non-profit organisation serving the poor and needy of the Berra, Durban I am delighted to affirm our committee's full support for Mrs Dorien Wentzel's study proposals.

Dorien has been a keen member of our volunteer team, and we believe that through her research she will also be able to assist us evaluate our work. We give full permission for her access to all our information and we will be pleased to assist her in any way we can.

I wish Dorien well in this study venture.

Yours faithfully

Rev. Peter J. Buttenworth
Chairperson – Kathleen Voysey Health Care Clinic

EMKANYINI MUNICIPALITY
Central Operational Entity
Corporate Services
Housing Department

7th Floor
Martin Wenzel Building
325 South Street
Durban 4001
KwaZulu Natal
Durban 4000
Tel (093) 241 1111
Fax (093) 241 7700



15 September 2006

Dorien Wentzel
School of Nursing
Howard College Campus
University of KwaZulu Natal

Dear Dorien

**RE: PERMISSION TO CONDUCT RESEARCH WITH A FEW OF THE HOMELESS RESIDENTS
AT DALTON HOSTEL**

Your undated letter in respect of the above makes reference:

Permission to interview homeless people residing at Dalton Hostel is hereby granted. You are therefore requested to meet **Ms Benedicta Mthembu**, Superintendent at the Hostel who will then guide you accordingly. Her contact number is **031 306 5266** or alternatively **031 301 0989**.

I wish you success in your research work.

Sincerely Yours

Walter Ngubane
Walter Ngubane
Project Executive: Hostels



Berea Presbyterian Church

Rev. W.D. Pool B.A. Hons
Church Telephone 2015842/2023444
Fax 2014158
Maase Telephone 2616830

459 Berea Road
DURBAN
4 001

30th August 2006

TO WHOM IT MAY CONCERN

At Berea Presbyterian Church, 459 Berea Road, Durban, we run the Kathleen
Voysey Primary Health Care Clinic.

This services the destitute people of this area. Mrs. Dorfen Wentzel is one of
the volunteer nursing sisters who helps to run this clinic and has been involved
in its work and planning for a good number of years now.

On behalf of Berea Presbyterian Church, we are very pleased to support Mrs.
Wentzel in the research work that she is doing in this area and on this subject.
We wholeheartedly support her and are perfectly happy for her to carry out her
research work at the clinic which operates out of our premises.

Yours sincerely,

W. D. POOL
(Minister)

Glory to God in the Highest

ANNEXURE E
114

I, Busisive Rosemary Bhengu, being a Zulu speaking academic, have translated this document on **Health Care Seeking Behaviour and experiences of homeless people in South Central, Durban**. I translated it from English to Zulu.

Signature: _____

B R Bhengu

22.08.2006

I, Nondumiso Shangase, being a Zulu speaking academic, have translated this document on **Health Care Seeking and experiences of homeless people in South Central Durban**. I translated it from Zulu to English

01.09.06.

I, Thandwe Ndopele, being a Zulu speaking academic, have moderated the translations and made the necessary corrections in this document on **Health Care Seeking and experiences of homeless people in South Central Durban**.
Signature: _____
Date: 09/10/2006

Consent letter to Health Care Workers

Mrs D Wentzel
340 Nicolson Road
Glenwood
Durban
4001

Dear Sir/Madam

Research on: To describe the health care seeking behaviours
and experiences of homeless people in South Central, Durban.

I am Dorian Wentzel, a student at the University of KwaZulu-Natal, Durban. I
am required to undertake a research project in fulfillment of my master studies
in Public Health at the University.

I am inviting you to participate in the above mentioned study which, has been
designed to describe the health seeking behaviours and experiences of
homeless people in South Central, Durban.

You will be requested to give information about your experiences in providing
of health care to homeless people. The in-depth interview should take
approximately 30 to 40 minutes to complete.

Participation in this study is voluntary and that you may discontinue
participation at any time.

Your name will not appear on the interview notes, you will be assured of
confidentiality.

Contact details of researcher/s - Mrs D Wentzel, 340 Nicolson Road, Glenwood,
Durban, 4001.

Thank you kindly
Yours sincerely
Dorian Wentzel

Participants Consent Form

I agree to participate in the study
Name
Signature..... Date

This interview guide is for health care workers.

Interviewer Administered Questionnaire

Date

Study Identification No.

Interviewer's name

Good Morning

Can you describe the health care needs of homeless people coming to your clinic.

- Needs in order to maintain well being
- Problems encountered by homeless e.g. health problems, social problems and economic problems

Can you describe the health seeking behaviours of homeless people coming to your clinic.

- At what stage of illness do they come to the clinic e.g. minor aches or late serious problems
- Do they come for follow up visits
- Are homeless people compliant with their medication
- Are the homeless coming for health problems or other problems

Can you describe where homeless people access health care.

Can you describe factors that facilitate access to health care by homeless people.

Can you describe factors that hinder (barriers) access to health care by homeless people.

Can you make any suggestions regarding provision of health care services for homeless people.

Thank You for your time in completing this interview

LETTER FOR PERMISSION FOR THE HOMELESS

Mrs D Wentzel
340 Nicolson Road
Glenwood
Durban
4001

Dear Participant

An investigation on the Health needs and impact on the homeless living in South Central, Durban.

I am Dorien Wentzel a student at the University of KwaZulu Natal in Durban. As a requirement of my studies it is necessary that I research in Community Health. I am doing this study because it is a requirement that I do research in order to complete my degree (course) in Community Health.

I am requesting your cooperation in this research which aims at finding the problems that the homeless encounter when trying to get health assistance in South of Durban Metro.

In this research you are required to inform us about all your experiences when trying to access health assistance. This is going to take about 30- 40 minutes.

You are not forced to take part in this research and you can withdraw from participation at any time.

Your name will be kept anonymous and the information that you will give will not be published but will be kept in confidence between me and my supervisor.

You can find me at this address: Mrs D Wentzel, 340 Nicolson Road, Glenwood, Durban, 4001.

Thank You kindly

Yours Sincerely

Dorien Wentzel

Participants Consent Form

I agree to participate in the study.....

Name Date

Signature Date

Incwadi yemvume ngabantula amakhaya ngesiZulu

Mrs D. Wentzel
340 Nicolson Road
Glenwood
Durban
4001

Mhlolo othandekayo

Uwano ngoKufunwa kosizo lwezempilo kanye nabahlangabezana nakho abantula amakhaya e Ningizimu ephakathi neTheku

Ngingunkosikazi Dorten Wentzel, umfundi eNyumivesi yakwaZulu Natal eThekwini. Kuleziifundo kunesidingo sokuba ngenze ucwaningo oluthele ukuzi zifezeke ngokugwele izifundo zani kwezempilo yomphakathi.

Bengicela ukuba ubambisane nani kulolucwaningo oluhlose ukuthola izingqinamba kubantu abantula amakhaya ababhekana nazo uma bezama usizo lwezempilo eNingizimu ephakathi neTheku

Kulolucwaningo kuzofanele usazise nobahlangabezana nakho uma uzama ukuthola usizo lwezempilo . Lokhu kuzokuthatha isikhathi cisse sibe ngamamithi angamashumi amathathu kuya kwangamashumi amane.

Awuphoqelelele ukusiza ngalolucwaningo futhi usengahoxa noma yimini ekubambisane nathi ngalolucwaningo

Igama lakho ngeke livezwe ndawo futhi noma yini noyishoyo ngeke idalulwe, iyogcina kimi nomphathi wami kuphela

Ngiyadlakala kuIkheli: Mrs. D. Wentzel; 340 Nicolson Road; Durban. 4001

Ngiyabonga.

Ohloniphayo

Dorten Wentzel

.....

Ngiyavuma ukungena lolucwaningo.....

Igama..... Usuku

Sayina..... Date

If unable to sign.. Witness signature:.....

INTERVIEW GUIDE

Date: _____

Number of participant : _____

Researcher's name: _____

Greetings

1. Do you reside in a rural area?
2. If so where?
3. How long have you been living in Durban /in the city?
4. What were your reasons for coming to Durban?
5. Where in Durban do you stay?
6. What type of activities does your average day here in Durban consist of?
7. Where do you sleep at night?
8. What is the meaning of Health / Life to you?
9. Would you classify yourself as a healthy person? (yes / no)
10. If no, give a brief reasoning for your response.
11. Where do you look for health aid when you are not well?
12. Is it your first time to visit this clinic? (yes / no)
13. If no, how long have you been using this Clinic?
14. Have you attended another Clinic either than this one, if so, how was the service there?
15. Why have you come to this particular Clinic?
16. How did you find out about this clinic?
17. How far is the clinic from where you are staying?
18. How much time did it take you to get to the clinic from the place at which you are staying
19. How much did it cost you (transport costs) to come to this clinic?
20. What would you like this clinic to assist you with today?
21. Please tell us how you found our service to you at this clinic.
22. Please describe the problems you have experienced in accessing health care.
23. Have you thought of other types of aid you may/ can receive from the clinic

Thank you for all the time and effort you put into answering the questionnaire.

Isonga mibuzo

Usuku _____

Inombolo yophendula imibuzo _____

Igama lomcwangeli _____

Sawubona

1. Ngicela ukwazi ukuthi ifamu lakho likuphi uma, unalo
2. Yishe igama lendawo yefamu lakho
3. Wafika uzakwenzani eThekwini?
4. Uhlaphi-ke nedawo lapha eThekwini?
5. Uhlaphi ebusuku?
6. Kushi ukuthini ukuphila kuwena?
7. Uma ubhekele uphiliwe wena? Yehho noma cha?
8. Uma uhi eha yini eyenza uhi awuphiliwe?
9. Uluqinophi usizo uma uzizwa ungaphiliwe?
10. Uyagula yini ukuza kulomtholampilo?
11. Uma ungagali, ususesikhatshi esingakanani ugaliwe kulomtholampilo?
12. Usike waya komunye umtholampilo ngaphandle kwalo? Waphathwa kanjani?
13. Uzeleli namhlanje kulomtholampilo?
14. Wezwa kanjani ngalomtholampilo?
15. Kukude kangakanani lapho uhlaia khona nalomtholampilo?
16. Kukubhele isikhathi esingakanani ukufika lapha usuka lapho uhlaia khona
17. Kukubiza malini ukuza lapha kulomtholampilo namhlanje?
18. Lusizo luni ozolufuna namhlanje lapha?
19. Awusheke ukuthi uphathwe kanjani namhlanje kulomtholampilo?
20. Ake uchaze izinkanga ohlangabezane nazo uma uzama usizo lwezempilo lapha
21. Usike wacabanga ngolunye usizo ongathuthola emtholampilo?

Ngiyabonga kakhulu ngesikhathi sakho osisebenzisile ukuphendula lembuzo