The Role of Public Healthcare Facilities in Improving the Health Security of Impoverished people in Fetakgomo Tubatse Local Municipality in Limpopo Province

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MOGAU MOGALADI

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SUPERVISOR: Dr Stanley Osezua Ehiane

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DECLARATION

Name: **Mogau Mogaladi**
Student number: **58019510**
Degree: **MA Development Studies**

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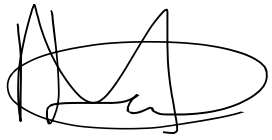

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ABSTRACT

The success of achieving health security is depended on healthcare facilities, thus making comprehensive healthcare service provision fundamental. This study aimed to formulate strategies to ease the serve delivery of quality healthcare in public healthcare facilities in Fetakgomo Tubatse Local Municipality.

Quality healthcare is a crucial need for every individual. Good health nurtures happiness and fosters a positive self-esteem. However, numerous public healthcare facilities are facing a number of hurdles that hinder good service delivery for communities nationwide, especially those in rural settings. For instance, overcrowding is one of the main issues highlighting poor service delivery, resulting in people not receiving good quality of care. This affects the patients' healthcare experience and outcomes. The prevailing challenges emphasise the fundamental issues of healthcare in society. The difficulties faced by both healthcare workers and patients due to poor service delivery spiral out of control. Some of the common issues include inadequate facilities, insufficient resources, poor infrastructure, shortage of medical equipment and supplies, shortage of staff and no consistent water supply among others.

The study adopted the Batho Pele Principles and Donabedian Model to understand and analyse the role public healthcare facilities play in improving health services. By examining how these facilities contribute to overall health security. The study aimed to acquire to acquire knowledge into the efficacy of public healthcare facilities in achieving health security.

Qualitative methods were adopted for this study. The study population was constituted by auxiliary nurses, assistant nurses, professional nurses, operational managers, home-based care workers, counsellors, patients, and/or community members. Fieldwork was conducted using observations, semi-structured interviews, and focus group discussions with healthcare workers and patients who were the community members. The study area was Fetakgomo Tubatse Local Municipality; however, the research was undertaken only in the Fetakgomo Municipal area, excluding the Tubatse Municipal area, as the two municipalities are now amalgamated.

Findings shows that limited facilities, a shortage of resources, a lack of 24-hour services, and poor infrastructure hinder healthcare access. Despite these challenges, patients are generally satisfied with the health services, although issues such as slow services and medication shortages persist.

The findings of the study contributes to the advancement, awareness and comprehension of the role management of the facilities play in ensuring effective healthcare provision and that vulnerable populations have access to public healthcare services. Furthermore, the study greatly contributes to the achievement of public health and provides nuances and understanding on the strides, challenges and way forward for attaining health for all and ultimately contributing to broader discussions on public healthcare, sustainable development and poverty alleviation in South Africa.

The study concludes that the healthcare facilities in Fetakgomo contributes to health security; however, they face structural and operational challenges. There is a need for policy interventions in healthcare to enable facilities to narrow down the quality care provision gap that already exist. This also study contributes to the current policy dialogue and serve as a foundation for proven methods aimed at enhancing healthcare security for the impoverished people and assisting the country to achieve universal health coverage.

KAKARETŠO

Katlego ya go fihlelela tšhireletšo ya maphelo e ithekgile godimo ga mafelo a tlhokomelo ya maphelo, ka go realo e dira gore kabo ya tirelo ya tlhokomelo ya maphelo ye e feletšego e be ya motheo. Maikemišetšo a nyakišišo ye ke go hlama maano a go nolofatša kabo ya ditirelo tša tlhokomelo ya maphelo ya maemo a godimo ka mafelong a tlhokomelo ya maphelo a setšhaba ka gare ga Mmasepala wa Selegae wa Fetakgomo Tubatse.

Tlhokomelo ya maphelo ya boleng ke tlhokego ye bohlokwa go motho yo mongwe le yo mongwe. Bophelo bjo bobotse bo godiša lethabo le go hlohleletša boitlhompho bjo bobotse. Efela, mafelo a mantši a tlhokomelo ya maphelo a setšhaba a lebane le mapheko a mmalwa ao a šitišago ditšhaba nageng ka bophara go hwetša kabo ye botse ya ditirelo, kudu tšeo di lego ditikologong tša dinagamagaeng. Go fa mohlala, go tlala kudu ke e nngwe ya ditaba tše dikgolo tšeo di laetšago kabo ye e fokolago ya ditirelo, yeo e feleletšago ka go dira gore batho ba se hwetše tlhokomelo ya maemo a mabotse. Se se ama maitemogelo a tlhokomelo ya maphelo a balwetši le dipoelo. Ditlhohlo tše di lego gona di gatelela ditaba tša motheo tša tlhokomelo ya maphelo setšhabeng. Mathata ao bobedi bašomi ba tlhokomelo ya maphelo le balwetši ba lebanego le ona ka lebaka la kabo ye mpe ya ditirelo a tšwela pele ka ntle ga taolo. Tše dingwe tša ditaba tše di tlwaelegilego di akaretša mafelo a a sa lekanego, methopo ye e sa lekanego, mananeokgoparara a mabe, tlhaelelo ya didirišwa tša kalafo le disapholaye, tlhaelelo ya bašomi le kabo ya meetse ye e sego ya ka mehla.

Nyakišišo e amogetše melawana ya Batho Pele le mmotlolo wa Donabedian go kwešiša le go sekaseka tema yeo mafelo a tlhokomelo ya maphelo ya setšhaba di e kgathago go kaonafatša ditirelo tša maphelo, ka go hlahloba ka moo mafelo a a nago le seabe ka gona go tšhireletšo ya maphelo ka kakaretšo. Maikemišetšo a nyakišišo ye ke go hwetša tsebo ka ga go šoma gabotse ga mafelo a tlhokomelo ya maphelo a setšhaba go fihlelela tšhireletšo ya maphelo.

Mekgwa ya khwalithethifi e amogeletšwe nyakišišo ye. Bakgathatema ba nyakišišo ba bopša ke baoki ba okesilari, bathušabaoki, baoki ba profešenale, balaodi ba tshepedišo, batlhokomelabalwetši ba ka magaeng, bathobamatswalo, balwetši

le/goba maloko a setšhaba. Mošomo wa kgoboketšo ya tshedimošo o dirilwe ka go šomiša ditemogo, dipoledišano tša peakanyoseripa le dipoledišano tša sehlophanepišo ka bašomi ba tlhokomelo ya maphelo le balwetši bao e bego e le maloko a setšhaba. Lekala la nyakišišo e be e le Mmasepala wa Selegae wa Fetakgomo Tubatse; efela, nyakišišo ye e dirilwe fela Mmasepaleng wa Fetakgomo, go sa akaretšwe Mmasepala wa Tubatse, ka ge bjale mebasepala ye mebedi ye e kopantšwe go ba o tee.

Dikutullo di laetša gore mafelo a a sa lekanego, tlhaelelo ya methopo, tlhaelelo ya ditirelo tša diiri tše 24 le mananeokgoparara a mabe di šitiša phihlelelo ya tlhokomelo ya maphelo. Ntle le ditlhohlo tše, balwetši ka kakaretšo ba kgotsofetše ka ditirelo tša maphelo, le ge e le gore ditaba tša go swana le ditirelo tša go nanya le tlhaelelo ya dihlare di sa dutše di le gona.

Dikutullo tša nyakišišo di na le seabe go tšwetšopele, temošo le kwešišo ya tema yeo taolo ya mafelo e e kgathago go kgonthiša kabo ya tlhokomelo ya maphelo ye e šomago gabotse le gore badudi bao ba lego kotsing ba na le phihlelelo ya ditirelo tša tlhokomelo ya maphelo ya setšhaba. Go feta moo, nyakišišo ye e na le seabe kudu go phihlelelo ya maphelo a setšhaba gape e fa dintlha le kwešišo ka ga dikgato, ditlhohlo le dikgato tse di latelago go fihlelela maphelo a bohle, mafelelong e ba le seabe go dipoledišano tše di nabilego ka ga tlhokomelo ya maphelo a setšhaba, tlhabollo ya moyagoile le phokotšo ya bodiidi ka Afrika Borwa.

Nyakišišo e tšea sephetho sa gore mafelo a tlhokomelo ya maphelo ka Fetakgomo a na le seabe go tšhireletšo ya maphelo; efela, a lebane le ditlhohlo tša popego le tša tshepedišo. Go na le nyakego ya magato a tsenogare a pholisi ka go tlhokomelo ya maphelo go kgontšha mafelo go fokotša sekgoba sa kabo ya tlhokomelo ya boleng seo se šetšego se le gona. Nyakišišo ye gape e na le seabe go poledišano ya bjale ya pholisi gape e šoma bjalo ka motheo wa mekgwa ye e hlatsetšwego yeo e lebantšhitšwego go kgodišo ya tšhireletšo ya tlhokomelo ya maphelo go batho bao ba ihlokelago le go thuša naga go fihlelela kakaretšo ya maphelo ya lefase ka bophara.

NKOMISO

Ku humelela ko fikelela vusirhelri bya rihanyu swi lawuriwa fi switirhisi swa nhlayisorihanyu, ku endla nyiketo wo nhlayisorihanyu wo twisiseka na vukorhekeri byo sungula. Dyondzo leyi ley iyi kongomisa ku vumba switirateji ku olovisa vukorhokeri bya nkoka bya nhlayiso rihanyu eka switirhirhisi swa nhlayisorihanyu eMasipala wa Xikaya wa Fetakgomo Tubatse

Nhlayisorihanyu wa nkoka i xilaveko xa nkoka ka munhu un'wana. Rihanyu ra kahle ri byara ntsako no kondltela vumunhu kahle. Hambiswiritano, switirhisi swa nhlayisorihanyonyingi swi na swiphiqo swo tala leswi kavanyetaka vukorhokeri bya kahle migangeni ya tiko hinkwaro, ngopfu eka lava nga etindhawini ta le matikoxikaya. Xikombiso, ku tala ka vona ii xin'wana xa swiphiqonkulu swo kombiso vukorhokeri bya le hansi swo va vanhu va nga kumi nhlayiso wa nkoka wa kahle. Leswi swi khumba nhlayiso wa xipiriyoni xa vavabyi na mimbuyelo. Mitlhotlho yi nga kona yi tiyisisa masungulo ya swiphiqo swa nhlayiso wa rihanyu evanhwini. Ku nonohwa loku langutaneke hi vatirhi va hinkwavo va nhlayisorihanyu na vavabyi hikwalaho ka vukorhokeri bya le hansi a bya ha lawuleki. Swin'wana swa swiphiqo swo fanana swi katsa switirhisiwa swi nga ringaniki, swithirisi swi nga ringanelangiki, swimakiwa swa le hansi, vuhlayiseki bya swa vutshunguri na miphakelo, ku kayivela ka vatirhi na nkayivelo wo phakela mati nkarhi un'wana na un'wana.

Dyondzo yi tirhisile milawu ya Batho Pele na modele wa Donabedian ku twisisa no hlela ntirho wa switirhisiwa swa vanhu swa nhlayisorihanyu swi wu tlangaka ku antswisa vukorhokeri bya rihanyu, hi ku kambisisa leswi switirhisiwa swi nga na xiae ka vusirheleri hinkwabyo bya rihanyu. Dyondzo yi kongomisa ku kuma vutivi mayelana na vuswikoti byo humesa mbuyelo wa switirhisi swa vanhu swa nhlayiso wa rihanyu.

Maendlelo ya nkoka ya tirhisiwile ka yondzo leyi. Eka vanhu hinkavo va dyondzo leyi ku na vaongori va le kaya, vapfuneta vaongori, vaongori va xiphurofexinali, vafambisi va swa matirhelo, vatirhi vo hlayisa va le kaya, vatsundzuxi va swa miehleketo, vavabyi na/ kumbe swirho swa muganga. Ntirho wa le handle ka hofisi wu endliwile ku tirhisiwa vuxoperi, swihlolahlola swa swivutiso fanana na mikanerisano ya ntlawa

nkongomo hi vavabyi na vatirhi va nhlayiso rihanyo lava a va va ri swirho swa miganga. Nkongomo wa dyondzo a ku ri wa Masipala wa Xikaya wa Fetakgomo Tubatse, hambiswiritano, ndzavisiso wu endliwile ntsena endhawini ya Masipala wa Fetakgomo, ku nga katsiwi Masipala wa nhawu ya Tubatse, tanihihileswi timasipala letimbirhi tikatsiweke.

Swikumiwa swi komba leswaku ku na switirhisiwa swo pimiwa, ku kayivela ka switirhisiwa, pfumaleko wa vukorhokeri bya 24-awara na swimakiwa swa le hansi swi kavanyetaka mfikelelo wa nhlayisorihanyu. Handle ka mitlhontlho leyi, vavabyi va enetekile hi vukorhokeri bya rihanyu, hambileswi swiphiqo swo fana na vukorhokri byo nonoka na nkayivelo wa mirhi ya vutshunguri yi yaka emahlweni.

Swikumiwa swa dyondzo swi na xiave ka yiso emahlweni, mipfhumba na matwisiselo ya ntirho wa mafambiselo ya switirhisiwa wu nga na nkoka ku endlela ku va na nyiketo wa nhlayisorihanyu na vanhu hinkwavo va nga riki na ntshembo wo fikello ka vukorhokeri bya vanhu va nhlayisorihanyu. Ku yisa emahlweni, dyondzo yin a xiavenkoka ka ku kuma rihanyu ra vanhu no nyika mavonelo yo hambana na matwisiselo ya magoza, mitlhontlho no yisa emahlweni ku kuma rihanyu ra hinkwavo, emakumu ku va na xiave ka mikanerisano yo anamanyana eka nhlayisorihanyu wa vanhu, nhluvkiso wo yisa emahlweni no susa vusiwani eAfirika Dzonga.

Dyondzo yi gimeta leswaku switirhisi swa le Fetakgomo swi na xiave ka vusirheleri bya rihanyu; hambileswi, swi nga na mitlhontlho ya swa xivumbeko na swa matirhelo. Ku na xilaveko xa manghenelelo ya pholisi eka nhlayisorihanyu ku endla leswaku switirhisi swi tsongahata nyiketo wa vangwa ra nkoka wa nhlayiso lowu nga kona. Dyondzo leyi yi na xiave ka n’wangulano wa pholisi ya sweswi no tirha tanihi masungulo ya maendlelo ya vumbhoni yo kongomisiwa ku fikelela mphutselo wu nga pimiwiki wa rihanyu.

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LIST OF ABBREVIATIONS

COVID-19	Coronavirus Disease 2019
STATS SA	Statistics South Africa
UHC	Universal Health Coverage
WHO	World Health Organisation
SDGs	Sustainable Development Goals
UNGA	United Nations General Assembly
NDP	National Development Plan
NHI	National Health Insurance
IDP	Integrated Development Plan
IHR	International Health Regulations
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
GHSA	Global Health Security Agenda
GSDM	Greater Sekhukhune District Municipality
COVID-19	Corona Virus Disease 2019
PPHCS	Public Primary Healthcare Services
NDOH	National Department of Health
SANC	South African Nursing Council
NHRC	National Health Research Council

CHAPTER 1
INTRODUCTION AND BACKGROUND

1.1. Introduction

Numerous countries, including South Africa, are working hard to ensure that Universal Health Coverage (UHC) is achieved (Maseko & Harris, 2018, p. 22). In South Africa, affordable healthcare is funded by the government and provided by public healthcare facilities for all citizens (Maseko & Harris, 2018, p. 22-23; Young, 2016, p. 4). Research regarding improvements in health security has been conducted internationally and in South Africa;however, the South Africans are still not receiving equitable health care at the time of their needs. The awakening of the COVID-19 exposed many challenges faced by the health sector. For example, a recent study on hospital resilience and preparedness in the Free State province has discovered that "the hospital was not prepared holistically for the COVID-19 pandemic and was not resilient to pandemics" (Raphela, 2024, p.1). This situation is concerning given the targets set in Sustainable Development Goal (SDG) 3 which aims to promote of good health and well-being, as well as the Chapter 10 of the National Development Plan (NDP) (Vision 2030), these two frameworks are promulgated to ensure healthy lives and promote well-being for all at all ages. This includes accelerating health services in order to:

- Achieving universal health coverage
- Improve access to quality essential healthcare services
- Strengthen the capacity of health systems

The NDP Vision 2030 outlines the need for:

- Improved quality of public health care and better health outcomes.
- Universal access to quality health services, regardless of income or location.
- A responsive, people-centered healthcare system**.**
- Strengthening the health system through better management, infrastructure, staffing, and service delivery.

Over the past two decades, the rise of health security as a new global priority has also given rise to new research focus in Global Health Studies, and to a smaller degree in international relations (Bengtsson, 2019. p. 8). Several national strategic plans and

international initiatives, such as the Global Health Security Agenda (GHSA) and One Health, which are intended to enhance the implementation of International Health Regulations (IHR), have begun to emphasise the links between health systems and health security (Peiris, 2005; cited in Debie et al., 2024, p.2). Achieving health security simply means achieving human security. As noted by Malik et al. (2021, p.1) that health security is linked to every aspect of public health that protects the essential elements of human existence. Therefore, this highlights that human security outcomes are directly affected by the effectiveness of healthcare systems. In the south African context, challenges to access healthcare services demonstrate this relationship.

There is a high demand for medical services in South Africa, especially in public hospitals and clinics. Mhlanga (2021) notes that many South African households rely on public healthcare services, particularly clinics, compared to private traditional health facilities. He further explains that in cases where services are available, demand side barriers such as travelling expenses, quality and the cost of treatment have led to limited utilisation of health services (Mhlanga, 2021. p. 485). These factors impact access, timeliness and quality of care in public healthcare facilities. Therefore, this research investigated the impact healthcare facilities have on enhancing health security and ensuring sustainable livelihoods.

A major hurdle that the public healthcare sector experiences in South Africa is its service delivery. For provinces such as Limpopo, health service delivery is prone to be poor, particularly in the local municipalities such as the Fetakgomo Tubatse Local Municipality, the area of this research. This research study explored the work of public healthcare facilities by investigating the challenges and experiences faced by these facilities in the Fetakgomo municipal area regarding health security. The study focused on the link between public healthcare facilities and health security by describing and analysing the current policies and framework around the issue of achieving health security for vulnerable people. The study further explained why healthcare facilities are regarded as fundamental tools to achieve health security and investigated whether these facilities are effective in accomplishing the goal of health security. The relevance and importance of this study were highlighted, with particular emphasis for municipalities and future researchers.

1.2 Background of the Study

Health security refers to preventative and reactive strategies that are essential in reducing the risk of life-threatening public health events that affect the wellbeing of populations across different regions, both locally and internationally (WHO, 2007, p. 6). Improved health security is among the most significant goals of the international development agenda. Although difficulties in accessing public healthcare exist worldwide, socioeconomic inequalities in the use of healthcare services are observed in both the Western nations and low-to-middle income countries, including those with Universal Health Insurance (UHI) (Chai et al., 2024, p. 2). For instance, China experiences a problem of inequalities in healthcare access, such as pro-rich inequalities for the elderly people (Chai et al., 2024, p. 2). Similarly, Brazil's experience with its unified Healthcare Systems (SUS) highlights challenges that undermine health security, including fragmented governance, underfunding, limited transportation restricting healthcare access for underserved populations, and these persistent inequalities continue to affect healthcare outcomes (Martins et al., 2025, p. 1). Other studies in countries such as, Australia, Hong Kong, Japan, South Korea, Taiwan, and Thailand emphasise that difficulties in accessing healthcare results from distance to facilities, long waiting periods and costs (Meyer et al., 2013, p. 2). These experiences across different countries show that challenges in accessing adequate and fair healthcare are prevalent, highlighting the importance of enhancing health security globally. Considering these factors, enhancing health security is pivotal to the SDGs, with specific reference to SDG 3, which promotes good health and wellbeing of the people. As such, healthcare facilities play a vital role in achieving these goals. Healthcare facilities include hospitals, clinics, mobile clinics, birth centres, mental health centres, addiction treatment centres and many more (Rasanathan et al., 2017).

A study by Mhlanga and Garidzirai (2020, p. 1) underlines that, the majority of South Africans rely upon public healthcare facilities for healthcare services. In support of this, the 2019 Statistics South Africa (Stats SA) report shows that 71 per cent of households in the country utilised public healthcare facilities for healthcare services, and 27 per cent used private healthcare (Stats SA, 2019, p. 25). This suggests that many people cannot afford private healthcare services, as they come with a high cost. As such, it is critical for South Africa to have sufficient public healthcare facilities to

accommodate its people, as well as an effective healthcare system that enables people to receive the care they need. Public healthcare facilities supply healthcare which is affordable to citizens (Maseko & Harris, 2018, p. 22-23), mostly to the impoverished people who rely on free care in public healthcare facilities.

During the apartheid period, the South African healthcare system was characterised as a 'two-tiered' system and 'racialised' (The Republic of South African Health Department, 2015). The white minority received medical care from a system that was highly resourced, whereas the black majority received care from a systematically under-resourced system (The Republic of South Africa Health Department, 2011, p. 15). Maseko and Harris (2018, p. 25) further state that, the healthcare system in South Africa remains a 'two-tier' system divided into the government and the private sectors. From 1994 to the present, South Africa's government has developed a wealth of laws, strategies, legislations, plans, as well as policies to protect and improve health security and the livelihood of the people. The advancement in the performance of public healthcare systems and service delivery has been made with great effort since the advent of democracy. However, the outcomes of public healthcare facilities and their programmes remain poor, while an increase in demand for healthcare access and services remains high.

The NDP aims to improve and strengthen the healthcare system in South Africa to the extent that the system can be successful and produce the intended results (National Development Plan 2030, p. 2011). South Africa's government strives to implement a National Health Insurance (NHI) system for citizens to access quality healthcare whenever they require it, regardless of their socioeconomic status [Global Coalition for Universal Health Coverage, 2015 (in Maseko & Harris, 2018, p. 22)]. Therefore, equity can be achieved through the NHI regarding health access; the NHI could bridge the gap between the government and private sector.

In South Africa, the government's health industry is in a difficult situation owing to a lack of healthcare amenities, limited resources and under-funded health systems, which result in the delivery of poor results. Makgoko (2013, p. 1-3), Olaifa et al. (2018, p. 138), and Roodt and Fleming (2018, p. 2-3) include healthcare workers' attitudes, overcrowding in public healthcare facilities, corruption, medical negligence, and poor

safety control, as other challenges that exist within the South African public healthcare sector. This is also the case in Limpopo Province, where a significant number of public healthcare facilities are fighting the endless struggle to provide access to healthcare, reduce costs and fund healthcare for the needy and vulnerable. The number of healthcare facilities in Limpopo Province is generally lower than the other provinces in South Africa. Health-E-news (2021, para. 5) reports that, in Limpopo province, patients seeking healthcare services in health facilities are obliged to wait for long hours before health officials on duty can attend to them. This is as a result of inadequate health facilities, limited resources and insufficient staff. Healthcare facilities in Sekhukhune District Municipality are scarce and of moderately resourced. Fetakgomo Tubatse Local Municipality, as part of the Sekhukhune District Municipality, is therefore affected by these common obstacles. According to the Integrated Development Plan (2008/9, p. 38), within the Sekhukhune District, a single clinic serves around 17 000 people, while one hospital serves approximately 97 500 people. Most healthcare facilities in the area do not have the capacity and capability to accommodate such high numbers.

Fetakgomo Tubatse constitute approximately 530,000 residents with 6 per cent of informal settlements higher than the 5 per cent provincial average (Crichton, 2021, p21). Crichton further explains that the area has limited health infrastructure and poor service deliver remains a challenge (Crichton, 2021). For instance, in 2018, 27 children died from severe acute malnutrition, while 289 were admitted for treatment. Immunisation coverage of 66 per cent was below the standard of 90 per cent; and measles immunisation coverage at 76 per cent is below the 95 per cent requirement (Crichton, 2021, p. 25).

The Fetakgomo Municipal area, which has approximately 25 villages has eleven clinics and one healthcare centre at Ga-Nchabeleng and no hospitals. There is the availability of a mobile clinic service group, which visits areas with no clinics, on a weekly or monthly basis. The nearest hospitals that the people of Fetakgomo can access are the Mecklenburg hospital which falls under the Tubatse Municipal area and is approximately 29 km away, the Jane Furse Memorial hospital situated at Makhuduthamaga Local Municipality at 36 km away, and Lebowakgomo hospital located at Lepelle-Nkumpi Local Municipality which is about 31k m away. The Fetakgomo Municipal area is impoverished; as Sebei (2014, p. 127) highlights that the

poverty rate is too high, there is poor infrastructure with houses far apart, and there are significant delays in service delivery. Not having a hospital in the area means that the people of Fetakgomo face challenges regarding healthcare delivery. Although mobile clinics are available, they do not have sufficient equipment and staff to render good services. Other challenges the community faces include the lack of integrated HIV/AIDS programmes, shortage of water in the facilities, insufficient backup generators, clinics not having enough nurses for shifts, shortage of medication and long waiting periods. Furthermore, the clinics are not situated in convenient locations within settlements, resulting in people being required to cover the cost of transport to access the facilities.

Therefore, this study focused on the public healthcare facilities of Fetakgomo Municipal area, in the Limpopo Province and explored how these facilities enhance health security for the vulnerable population. The researcher highlighted challenges and problems surrounding public healthcare facilities on service delivery and how to tackle the problems to ensure that the goal of health security is achieved.

1.3 Description of the Study Problem

Public healthcare facilities in South Africa, particularly in rural municipalities such as Fetakgomo Tubatse, continue to face severe challenges due to limited resources. These facilities often operate with too few doctors and nurses, a shortage of essential medicines and medical equipment, and poor infrastructure. In many cases, buildings are in disrepair, and access to emergency transport such as ambulances is unreliable or entirely absent. These shortcomings are particularly concerning in rural areas, where most people cannot afford private healthcare and rely entirely on the public system. For communities in Fetakgomo Tubatse, accessing healthcare services means travelling long distances to understaffed clinics, often only to face long queues, limited treatment options, and inconsistent service delivery. These issues make healthcare access both physically and economically difficult for rural populations. The lack of properly resourced health facilities reflects a broader problem: the failure to achieve health security.

Furthermore, the South African constitution's rights have also not been fully realised, as evidenced by the persistent absence of adequate healthcare, section 27 of the constitution affirms that all individuals in the country have the right to basic healthcare, implying that the health sector cannot deny anyone access to health services, especially in cases of emergencies (The Constitution & the National Health Act 61 of 2003). According to the Constitution, public healthcare is guaranteed for all individuals in the country, and efforts have been made to fulfil universal health coverage, as well as a unified system that enables people to access medication equitably (The Department of Health, 2012; 2015, Sekejane, 2013) (in Meyer et al., 2017: p. 2).

However, health security involves more than just the availability of clinics. It means ensuring that people can receive timely, safe, and effective care when they need it. In this case, the shortage of healthcare professionals, the frequent lack of medication, and reports of negligence contribute to poor health outcomes and deepen the sense of vulnerability among already disadvantaged communities. In places like Fetakgomo Tubatse, the situation shows how health insecurity is not just about individual illness but also about systemic issues in the healthcare system. These conditions limit the country's ability to improve public health, reduce inequality, and achieve the vision set out in national policies such as the National Development Plan 2030. Unless these structural problems are addressed, communities will continue to face barriers to quality care, and meaningful progress in healthcare delivery will remain out of reach.

1.4 Aim and Objectives of the Study

The principal aim of this research was to explore the challenges faced by the public healthcare facilities in Fetakgomo Tubatse Municipality to improve the health security of impoverished people. The study's aim was guided by the following objectives:

1. To explore the service delivery of public healthcare facilities in Fetakgomo Tubatse Local Municipality.
2. To examine the challenges of public health delivery in Fetakgomo Tubatse Local Municipality.
3. To develop management strategies for public health facilities to improve health security.

4. To determine the strategies employed by public healthcare officials in Fetakgomo Tubatse Local Municipality to respond to potential health emergencies.
5. To examine existing measures to alleviate the challenges public healthcare facilities face to guarantee health security.

1.5 Research Questions

The research questions for the study are detailed below:

1. What are the services delivered by the public healthcare facilities in Fetakgomo Tubatse Local Municipality?
2. What are the challenges of public healthcare facilities in Fetakgomo Tubatse Local Municipality?
3. What management strategies are employed by public health facilities to improve health security?
4. What are the strategies employed by the public healthcare workers in Fetakgomo Tubatse Local Municipality to respond to potential health emergencies?
5. What measures are in place for alleviating the challenges public healthcare facilities face in order to guarantee health security?

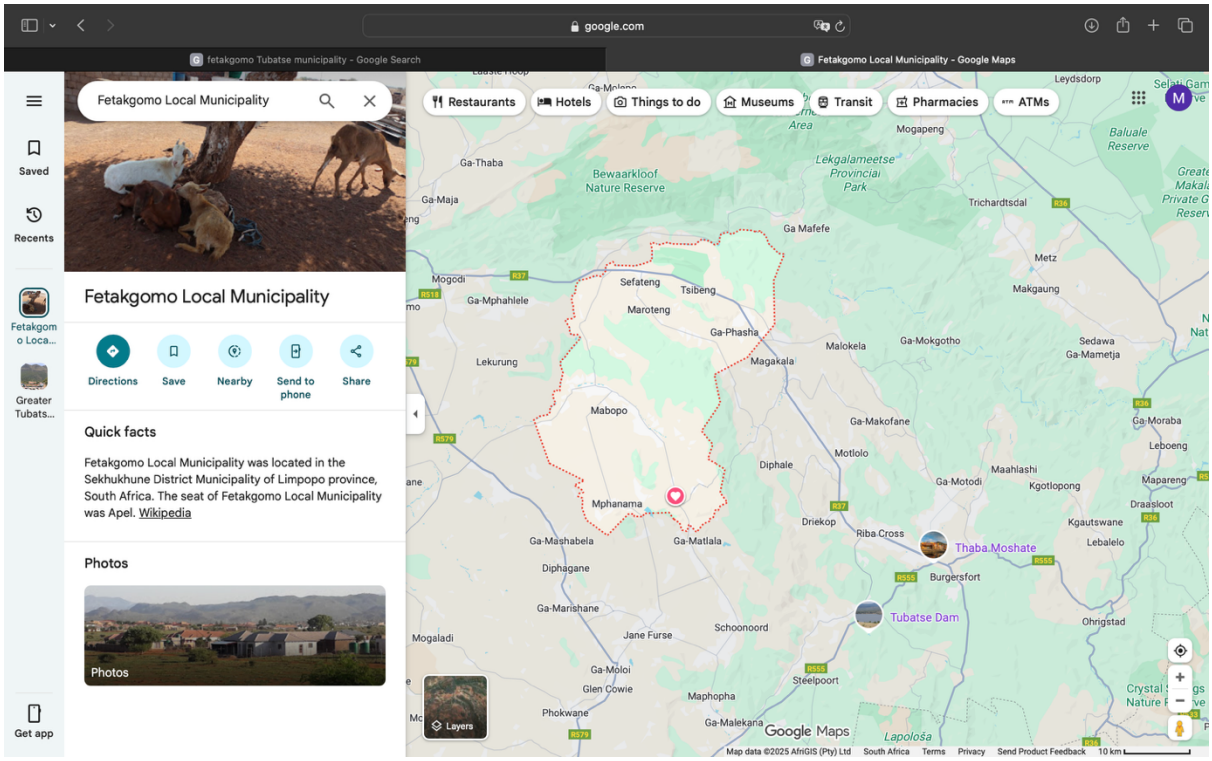
1.6 Description of the Study Area

The study was conducted in Fetakgomo Tubatse Local Municipality, within the Sekhukhune District Municipality. The Sekhukhune District is counted among the five district municipalities in the Limpopo Province. The study area is situated at the eastern part of the Limpopo Province. Therefore, this study is only limited to Fetakgomo Municipal area and excluded the Tubatse municipal area as illustrated in (Figure 1). The Fetakgomo municipality primarily serves the needs of rural communities and is classified as category B4, indicating that it primarily consists of rural areas and its location is in economically underprivileged areas. The area comprises around 57 settlements, eleven clinics, and one healthcare centre. Like other rural municipalities throughout the country, Fetakgomo is characterised by significant poverty levels, service delivery bottlenecks, a lack of adequate infrastructure, as well

as a vulnerable economic backbone (Fetakgomo IDP, 2015/16) (cited in Radingoana et., 2019, p. 21).

The study was conducted in seven clinics and one healthcare centre: Ikageng Clinic, Mohlaletse Clinic, Seroka Clinic, Nkoana Clinic, Phaahla-Manoge Clinic, Nchabeleng Clinic, Mankotsane Clinic and the Nchabeleng Community Healthcare Center. The clinics are in different settlements and villages and the communities in each village rely on at least one clinic. The only area with more than one healthcare facility is Ga-Nchabeleng area with a clinic and a community health center.

Figure 1: Map of Fetakgomo Local Municipality



Source: https://www.google.com/maps/place/Fetakgomo+Local+Municipality/@-24.4586486,29.8069659,10z/data=!4m6!3m5!1s0x1ec1694bdad8dcd5:0xbab661774df77a3e!8m2!3d24.3909787!4d29.8352303!16s%2Fm%2F0c40l3t?entry=ttu&g_ep=EgoyMDI1MTIwMi4wIKXMDSoASAFQAw%3D%3D [Accessed 09 December 2025].

1.7 Scope and Limitations of the Study

1.7.1 Scope of the study

The study was conducted in Fetakgomo Tubatse Local Municipality in Limpopo Province; however, the sample for the study was drawn only from the Fetakgomo Municipal area. The Municipality falls under The Greater Sekhukhune District. This study was undertaken in the Fetakgomo Municipal area, and it excluded the Greater Tubatse Municipal area. The two municipal areas are part of the Greater Sekhukhune District Municipality (GSDM) in Limpopo Province. The reason for the study to exclude the Tubatse Municipal area is that, in 2016, new municipalities were established by the government in the Limpopo Province. As such, Fetakgomo and Tubatse were amalgamated forming one municipality under the Sekhukhune District. Therefore, the Fetakgomo Tubatse Local Municipality now covers a large area within the district, and the researcher only focused on one area.

The focal point of the research was the healthcare services the government healthcare facilities provide in the Fetakgomo municipal area, which compromises approximately 25 villages. Fetakgomo is entirely rural. The area extends to over 1123 km^2, which amounts to 8.4 per cent of the total land in the Sekhukhune District. The sample study only includes public healthcare facilities which are available in the area, such as clinics, and a healthcare centre.

Presently, the improvement in the health security of the people in Fetakgomo Local Municipality is not happening rapidly. These health facilities are expected to improve the quality of healthcare. The study therefore explored the need for public healthcare facilities to improve health security. The study utilised a qualitative methodology with a sample size of 27 participants representing public healthcare facilities within Fetakgomo and 11 participants who require healthcare or live with chronic illness, who are residents of Fetakgomo.

1.7.2 Limitations of the study

The study was limited to the Fetakgomo Municipal area and excluded the Tubatse municipal area, as qualitative studies do not favour large populations. The challenges encountered during the study included the researcher being turned away by

healthcare workers due to poor timing. After being turned away on numerous occasions, the researcher requested to schedule appointments with healthcare workers on different days. However, things did not go as planned, as the researcher would still wait for them to be free. This resulted in fewer than the scheduled number of interviews in each facility because some of them were still unable to attend to the researchers' request. Furthermore, the researcher had limited time and budget constraints due to travel expenses. This resulted in the study not being able to cover all the healthcare facilities like visiting mobile clinics in the area. A significant challenge faced by the researcher with healthcare workers was the fear of sharing information, especially during focus group discussions. It was noticed that some participants were uncomfortable sharing information in front of their seniors and remained quiet most of the time, with mainly the seniors providing more information and others filling in here and there. The participants were informed of the importance of the study and how their contribution is vital in alleviating the challenges they experience as healthcare workers, and that the study would help them to improve service delivery. Furthermore, the researcher allowed them to feel comfortable and assured them that their personal information would be protected, although some were not free to share information in front of their colleagues.

1.9 Significance and Rationale of the Study

The purpose of this study was to investigate how public healthcare facilities shape the health security of impoverished people in underserved communities. By focusing on health security, the study moves beyond traditional measures of access to healthcare, considering broader social and constitutional factors that impact wellbeing. It also highlights the broader discourse on health security, with a specific focus on the ongoing challenges faced by residents of Fetakgomo. The researcher aimed to identify the challenges and success factors of healthcare delivery. The findings focus on the lived experiences of rural communities in accessing public health facilities and on the state of public healthcare in South Africa during President Ramaphosa's administration.They will assist public healthcare facilities to implement strategies to alleviate healthcare barriers and provide answers to questions regarding the existing gaps in healthcare. Furthermore, the study reveals the ongoing marginalisation of South Africans resulting from the absence of accelerated and integrated healthcare

systems capable of fulfilling their constitutional rights. Unlike many existing studies that primarily emphasise access to healthcare, this study introduces a fresh perspective by engaging with health security as a fundamental constitutional right. It contributes to greatly to broader discussions on public healthcare, sustainable development and poverty alleviation in South Africa

1.10 An Overview of the Methodology

Methodology is essential to the research process because it provides framework through which the researcher use to answer research questions (Ngulube, 2015, p.7). The research methodology used in this study represents the approach through which the drive to gain knowledge` about the work of public healthcare facilities to improve health security is investigated. The study adopted a qualitative approach to explore the challenges that health facilities in Fetakgomo face in their efforts to improve health security for vulnerable populations. A qualitative approach characterised by non-numerical data collection and analysis; for instance, texts, videos or audios to understand concepts, opinions or experiences (Bhandari, 2020). As such, interviews, focus group discussions and observations were used to collect data for this study and to address knowledge gaps regarding public healthcare provision and explore potential solutions to address the challenges that healthcare facilities face in providing care. The setting for this study was Fetakgomo Municipal area covering seven clinics and one healthcare center.

1.11 Structure of the Dissertation

The chapters of this dissertation are presented as follows:

Chapter 1 provides a brief overview of the research focus and the study's background. The problem statement, aim and objectives of the study are discussed in this chapter. In addition, the significant of the study, scope and limitations are also explained.

Chapter 2 is the literature review and focuses on public healthcare provision in health facilities, examining their systematic and structural problems as a means of understanding progress in healthcare delivery. The chapter also explores the

challenges related to healthcare access, the quality of healthcare provision, and the role of healthcare facilities in addressing these challenges, as well as how disadvantaged populations that rely on these facilities are affected by these barriers.

Chapter 3 presents the theoretical framework used in this study. The chapter illuminates the Donabedian Model, which guided the study and served as a basis for understanding the research problem and interpreting the study's findings.

Chapter 4 deals with the research methodology used in this study, including the research design and approach. The journey of field work is explained in detail, as well as the methods of data collection, sampling and data analysis strategies.

Chapter 5 provides a comprehensive overview of data presentation and the use of the ATLAS.ti software to analyse data rather than doing a manual analysis. The chapter explains the process of coding and generating themes in detail, which led to the findings that merged.

Chapter 6 present the discussion of findings. The findings are aligned with the aim, and objectives of the study, as research questions of the study. The narratives provided by participants offer valuable insights into their lived experiences, particularly in relation to access to medical facilities and health insecurity.

Chapter 7 provides the summary of the findings, recommendations and conclusions emerging from the research questions and research objectives. Suggested recommendations for future research are provided in detail.

1.12 Conclusion

This chapter introduced the study and provided a background of the research topic. Furthermore, it described the study's problem statement which outlined the challenges public healthcare facilities face when providing care, and the health outcomes in relation to the challenges. The objectives and research questions were developed to address the challenges encountered. And lastly, the study area, scope and significant

of the study was presented, as well as the limitations that restricted the study from exploring in greater depth.

The next chapter, (chapter 2) presents the literature review of healthcare services and access from both national and international literature.

CHAPTER 2
LITERATURE REVIEW

An overview and rationale for this research study were presented in the previous chapter. Background to the research study was explained in detail, along with the importance and contribution of the study. In addition, research objectives were developed and mirrored the research questions, which were formulated in the previous chapter.

This Chapter presents the review of literature that informs the study. It starts by exploring the work of public healthcare facilities, including the accessibility, availability, and quality of care. Moreover, it discusses the Batho Pele principles to address service delivery challenges, and reviews the challenges that disadvantaged populations living in a deep rural area face in accessing healthcare, as well as equity and equality in healthcare services, the adoption of technology in facilities, healthcare facility management and inadequate funding of healthcare. The study is informed by the Batho Pele Principles and the Donabedian Model. The Model will be discussed in Chapter 3 as the theoretical framework that guided the study.

2.1 Introduction

Research has been conducted on the work of public healthcare facilities to guide authorities with public health service delivery. For instance, a study by Magqadiyane (2022, p. 5) aimed to develop a model to help enhance quality of care to improve health outcomes of women and newborns in public healthcare facilities in South Africa. Lewis et al. (2023) also investigated the quality of healthcare services in 2,929 public and private healthcare facilities in low-and-middle income countries, showing how evaluations within facilities revels shortcomings that officials can address to enhance service delivery. This shows that research is critical in developing strategies that can be employed by public healthcare officials to address service delivery challenges.

In developing countries, the acknowledgement of the shortcomings in the standard of care has resulted in greater effort to monitor and measure health services to achieve health security. Haemmerli et al. (2021, p. 2) state that research has found that poorer

populations are prone to receiving poor quality care. In support of this, Willie and Maqbool (2023, p. 0110) explain that in rural areas there is less distribution of healthcare facilities and when they are available, they lack infrastructure and human resources such as physicians, dentists or specialists. As such, the evaluation of these shortcomings, including access to healthcare remain central to high income countries and developing nations (Moeti et al., 2023). Therefore, to address service delivery challenges, countries conduct performance assessments to monitor their health systems (Bangalore Sathyananda et al., 2018, p. 2). However, Nickerson et al. (2014) argue that the ability to provide care has been monitored in health facilities of low-middle income countries, yet evidence suggest that these evaluations are commonly incomplete and undermine the goal of improving health outcomes. There is always the constant threat of the emergence of dangerous and severe diseases such as the global "COVID-19 pandemic disrupting people's health" (WHO, n.d.), and the recently discovered Monkey Pox diseases that continues to be a health threat (WHO, 2024). As such, strong healthcare systems are require to be able to overcome such pandemics.

The literature review is focused on health service delivery, shortcomings and common challenges affecting public healthcare facilities domestically and globally.

2.2 Public healthcare facilities: A fundamental concept of health security

The National Health Insurance is being implemented within the country to guarantee that all South African citizens are accessing healthcare services (Meyer et al., 2017, p. 2). There will be greater demand for empirical evidence to direct and educate policy as South Africa begins to implement significant healthcare changes under the guidance of the NHI strategy (Burger & Christian, 2020, p. 53). A broader perspective of public healthcare facilities is to ensure equitable healthcare service delivery, while fostering improved overall well-being of the people (WHO, 2019). As such, WHO (2007) notes the basic elements of the healthcare system as service delivery; the availability of healthcare workers and medical supplies, such as vaccines and technology; availability and access to financing and information systems; as well as leadership and governance.

Given that the majority of the globe's population rely on public health services, it is one of the most significant disciplines in the global economy. Abrahams (2021, p. 2) states that public primary healthcare services are responsible for achieving effective health service delivery for the majority of the South African citizens, ensuring that they receive high standard care. The primary healthcare clinics and the community health centres are currently South Africans' first point of contact with healthcare services, and they provide care for persons who can walk and do not require bed rest, or what medical experts refer to as “ambulatory patients” (Cullinan, 2006). Cullinan further explains that a clinic which functions as a public healthcare service provider commonly operates for eight hours on weekdays. However, healthcare workers are normally required to be available on call to attend to emergencies. The community health centre operates for 24 hours with a variety of services that are on high demand as emergencies such as accidents, expectant mothers going into labour, urgent care, and trauma.

Benatar (2013, p. 54) notes that it is a privilege for the South African health sector to have the opportunity to train skilled healthcare professionals who are dedicated to provide high quality care in both private and public facilities. Despite this, there is still a severe shortage of healthcare workers, mainly doctors, in the country. This shortage affects health service delivery, especially in the (rural) districts (Dookie & Singh, 2012, p. 2). Therefore, the shortage of doctors reveals a critical health concern in public hospitals in the country. The shortages are prevalent in rural settings as shown by lack of facility infrastructure, inadequate services and poor environment leading to poor attraction of nurses and doctors to work in rural areas (Nemutandani et al., 2006, p. 180). The urban and peri-urban areas also experience the same challenges but not necessarily to the same extent. For instance, in a provincial hospital in the Gauteng province, such as Baragwanath hospital, staff shortages affect service standards including quality of care (Child, 2017). In addition to the number of healthcare workers, competent and highly skilled health experts are scarce (Asif et al., 2019, p. 10). The foundation of healthcare services is provided by qualified nurses (Matlala et al., 2021, p. 1). Zweigenthal et al. (2019, p. 2) posit that clinicians are the core pillars of every healthcare system, making it essential to implement interventions to maintain experienced, skilled, effective and highly motivated healthcare personnel.

According to Mothupi et al., (2018 in Abrahams et al., 2022, p. 74), public healthcare services are characterised by available resources including adequate facilities, health practitioners, equipment, supplies, and medications. Abrahams (2021, p. 51) note that the COVID-19 pandemic has revealed factors that cause healthcare service bottlenecks including workforce availability. As such, the pandemic demonstrated daunting obstacles that the health sector faces, such as shortages of resources, including staff (Harrisberg & Khan 2020, p. 1). Moreover, Rispel (2016, p. 17) cites three significant flaws in the health sector:

- The leadership and management in healthcare is unable to implement essential changes in the sector.
- There is an absence of efficient health systems in districts.
- There is a lack of capacity to address the ongoing crisis in the health workforce.

The South African Health Department is dedicated in its efforts to raise the standard of healthcare (Whittaker et al., 2011, p. 60). The best indicator of healthcare is access, and according to Scheffler et al. (2015, p. 1), it is a basic human right to have access to healthcare, and it is a requirement that all services be made available for everyone. However, despite South Africa's well-developed constitution, Maphumulo and Bhengu (2019: 2) observe that progress on basic human rights issues, including quality care and accessibility, is still slow. Regarding South Africa’s health accessibility hurdles, the recent scholarship from Willie and Maqbool (2023) assert that, what is known is that, general people are left behind from the comprehensive health agenda because they are unable to afford private and advanced medical care. This is due to their socio-economic statuses which include unemployment, poverty and resourced rural medical care facilities. Harris et al. (2011, p. 102) further explain the importance of understanding the challenges of accessing healthcare from the viewpoints of people using it, to enable the expansion of health coverage in developing countries, including South Africa (Harris et al., 2011, p. 102). It is imperative to work toward achieving universal access to basic healthcare (Benatar, 2013, p. 154). It is also important to investigate the appropriateness and efficacy of healthcare in various levels, including ambulatory care, such as community health workers and home-based care workers, in ensuring continuity of medical care (Dookie & Singh, 2012, p. 3).

The expanding scope of services supplied by public health facilities due to the shifting epidemiological profile in South Africa has placed tremendous pressure on existing resources, contributing to insufficient medicines and issues with the standard delivery of care (Meyer et al., 2017, p. 7).

The National Department of Health (2020) affirms that in South Africa, approaches to change funding systems for healthcare are about to happen. This includes providing equitable healthcare for all, ensuring social cohesion, and achieving Universal Health Coverage (UHC) through optimal health systems that focus on the impoverished, and tackle challenges (NDoH, 2020). To achieve a balanced UHC, the whole population must be able to receive affordable healthcare (Harris et al., 2011, p. 102).

Hunter et al. (2017, p. 112) found that the data demonstrate that the use of clinics by South Africans is increasing. However, the challenge South Africans face regarding healthcare is the poor healthcare infrastructure, including equipment, and emergency services such as ambulances. Afshari and Peng (2014) posit that “healthcare infrastructure is essential for effective operations of healthcare systems” (p. 1). This aligns with Hunter et al.’s (2017, p. 111) description an ideal clinic demanding adequate resources, such as, infrastructure, medical supplies and equipment, stakeholder support and policies that enable the clinic to follow guidelines to provide excellent services.

Abrahams et al. (2022, p. 63) note that a larger portion of the population relies on services provided by public primary healthcare facilities as a gateway for accessing healthcare, therefore, continuously putting the facilities on spotlight. This is because there is a high demand of healthcare services and people also have high expectations with regards to the quality of care provided. At the same time, complaints are being raised by the people about the services provided in the facilities in terms of inefficiencies and inequalities in healthcare access (Abrahams et al., 2022, p. 63). Even urban population groups experience inequalities. In addition, poor population groups have limited healthcare benefits, much lower than rich populations in the same society (Ataguba & McIntyre, 2012, p. i36). Therefore, this reveals that the delivery of healthcare does not meet the level of care needed (Ataguba & McIntyre, 2012, p. i36).

Colonialism and apartheid are the root cause of the overall inequalities that persist in South Africa. The provision of services such as healthcare will continue to face issues related to inequality as a result of the nation's unjust past (Abrahams et al., 2022, p. 67). In particular, the following areas: physical accessibility, organisational accessibility, cultural accessibility, and acceptability, access to adequate services of care continues to be a concern. It is significant to note that access alone does not meet the standard of satisfactory service delivery; the accessibility of resources, supplies, and equipment affect the provision of services (Snell & Bengu, 2020, p. 261).

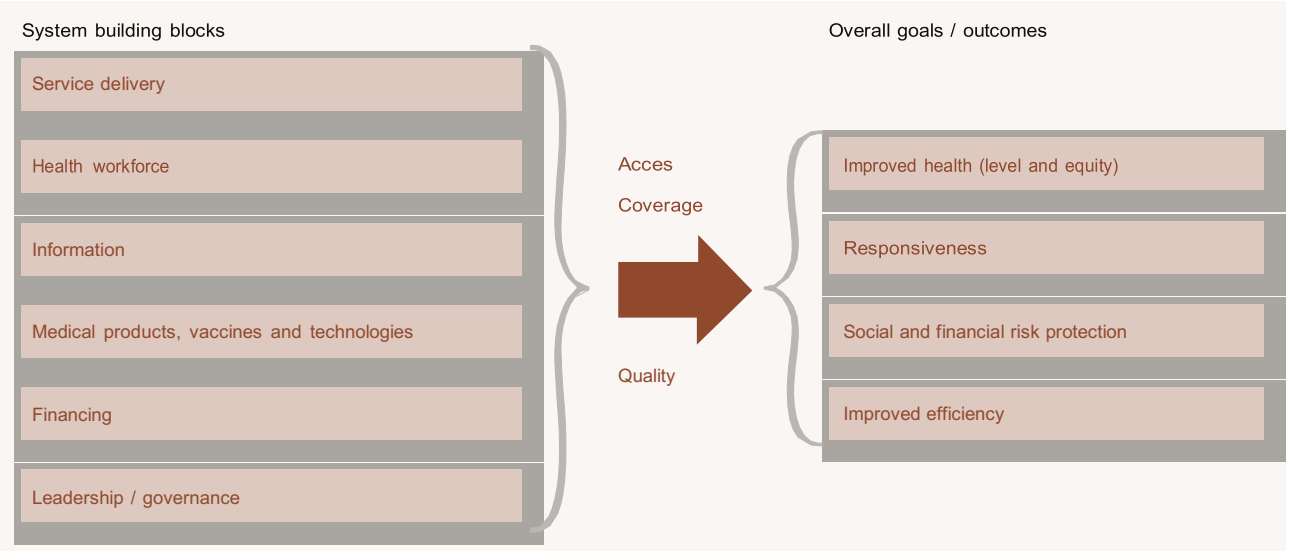
Furthermore, Snell and Bengu (2020, p. 261) explained that geographical distance and lengthy wait times were barriers to early accessibility of medical facilities. According to the standards of an ideal clinic, patients should not wait more than three hours to receive care (Scott & Moosa 2019, as cited in Abrahams 2021, p. 71). In the literature, Maphumulo and Bhengu (2019), as cited in Mhlanga and Garidzirai (2020, p. 2), lengthy waiting times are one of the key characteristics of public healthcare, as well as limited resources of staff, medicine and equipment. In addition, there are also traits of unhealthy environments in healthcare that attributes to poor strategies of infection control, as well as a lack of proper poor record keeping (Maphumulo and Bhengu, 2019, as cited in Mhlanga & Garidzirai, 2020, p. 2). For instance, mismanaging medical records might be detrimental to patient's lives because if records are missing it means the medical history of patients are lost (Marutha & Ngoepe, 2017, p. 1). It was acknowledged by Katuu and van der Walt (2016, p. 1) that patients' medical records are not being handled properly in public healthcare institutions.

Moreover, Dolamo (2018, p. 4) states that it is frustrating and inconvenient for patients to wait long hours in clinic waiting rooms, as they spend most of times there. Some might have arrived in the early hours of the morning to be the first in line. However, it is more frustrating for the healthcare workers because they are aware of the situation, but in most cases, it is beyond their control.

According to the White Paper for the Transformation of the Health System in South Africa (1997), there is an emphasis on decentralising the administration of healthcare services in districts to ensure increased quality healthcare access and availability to

everyone, as well as the availability of essential medications and healthcare funding. A well-designed healthcare system is significant for effective and impartial health service access. The figure below presents the framework for health systems:

Figure 2: The WHO's Health Systems Framework



Source: WHO (2007)

Building on this framework and to address these service delivery challenges, the government introduced the Batho Pele Principles. In 1997, the Batho Pele Principles were established to advance and enhance service delivery in South Africa. The Batho Pele White Paper is an initiative to transform public service delivery, including healthcare services (The Republic of South Africa, 1997). Batho Pele is a Sepedi or Sesotho phrase that means "people first." In this context, "service delivery" specifically refers to the delivery, provision or acceleration of public healthcare. The Constitution requires that services be delivered to society in an effective and efficient manner, and this is the rationale behind the Batho Pele principle in South Africa (Gcabashe, 2021, p. 23). This study's aim is to explore the challenges of public healthcare facilities to improve health security. The principles can be used to assess how healthcare services are provided, managed and the extent to which they received by primary beneficiaries that are intended to benefit from. By implementing these principles, healthcare institutions can develop the measures to alleviate the challenges public healthcare facilities face to guarantee health security. The compliance with the Batho Pele Principles by healthcare institutions is fundamental to overcome and address patient's

negative perceptions regarding health services, and enhance their satisfaction, as well as the overall service delivery in these healthcare facilities (Gcabashe, 2021, p. iii).

The Department of Public Service and Administration (1997) announced the listed Batho Pele principles:

1. Consultation – people must always be allowed to state their views on the scope and standard of quality regarding public services and be free to select the services of their choice.
2. Service standards – the significance of describing quality standard for public services involves informing people of the quality level, thus allowing them to have expectations.
3. Access – all citizens are entitled to equitable access of public services, thus making it a priority.
4. Courtesy – dignity, politeness, and consideration are a must when working with people.
5. Information – all citizens are allowed to receive comprehensive and reliable information regarding public services.
6. Openness and transparency – public entities are obligated to be open about budgets, expenditures and management structures to citizens.
7. Redress – when public services fall below the mandated standard of delivery, there must be an apology, accountability, and resolutions, and when complaints are lodged by citizens, they should be addressed with compassion.
8. Value for money – to deliver public services to all without wasting resources.

These eight principles are aligned with the services provided in public healthcare facilities. For instance, the principle of service standards is an indicator of quality healthcare. The third principle (access) advances the expansion of healthcare access. The significant objective of the public health sector is to ensure that patients receive quality healthcare; therefore, this implies consultation, courtesy, openness, and transparency. Another major goal is the enhancement of service delivery, which will result in health security being improved.

Key ideas emerging from the literature that inform this study include public service delivery, public healthcare facilities, quality healthcare, people living with chronic illnesses and healthcare facility resilience. The concept of service delivery is the focal point in public healthcare facilities for achieving health security, mainly for disadvantaged people. Samihah (2012, p. 86-87) states that service delivery is a commitment to the citizens when an enterprise tries to succeed in fulfilling its duties. Improving service delivery is undoubtedly a key pillar of the governance process. In this case, improved service delivery in healthcare is a fundamental tool to enhance health security and simultaneously achieve human security. This study investigated the role of public healthcare facilities in improving the health security of disadvantaged people in Fetakgomo Tubatse Local Municipality. The findings from the reviewed literature show that the municipality and the government require integral intervention to deliver sustainable services.

A study by Mafolo and Smith (2009, p. 431) used the Batho Pele Principles as a remedy to address the challenges faced by the government and municipalities regarding public service delivery. Mafolo and Smith (2009: 431-432) advocate the Batho Pele Principles as a primary element of the operational culture to be practised in municipalities aiming to regain citizens' trust and as a strategy to address the shortcomings of municipalities. This approach could improve service delivery in municipalities and aid with delivering quality healthcare in public healthcare facilities. Therefore, patients and personnel of public healthcare facilities will benefit from this approach. Unfortunately, Schermerhorn (2012) (in Hafit et al, 2020, p. 7) found that research in the field of healthcare revealed that health workers were failing to adhere to the Batho Pele principles. The findings for their study show that the senior staff members neglect the adoption of Batho Pele Principles in the sector, resulting in doctors not committing to work with nurses and delivering effective patient care (Schermerhorn, 2012, in Hafid et al, 2020, p. 7). This could lead to conflict amongst doctors and nurses, resulting in poor service delivery of healthcare.

Complying with the Batho Pele Principles cannot be achieved if public healthcare facilities lack resources and infrastructure. The researcher believed that to address the issue of health facilities with a shortage of resources and poor infrastructure, the government needs to intervene in resolving this issue. The significance of the Batho

Pele Principles is to make people a priority. Therefore, embracing fully the Batho Pele Principle can be affected by a lack of proper infrastructure, as well as the resources that enable operational effectiveness in healthcare settings.

2.3 The significance of public healthcare facilities towards improving health security

Public healthcare facilities are meant to be for all, and all individuals are entitled to equal healthcare access. According to Maseko and Harris (2018, p. 22), public health facilities provide citizens with affordable healthcare. The former South African Minister of health, Dr Aron Motswaledi, explained that there are ongoing efforts to ensure standard quality systems for public healthcare and to decrease the cost of private healthcare [Dr Aron Motswaledi, August 2015 (in Maseko & Harris, 2018, p. 22)]. In South Africa, there are a substantial number of poverty-stricken communities; as such, free or subsidised healthcare benefits the people who are unable to afford it. However, there is a great difference in healthcare benefits between groups of people in terms of receiving healthcare, the indigenous versus the non-indigenous or the deprived versus the non-deprived as a result of social exclusion and discrimination. Castro et al. (2015, p. 103-104) describe it as evidence of denial of rights, racism, prejudicial treatment, as well as limited access to quality healthcare. Some people experience discrimination; others are abused in care and there is also a problem of unethical behaviour. Race and socio-economic status shape perceptions of healthcare and practice (Holthof, 1991, p. 245). However, South Africans no longer regard race as the ultimate source of division, but it remains a determinant of material and social exclusion along with class (Zwi et al., 2001, p. 463). Social justice is essential in the health sector for people to receive equal care.

According to Eteinne (2015, p. 1271), public healthcare facilities have inadequate infrastructure, are extremely underfunded with shortages of healthcare workers, and frequently run out of medicine and supplies. Nonetheless, the advantages of public healthcare facilities are that people receive free healthcare, which includes pharmaceuticals, wheelchairs, and crutches (Young, 2016, p. 4). Bateman (2010, p. 416) and Politics Web (2018) argue that aside from the dearth of beds, machinery, and essential medical instruments to run a healthcare facility, another basic need that

is not available for patients in public healthcare facilities is food. Patients require high-nutrient food when in healthcare. The inability to provide food for patients in healthcare facilities poses a serious threat. This implies that patients are required to provide food for themselves while in public healthcare and that the inability to do so may result in patients facing death. For example, those who live with HIV/AIDS require immune boosters (such as porridge supplements); when health facilities fail to provide them, patients' health may deteriorate.

Furthermore, public healthcare facilities experience overcrowding and are short-staffed. This results in negative health effects for patients and extremely tired healthcare workers (nurses and doctors) because they are overworked. Tana (2013, p. 82) highlights the physical and mental strain on nurses and doctors because facilities do not have as many healthcare professionals as needed, which in turn results in the deterioration of the medical conditions of patients. Overcrowding results in patients being frustrated due to not knowing whether they will receive the care they need. These effects negatively impact both patients and healthcare workers. A study by Virtanem et al. (2008) mentions healthcare worker burnout and dissatisfaction. Denison and Pierce (2003, p. 9) also report an increase in medical errors, Young (2016, p. 20) observed long waiting periods and Santibánez et al. (2009, p. 12) report that some of the negative effects of overcrowding include a decrease in patient safety. The current public healthcare facilities in South Africa are insufficient, whilst the population is growing at an alarming rate. The shortage of health facilities and insufficient health workers make it difficult to achieve health security.

2.4 International Perspectives on public healthcare

There are both challenges and success factors regarding healthcare provision globally. Over the past decades, developing countries reported improved health outcomes; however, that is not the case anymore, there has been a growing demand for healthcare as the public now has high expectations regarding healthcare provision. In addition, there are emerging health needs, and new health goals are being established, fostering healthcare systems to improve performance and produce better health results (Kruk et al., 2018). The COVID-19 pandemic era has exposed gaps in healthcare across the globe in terms healthcare systems, including government

responsiveness and readiness, infrastructure, supply chain and personnel (Filip et al., 2022, p. 2). For instance, high income counties such as Italy, Spain, France and the United States are among the countries that have proper healthcare systems, even so during the COVID-19 pandemic they were exposed as having inadequate resources (Manavgat & Audibert, 2024, p. 2). This era has revealed that many healthcare facilities were not prepared to respond to high inflow of patients, they had insufficient equipment and lacked proper medical training to handle such health threats (Filip et al., 2022). During the early stages of this period, guidelines and procedures for treating COVID-19 changed a lot, because of healthcare facilities not having adequate information about the disease, and having limited supplies, capacity and competence to treat it (Filip et al., 2022, p2).

However, historically many countries faced health provision barriers and inadequate facilities that provided poor services even before the COVID-19 pandemic, which hindered achieving UHC. A study by Vedom and Cao (2011) explain that China's rural areas have poor quality care where hospitals have limited beds and inadequate qualified healthcare workers. Similarly, public healthcare facilities in Bangladesh have common challenges including shortage of healthcare workers and support staff, limited medicines, supplies and diagnosis services, and limited government funding leading to out-of-pocket expenses (Korotki, 2022, p.8). Another study by Marten et al. (2014) on BRICS countries (Brazil, Rusia, India, China and South Africa) highlighted that there is insufficient healthcare provision in these countries due to lack of resources and proper healthcare systems. In Bazil, healthcare access is a challenge mostly for low-and-middle income populations, and there is a presence of health distributional inequalities that needs to be addressed, as well as shortages such as infrastructure and physicians. In Rusia, public healthcare facilities were permitted to charge for services, undermining free healthcare due to lack of funding. Furthermore, India's healthcare system has experienced a decline in the provision of healthcare services due to a shortage of skilled healthcare workers, medial supplies and equipment leading to reduced effort to achieve UHC. China has a population that grows rapidly with a high risk of chronic diseases, whereas it lacks proper disease preventative and monitoring methods. Lastly, South Africa also has a lack of healthcare funding and human resource shortage (Marten et al., 2014). As illustrated in Figure 3 below, India

and Brazil populations have the highest rates of out-of-pocket money spending on healthcare, while South Africa rank lowest at 7 per cent.

Figure 3: Healthcare similarities among the BRICS countries

	Brazil	Russia	India	China	South Africa
Out-of-pocket spending on health (% of total health expenditure, 2011)[52]	57·8%	35%	59%	35%	7%

Source: Marten et al. (2014)

Moreover, Ethiopia also experiences significant health challenges, including high rates of disease burdens, a shortage of healthcare workers, poor quality care and limited-service delivery, and the country's health system is not fully prepared for health emergencies (Hierink et al., 2023, p. 2).

These challenges show that achieving health security is dependent on healthcare systems that function effectively. As such, without proper healthcare, health security cannot be achieved. A recent systematic review explains that to achieve health security, there should be "better governance, leadership, financing and equity" (WHO, 2020) (Cited in Bashai et al., 2024, p.1). Moreover, it is also important to assess whether the insufficient resources in facilities are being allocated to relevant parts of healthcare systems and are being maximised for impact (Lamesgen, 2025, p.2).

2.5 Access to healthcare

The idea of healthcare access has evolved to consider aspects of healthcare that influence the availability of services and the level of demand (Guimaraes et al., 2019, p. 1-2). From the 1970s to date, literature has defined access to healthcare in many ways. According to Donabedian (1972, p. 111), access is the action of making practical, effective, and efficient service utilisation, as opposed to initiation and continuance, which are the successive uses of healthcare. Aday and Anderson (1974, p. 209), further explain access based on the level of healthcare services that are available and easy to access. They identify two concepts about healthcare access which are gaining access and having access. As such, gaining access is the use of healthcare and having access is the potential to use healthcare.

According to Mothupi et al. (2018 in Abrahams, 2022, p. 74), for a public healthcare system to be sufficient, strategic approaches must be applied to ensure coverage, address social factors, and achieve the standard of quality care. Healthcare facilities may be available, but people may still not receive the healthcare they need. “Access includes not only affordability and availability but also acceptability and effectiveness” (Dolamo, 2018, p. 3-4). Access to healthcare services is a global issue, and according to Mbemba et al. (2016), one of the major problems for over half of the population who live in rural and Isolated locations is accessing excellent services. Guimaraes et al (2019, p. 1) agreeing with this, notes that the lack of access results in inequalities in healthcare, and more likely affects impoverished families who often get sick or have a shorter life- expectancy.

Statistics show that that 84 per cent of the South African citizens utilise public healthcare, and 16 per cent opt for private healthcare (Turner, 2021, p. 1). Although it cannot be completely denied, healthcare access may be limited owing to a shortage of resources. Access to healthcare can also be dependent on money and time (Legrand, 1982, p. 15; Penchansky & Thomas, 1981, p. 128; Mooney, 1983; Oslen & Rogers, 1991, p. 93). Disadvantaged people tend to struggle with access due to money and time constraints, and these are based on the social class of individuals and the geographical setting of facilities. Though the healthcare is free, the patient may incur other expenditure such as travel expenses or lost wages from attending medical appointments (Fusheini & Eagles 2016, in Abrahams, 2022, p. 74). According to the National Department of Health (2009) (in Burger & Christian, 2020, p. 46), healthcare facilities should be no more than a distance of five km from the patient’s home. However, in most cases, people who live in isolated areas travel or walk more than five km to local clinics or a healthcare centre.

As the nation strives to achieve universal health for all, there are always setbacks that negatively affect the wellbeing of South African communities (Department of Health, 2015). As such, access to universal health continues to be a major priority in the country to resolve healthcare setbacks (Christian, 2014, p. 5).

Many South Africans depend on free healthcare services from public health institutions as part of their right to medical care. The lack of access to healthcare sometimes is a

result of personal circumstances. Disadvantaged people are further affected by certain factors regarding healthcare access. Penchansky and Thomas (1981, p. 128), Peter et al. (2008, p. 161) and Obrist et al. (2007, p. 1585) mention these factors as affordability, accommodation, accessibility, availability, and adequacy. The South African Government has a responsibility to develop strategies that guarantee universal access to equitable care for the population. As such, investing in financial resources should be a priority for authorities in the health sector. As access to primary healthcare is an essential requirement of the state, the government must aim to raise finances and increase the efficiency, success and fairness of health facilities.

2.5.1. Healthcare access indicators

Access to healthcare is a comprehensive and multifaceted notion, and according to Gulzar (2007), it is a critical challenge for health policy. Since key areas of access in healthcare are not fully understood, this leads to the struggle of addressing access clearly. Christian (2014, p. 3) explain that the absence of a clear understanding of healthcare access dimensions and their roles in health emergencies can jeopardise policies aimed at enhancing access and equitable care. Public authorities in South Africa have prioritised efforts to improve the accessibility of healthcare and also emphasised its affordability and availability (Christian, 2014). Availability, affordability and acceptability which are discussed below are the indicators of access to healthcare:

Availability: According to Penchansky and Thomas (1981, p. 128) availability refers to physical access, as well as the available services and resources required by patients. The availability indicator measures whether every person in the community have access to adequate healthcare services at convenient locations and at the times when care needed (Burger & Christian, 2020, p. 45). In this regard, availability is associated with the supply side of services, which includes the facilities and infrastructure, clinicians, medical equipment and drug availability, clinical guidance and healthcare programs, as well as emergency services. Although the availability indicator is a crucial component of access, it is not enough to ensure that patients are able to use the aforementioned services (McIntyre et al, 2009: 182). Hence, there are various indicators of access to healthcare to be considered such as affordability and accessibility.

Affordability: The cost of medical care and other healthcare services is correlated with the income of the patient and is known as affordability or financial access (Penchansky & Thomas, 1981, p. 128). Therefore, the affordability indicator considers the financial burden the patients will have to incur to use health services, whether they are aware of the costs, the options they have for treatment and if they can afford them. Consequently, it is associated with the value of money (Burger & Christian, 2020, p. 45). As such, being ill is a financial risk, particularly for the impoverished groups; thus it is the health system's duty to shield such groups by addressing the issue of affordability (Christian, 2014, p. 9). According to Booysen (2003), in South Africa, the wealthy are adequately insured for healthcare services, which allows them to access enhanced care as compared to the impoverished groups. Poor people are unable to access the costly private healthcare; hence, public healthcare must provide them with quality care.

Acceptability: According to Burger and Christian (2020) "… the acceptability indicator is more normative (p. 45)." It is also known as cultural access. Acceptability describes how patients feel about the personal and professional traits of healthcare professionals in comparison to the traits that are the *de facto* norm for current medical professionals (Christian, 2014, p. 9). For example, female patients may prefer to be examined by female gynaecologists in cases of reproductive issues. This is a complex perspective that patient might have based on their preferences of who need to care for them for various reasons (Ntunta, 2019, p. 9). These include attitudes, behavior, patience and empathy of medical personnel.

2.6 The availability of medication

In the literature, Meyer et al. (2017, p. 4) highlights that South Africa has implemented various interventions in public healthcare over the past few years focusing on the availability and accessibility of medications, and the use of guidelines to enhance healthcare that is safe for patients. Worldwide, people rely on different kinds of medicines for different types of health conditions. Malomane (2020, p. 54) notes that medications are essential for patient treatments in healthcare facilities. They are defined as the "science of healing," fostering health by means of preventing and

treating various health conditions (Goldberg, 2016) (in More, 2016, p. 1). For instance, millions of people across the world use medicine on a daily basis to treat or cure diseases such as, hypertension, mental health conditions (like anxiety, depression and bipolar), diabetes, tuberculosis and measles, the 'flu, pain and fever. And as such, medicines should always be available in facilities to ensure that people can access them at all times. In support of this, Meyer et al. (2017, p. 4) state that it is crucial for patients to get the required medicines whenever they need them.

However, in South Africa, there are reports of medication scarcity and outages, especially for HIV/AIDS and TB. This is a serious problem as the country has a very high rate of HIV infections. Therefore, a shortage of medicine impacts negatively on the health security of the nation. The table below presents reports on drugs.

Table 1:Stockouts for ARV or TB drugs per province for 3 months from 2013 to 2015 stockouts for each province from 2013 to 2015.

Province	Facilities reporting at least one ARV or TB medicine stock out % (n/N)		
	2013	**2014**	**2015**
Eastern Cape	20% (89/447)	28% (141/509)	32% (148/465)
Free State	54% (90/167)	28% (41/147)	53% (71/135)
Gauteng	20% (58/284)	25% (71/283)	56% (157/278)
KwaZulu-Natal	14% (45/332)	19% (83/436)	26% (108/417)
Limpopo	41% (89/218)	29% (77/266)	25% (63/248)
Mpumalanga	26% (58/224)	40% (82/205)	74% (163/220)
Northern Cape	18% (11/62)	21% (23/107)	23% (28/123)
Northwest	4% (8/182)	39% (86/222)	41% (92/223)
Western Cape	5% (11/223)	4% (10/279)	12% (32/261)
South Africa	21% (459/2 139)	25% (614/2 454)	36% (862/2 370)

Source: 2015 Stockouts National Survey

2.6.1 Access to medication for chronic health conditions

Chronic health conditions are those that last for very long times and are unlikely curable but are treatable. They are defined as “diseases that require continuous treatment management for a lifetime” (Kagura et al., 2023, p. 2). Walker (2001, p. 209) posits that “the insidious and ultimately incurable nature of an illness may mark it out as chronic.” These include conditions such as diabetes mellitus, heart conditions, hypertension, asthma, stroke, HIV/AIDS. They are the leading cause of premature fatalities among adults aged between 30 and 69 years across the globe and are responsible for 80 per cent of premature deaths (Mboweni and Risenga, 2023, p. 1).

Moreover, Adams et al. (2021, p. 2) note that as chronic patients frequently require medications and prescription renewals, they need to access them in the right quantities without limit. This demonstrates the importance of offering high-quality medical care to increase cooperation among patients and uptake in the effort to lower chronic illness death rates (Kagura et al., 2023, p. 2). To reduce morbidity and mortality from chronic illnesses, people with chronic health conditions are obliged to have a regular supply and collection of medications (Meyer et al., 2017). However, it has become common to experience insufficient medicine and/or drug stockouts (Health-E News, 2012; Roodt & Fleming, 2018). Stockouts are characterised by no supply of necessary medications at storage or a distribution side for a minimum of one day (WHO, 2005). Burger (2007) (in Ntunta, 2019, p. 15) further highlights that patients in public healthcare have raised their concern regarding the poor supply of medicines, as a result of prescribed medicine shortage. Therefore, Gray and Vawda (2017, p. 6) explains that whenever a patient experience prescribed medication or vaccine shortage, it indicates that the health system at large is a failure. Gray and Vawda further emphasise that if such events are reduced, it would be a major indicator for effective current and upcoming health system according to the NHI (Gray & Vawda 2017, p. 6).

Furthermore, the shortage of adequate healthcare facilities also affects chronic illness patients as they would have to travel long distances to collect their medication regularly or for their frequent check-ups with their doctors or nurses. A large number of the population rely on free healthcare in public facilities, although these facilities are

known for not having some prescribed medicines and for patients waiting lengthy hours to receive care (Burger & Van der Berg, 2008) (in Burger et al., 2012, p. 681). In South Africa, patients living with chronic health conditions frequently travel 60 km or more to reach a healthcare facility (Kagura et al., 2023, p. 7).

High-income countries have implemented numerous interventions to ensure that chronic medications are easily accessible, such as delivering medications in patients' place of residence, increased working hours for pharmacies, a system for refilling medicine prescriptions without visiting facilities (which leads to fewer clinical appointments) (Hersberger & Messerli 2016) (in Hlongwana & Gray, 2022, p. 1). Similarly, South Africa, followed the same path and introduced the Centralised Chronic Medicine Dispensing and Distribution (CCMDD) program to prepare for the NHI (Hlongwana and Gray, 2022, p. 2). Therefore, the purpose of the CCMDD program is for chronic patients to access their medicine in other ways, other than visiting the clinic (NDOH ,2016) (in Liu et al., 2021, p. 2). Yet, people in South Africa still travel to the local healthcare facilities and queue long hours to collect their medication. According to reports, Johannesburg, South Africa, is one of the major urban cities that is currently experiencing considerable issues where 78 per cent of patients receiving treatment are not satisfied with the standard of chronic healthcare they receive (Peltzer, 2000, in Kagura, 2023, p. 3). Hence, the experiences of patient regarding service delivery in health facilities have an influence in choosing their preferred facility, either public or private for better healthcare, thus making patient satisfaction a critical aspect in health investment (Ntunta, 2019, p. 5-6). Another challenge is that, "prescribing and dispensing errors are the most significant cause of medication errors" (Mabila et al., 2023, p. 2). Simonsen et al. (2011, in Mabila et al., 2023, p. 4) further draw attention to the fact that nurses often lack pharmacological expertise of medications, particularly when managing dosages of medications. This puts the health of patients in danger, and it can result in severe illness or even lead to death.

As countries work towards achieving the 2030 SDGs, initiatives are implemented to improve service delivery in healthcare and associated pharmaceuticals that provide medications maintaining accessible to people who need them, when and where they are most required (Grimsrud et al., 2016) (in Liu et al., 2021, p. 2). By taking comprehensive and coordinated measures at the country-led level and as a framework

for the 2030 agenda for SDGs, investment in the prevention, management, and control of chronic diseases should seek to reduce premature deaths by one-third globally (WHO, 2020).

According to Cullinan (2006), the guidelines and requirements issued under the Department of Health in 2001 concerning chronic health conditions and/or long-term illness are as follows:

- Every person with chronic health conditions who is receiving medication on an ongoing basis is evaluated by doctors at least every six months.
- A periodic monitoring program has been put in place to guarantee a good standard of life for patients living with chronic illness, and it explicitly outlines the anticipated frequency of follow-up visits to the hospital.
- The defined national guidelines are used for managing every individual with long-term medical conditions.
- Hospital stays for patients with simple acute diseases are limited to seven days.
- Over ninety-five per cent of the time, patients who are hospitalised receive their medication on time.
- The appropriate channels are used to notify every patient with reportable conditions.
- As part of an approach to enhancing quality, regular morbidity and mortality evaluations involving all personnel who care for medical patients take place at least three times per month.
- Latrogenic events are tracked and reduced, such as bedsores, responses to blood transfusions, and swelling drip sites.

2.7 Quality healthcare

After the apartheid era, access to quality healthcare for all citizens has been South Africa's ultimate goal. According to the Department of Health (1997, p. 17), enhancing health service delivery is a long-term aim for the public service transformation program to ensure quality services. This includes healthcare services, through restructuring the healthcare system in a way that will enhance human, and financial and physical resources in healthcare facilities to provide quality care. Quality healthcare refers to when science and technology are applied optimally in healthcare, without a correlated

risk increase [Donabedian, 1980 (in Mosadeghrad, 2012, p. 251)]. Quality care has progressively become the main element of health security. People always look for quality in healthcare services. In South Africa, the provision of quality healthcare services is a constitutional obligation (Struckler et al., 2011, p. 165). In support of this, Abrahams et al. (2022, p. 4) stated that, for South Africa to guarantee that the people have rights of access to quality care, in 2008, the Department of Health has implemented the 'National Patients' Rights Charter in accordance with section 27(1)(a) of the Constitution, with the goal of achieving quality healthcare access. As such, the government must be a key contributor to ensuring robust health systems that deliver quality care for the population. Thus, to have a healthy and active society, quality healthcare is visible in the context of healthcare facilities (Parsia & Tamyez, 2018, P. 598).

Domalo (2018, p. 3) highlights the six categories of quality health care established by the AHRQ (SA):

- Safe healthcare – Ensuring that patients are not harmed by the very care meant to help them.
- Effective healthcare – Delivering healthcare services informed by scientific knowledge for everyone.
- Patient-centered care – Ensuring that there is respect, consideration and responsiveness in healthcare.
- Timely care – Ensuring that waiting times are minimised, as well as anything that could lead delays resulting in patients queuing for lengthy hours in waiting rooms.
- Efficient care – Ensuring that resources are not wasted, for instance, medication, equipment, proposals and suggestions for improvement.
- Equitable care – Ensuring that everyone receives quality care irrespective of ethnicity, race, age, gender, disability status, and socioeconomic status, among others.

In a similar vein, Amankwah (2019, p. 267) (in Abrahams, 2021, p. 68), identifies four concepts of quality in healthcare systems, including:

- The quality of healthcare professionals.

- The quality-of-service delivery.
- The standard and sufficiency of resources used; and
- The quality of administrative and operational processes.

Therefore, healthcare facilities are required to meet all the standards of quality to be able to provide quality care to patients. Furthermore, Meyer et al. (2017, p. 3) highlight the need for healthcare facilities to engage with local communities and other health sectors, with the aim of ensuring the provision of quality care to communities, by promoting health, preventing diseases and other health issues. Nevertheless, the facilities aim to provide care that surpasses patient expectations, although numerous issues have been brought up for consideration by the public concerning these facilities, including poor disease and infection control practices, poor hygiene, and insufficient medicine and equipment. Young (2016, p. 20) also mentions dilapidated infrastructure. In support of this view, Ntuta (2019, p. 9) explains how patients view quality care based on their experiences with the service standards received in healthcare, and therefore, their views influence the demand for good health. How they assess the quality of care affects their behavior for seeking healthcare (Ntuta, 2019, p. 9).

The South African Medical Association (2015, p.138) further highlights quality healthcare issues in many facilities, including poor environment resulting from a lack of proper hygiene, waste management, or equipment maintenance. In such cases, people do not receive quality healthcare. Therefore, it is crucial to assess the quality in healthcare and enhance service delivery. Resource availability in healthcare influences service delivery. For instance, when a clinic lacks equipment such as a stethoscope or blood pressure monitor, this affects the overall work quality. As such, the lack of resources also stresses healthcare workers. Considering the increasing pressure on nurses to ensure that high-quality patient care is provided, it was acknowledged by the South Africa Nursing Council (SANC) during COVID-19 that a nurse-to-patient ratio was 1:213 (SANC 2021, in Abrahams, 2022). This indicates that a single nurse was seeing a high number of patients in a shift.

A study by Donabedian (1988) differentiates quality healthcare components based on: (1) technical quality, which is the quality of healthcare services provided to assist

individuals to enhance their health and well-being; (2) interpersonal quality, which refers to patient preferences in healthcare in terms of accommodation; and (3) amenities which relates to enhanced options or services to make the surroundings of the healthcare facilities substantially comfortable and satisfying (Donabedian, 1988, p. 260).

Øvretveit's (2009, p. 4) system of enhancing healthcare quality is based on professional quality, which characterises whether the professional is assisting beneficiaries and providing them with care applying the right methods and practices. Patient treatment quality is of crucial importance, which assesses whether or not the recipient feels they receive the services they need. Management quality ensures that the limited resources are used sustainably whilst providing services (Øvretveit, 2009, p. 4).

Furthermore, the health sector takes into account all these qualities in health service provision to make certain that patients receive appropriate, effective and efficient care. To achieve good quality healthcare, the environment where people receive care should be a safe space. Empathy in healthcare is one of the fundamental components which can lead to greater results for patients. People who require healthcare are satisfied when their feelings are understood. To ensure quality healthcare for the people, healthcare services must be available, easily accessible, accurate, and allow both patients and health workers to have privacy and confidentiality., It must be equitable and affordable as well (Mosadeghrad, 2012, p. 24). It is often difficult to ensure quality healthcare in public healthcare facilities due to the lack of resources. Nonetheless, these facilities are trying their best to enhance health security.

Research has been conducted on accessing and receiving decent healthcare, revealing that access and quality are key concerns for universal health coverage, thus helping to achieve SDGs related to healthcare (Barber et al., 2017; Fullman et al., 2017) (in Meyer et al., 2017, p. 3). Yet, very limited research has been done to address the significance of public healthcare facilities in enhancing health security, particularly for impoverished people.

2.8 Disadvantaged Populations: Particular issues in accessing quality healthcare

In South Africa, rural clinics find it challenging to provide quality care, and this persists as a challenge (Matlala et al., 2021, p. 2). This is owing to limited resource availability in rural settings. Vulnerable groups, for instance, people with low-income, immigrants, the elderly and homeless face health security challenges - and often experience hurdles in accessing adequate healthcare. This may include affordability and proximity. Burger and Christian (2020, p. 52) added the following to the list -black South Africans, people who are unemployed, and those who have lower education levels or the uneducated, and the poor. Other groups include farm and rural dwellers (Dolamo, 2018, p. 3). Also, there is a noticeable difference in the overall health of the people living in rural settings and those in urban areas. Another determinant of health is the socioeconomic factor (ICN-IND2018) (cited in Dolamo, 2018, p. 6). Therefore, as Burger and Christian (2020, p. 43) pointed out, it was the government's aim to ensure that the most vulnerable groups, including the poorest, have enhanced access to healthcare. As such, the healthcare facility network was expanded, and patients were not required to pay primary healthcare fees anymore. Furthermore, to make healthcare services easily accessible to disadvantaged populations, healthcare organisations should set up satellite clinics (Dolamo, 2018, p. 3). This will enhance accessibility and ensure that people get the required healthcare at all times.

2.9 Equity and Equality in Healthcare Services

According to Mahomed et al. (2022, p. 92), Sections 27(1) and (2) of the Bill of Rights of the Constitution, 1996, declare that every individual has a right to health service access, and therefore, the Government is responsible for ensuring that healthcare access is achieved within its means, by employing reasonable legislatives and alternative efforts. However, the colonialism and apartheid legacy resulted in inequalities with regard to services. As such, inequality in health service access prevails. Therefore, the challenge of inequalities in the country will persist because of what happened in the past (Abrahams, 2021, p. 47). There is strong evidence of inequalities related to health services. For instance, the socioeconomic differences in income, the level of education achievement, gender, and employment status, among others all contribute to the prevailing inequality (Evans eta al., 1994; Marmot, 2016;

Marmot and Wilkson, 2006) (in Guimaraes, 2019, p. 2). These inequalities in healthcare are unnecessary, unfair, and affect those that are already socially isolated, and they can be prevented (Benatar et al.,2018, p. 1533). Nevertheless, according to ICN Toolkit (2018) (in Dolamo, 2018, p. 2), failure to engage our household members, patients, and consumers in the healthcare process, set us to failure in eradicating the inequalities and enhancing healthcare for everyone.

2.10 Healthcare facility management

The leadership of health institutions is represented by managers in healthcare facilities, who oversee the operationality of the facilities(Abrahams, 2021, p. 6). They are responsible for various tasks including the well-being of patients, ensuring that facilities are practising healthcare ethics when providing care, the safety of both patients and staff, clinical governance and ensuring that risks are minimised (Sekhejane, 2013) (in Meyer et al., 2017, . p3).

Furthermore, Gilson and Daire (2011, p. 70) highlighted the need for South African healthcare managers to ‘step up’ and take the lead at all times. In contrast, Rispel (2016, p. 17) argues that it is common for healthcare services to be managed in an unsupported way. Competence in management contributes to good service delivery; hence, leadership roles in healthcare deserve great attention as they are vital to sustaining an effective healthcare system. For instance, the ICN Toolkit 2018 (in Dolamo, 2018, p. 3), highlights the following outcomes of an investigation in a hospital where several patients were near death: It was discovered that the fundamental components of care were overlooked. Patients endured being dirty for as long as thirty days, patients did not receive their medications on time, or at all, and they were afraid of being in the hospital. Such incidents make people fear going to hospitals whenever they require care, and as such, the management of healthcare facilities needs to ensure that people are comfortable receiving care in public healthcare centres and that they receive quality care and do not fear for their lives. Therefore, such issues persist. Alot of effort is required in districts and local healthcare facilities to enhance governance, leadership and accountability (Gray & Vawda 2017: 7).

2.11 Technology integration in healthcare facilities

Introducing new digital technologies in healthcare can enhance access and care efficiency. The field of digital healthcare has experienced significant growth on a global scale as a vehicle for innovation to solve these issues and accelerate the achievement of the SDGs and UHC (Bloom et al., 2018; Mehl GL et at., 2018 and the Secretary-General's High-level Panel on Digital Cooperation 2018) (in Olu et al., 2019, p. 2).The use of digital technologies for healthcare has several advantages, such as enhancing access to healthcare services, especially for rural communities ensuring that the security and efficacy of services are improved, increasing the uptake of healthcare services, and expanding knowledge and exposure as well as access to medical insights for communities and healthcare personnel (Shuvo et al., 2015 and Roess, 2012) (in Olu et al., 2019, p. 2). Despite these advantages, WHO (2015, p. 2) recognised that some societies were not able to finance modern technologies to support healthcare that is of good quality, easily accessible, cost-effective and efficient.

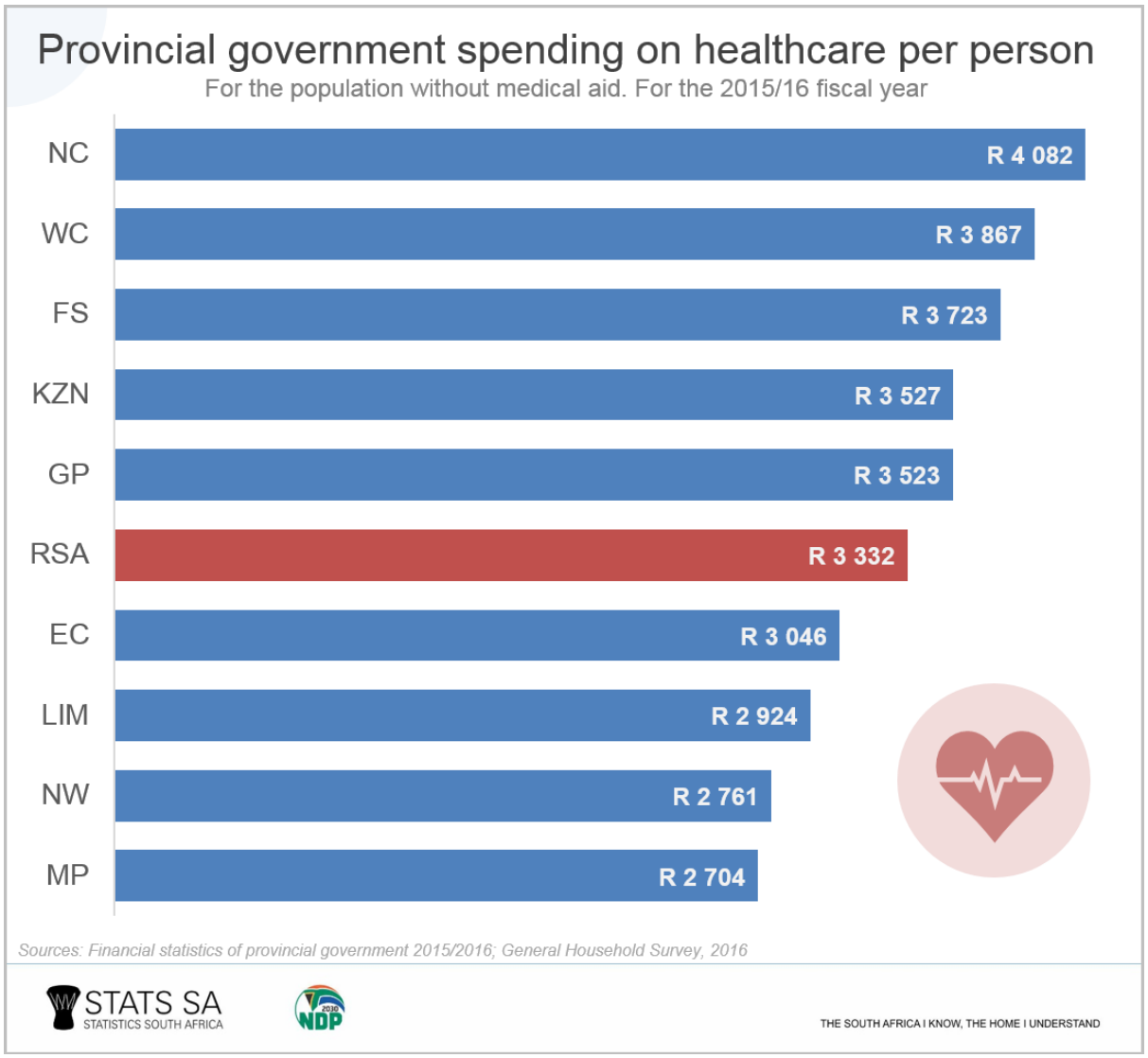
Meyer et al,(2017, p. 9) further highlight that the utilisation of modern technologies in the future will improve access to medications, the use of medicine, medication selection and prescriptions, follow up systems and processes of examining medicines, to assess whether they have to be discontinued or not. Therefore, investing in digital technology for healthcare can make life easier for patients, as well as healthcare personnel, and according to Ntunta (2019, p. 5), it is essential to invest in healthcare to have the ability to improve health workforce, to ensure productivity (Ntunta, 2019, p. 5). For instance, if medical records were stored in computers instead of files, there would be fewer incidents of missing records because technology has backup systems; if patients can access their medication prescriptions or appointments records on their cell phones, life would be so much easier for them. Matlala et al. (2021, p. 4) stated that a large number of professional nurses acknowledged that using contemporary technology electronics in healthcare enhance service quality. Sonars and digital BP machines are some of the machines that are examples of this.

2.12. Inadequate funding of healthcare

The World Health Organisation refers to healthcare funding as a mechanism of a health system to raise money and distribute it to patients' health needs (2010, p. 72). Due to Africa's slow development, the continent has problems with its healthcare system, which is exacerbated because of a lack of funding (Matlala et al., 2021, p. 2). As a result, people use their own money to pay for healthcare services (Okunogbe, 2019, p. 51). The insufficient funding of healthcare in Africa affects the potential to cope with the healthcare requirements (Nguyen & Sama, 2008, p. 249) (in Malakoane et al., 2020, p. 2). Given that public health facilities depend on government financing for operation, they compete against other government departments for the few available resources (Seymour et al., 2019, p. 1). Public health spending is further strongly impacted by the citizens' increasing need for unrestricted access to healthcare services as their life expectancy rises (Mkize, 2017, p. 59). To tackle the issue of limited financing for healthcare access, WHO's regional director has cautioned that a shortage of funding is impeding efforts to enhance healthcare and has called for more funding to increase access to crucial medical treatments (Ghani, 2017).

South Africa still has a high illness burden and overcrowded medical facilities despite having the biggest healthcare budget in Africa (Malakoane et al., 2020, p. 2). Given the amount of money the government spends on healthcare, healthcare performance in South Africa has been poorer than other nations with comparable economic levels (Gray & Vawda, 2017). The country's general health has improved somewhat because of increased spending in healthcare services, but even so, plans for health expenditures have not been properly developed (James et al., 2018, p. 97). They further advise including healthcare service providers in the planning phase to foster financial comprehension between all parties (James et al, 2018, p. 97). According to Child (2017), even though it has a big healthcare budget, South Africa does not have sufficient funds which leads to the government spending less on each individual in terms of healthcare, and also, to make matters worse, there is a freeze on workforce vacancies. The reduced public healthcare funding is a major problem since it affects l the delivery of healthcare services is delivered (Abrahams, 2021, p. 63). The diagram below presents spending on healthcare in the nine provinces of South Africa.

Figure 4: The provincial government spending on healthcare



Source: STATSSA (n.d)

All the provinces spent less than R5 000 on healthcare for every individual in 2015/16. The Northern Cape province spent the highest with R4 082. Three provinces - Limpopo, Northwest and Mpumalanga - spending was below the national average.

2.13 Conclusion

This chapter discussed the literature review and outlined the role of public healthcare facilities in healthcare provision, highlighting the need for quality equitable care to achieve health security for all. Research has revealed that South Africa faces numerous systematic and operational challenges in healthcare in relation to aspects such as access, quality and equity, as well as resource shortages, infrastructure,

facility management and limited coverage, particularly in rural areas. Nonetheless, the government has implemented frameworks, such as the Batho Pele principles to address service delivery issues; however, systematic gaps continues to burden facilities despite the presence of these frameworks. Disadvantaged populations are mostly affected by these gaps, as they fully rely on public healthcare due to affordability. Therefore this calls for more policy intervention to strengthen healthcare delivery through Improved financing, infrastructure and resources to ensure that health security is achieved. Globally, the COVID-19 pandemic uncovered healthcare system weaknesses even in countries that were considered to have strong health systems. Many developing countries experience challenges similar to those South Africa, such as lack of funding, resource shortage and insufficient service delivery. Therefore, the knowledge gaps identified in this literature were based on the research of the public healthcare facilities. This helped the researcher to link the findings of the study within the exiting body of knowledge.

CHAPTER 3
THEORETICAL/CONCEPTUAL FRAMEWORK

3.1 Introduction

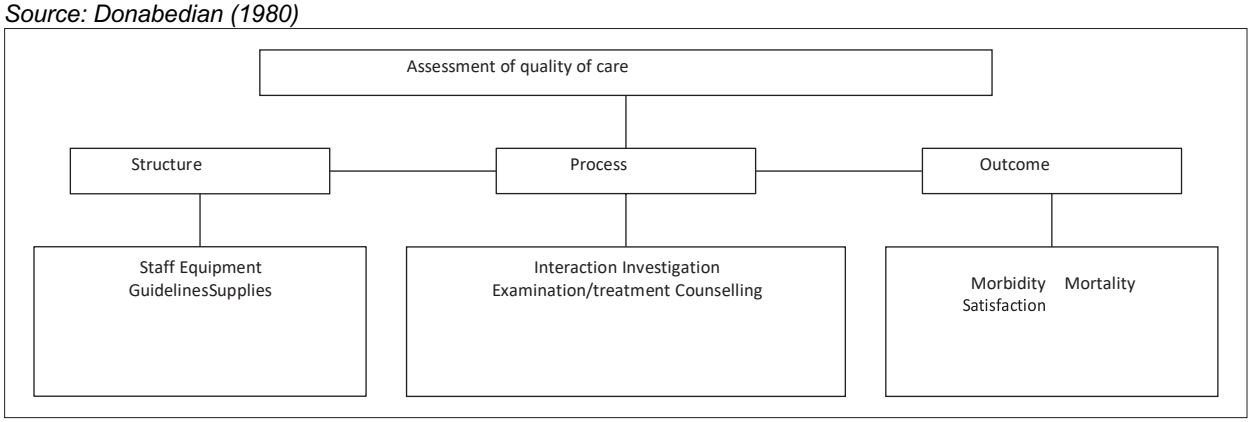
This study was guided by Donabedian's Model to identify gaps in public healthcare in Fetakgomo and evaluate the performance of healthcare facilities through their structure, process and outcomes. The Model provides a systematic way to understand how inputs (structure) influence activities (process) and then resulting effects (outcomes) on health security. The Donabedian's Model, also known as the American Father of quality control, is a quality evaluation model to assess healthcare and to inspect healthcare services (Malomane, 2020, p. 18). The model represents healthcare settings, including the environment and the resources required to provide health services, such as clinics and hospitals, healthcare workers, equipment and funding (LoPorto, 2020, p. 42). Furthermore, it acts as a mechanism to ensure "resilience to public health emergency preparedness" (Mulaudzi, 2022, p. 33). In this study, the model was adopted as a conceptual framework to examine whether the facilities in the study area are well equipped and able to provide quality care, to enhance health security, particularly for vulnerable populations.

3.3 The Donabedian's Model

The Model was established in 1966 for the purpose of evaluating the quality of healthcare. It uncovers weaknesses in the healthcare system by measuring the differences in healthcare efficiency and desired outcomes. The results would enable the healthcare system to implement initiatives to improve the quality of care (Crow et al., 2002 [in Sharew et al, 2020]). The model is widely used in healthcare research to determine areas for continued development and for growth in healthcare systems, and also to facilitate efforts to advance quality in healthcare delivery. Ayanian and Markel (2016, p. 2) note that the model separates quality into three elements: namely, structure, process and outcome (SPO), as presented in the figure below.

Figure 5: Donabedian's Quality of Care Assessment

Source: Donabedian (1980)



Structure – refers to the environment where care is provided, such as the hospital or clinic (Binder et al., 2021, p. 240). The structure component addresses shortages in healthcare inputs, including resources and staffing (Mulaudzi, 2022, p, 34). It points to the largely constant qualities of the healthcare providers and the environment in which they work. These qualities include the following: healthcare settings including how well-organised, equipped and staffed the facility is and the education, experience and certification pertain to personnel. LoPorto (2020, p. 42) further explains that structure is an essential element for the process component because the is no process without the structure.

In this study, the clinics being investigated represent the structure component of the model. It looks at the adequacy of clinics, infrastructure, and healthcare workers, the availably of equipment and medical supplies, and the environment, whether clinics are clean and well maintained. This component addresses objective two and three, which focuses on examining the challenges of service delivery, and developing facility-level management strategies to improve health security. In terms of objective two, the structure component addresses the actions and implementations in practice to improve the well-being of the people.

Process – refers to the exchanges that take place between patients and healthcare professionals during the provision of medical care. (Magqadiyane, 2022, p.48). The component focuses on the technical aspects of healthcare services through standards for assessment, delivery, and surveillance that are put in place to improve the quality of care (Mgqadiyane, 2022). It involves the actions carried out when providing patients

with care, for instance, diagnosis and prescription. As such, the component addresses objectives one and two in this study, focusing on exploring service delivery of public healthcare facilities in Fetakgomo, and determining the strategies employed by officials to respond to health emergencies such as child birth, accidents, trauma and violence related cases. In terms of service delivery in the facilities, the process component explores the key characteristics including, “comprehensiveness, accessibility, coverage, continuity, quality, person centeredness, co-ordination, accountability and efficiency” (Service Delivery Report, n.d.). Therefore, process is a prerequisite for the outcome component of the Donabedian Model (LoPorto, 2020, p. 42).

Outcome – refers to the final results and effects of healthcare interventions on people and populations (Moss-Sherman, 2025, p. 9). It focuses on addressing the implications derived from the structure and process components, which healthcare workers follow to provide care (Binder et al., 2021). The outcome component addresses the last objective of the study (objective 5), which focuses on examining existing measures to alleviate the challenges public healthcare facilities face to guarantee health security. It evaluates the strategies for improving healthcare delivery. These are the end results of healthcare activities. The effectiveness of care can be assessed using outcome metrics, which make an effort to ascertain whether the quality of care has been met.

Furthermore, Uys (2024, p. 25) states that “It is obvious that these three components are interdependent and influence each other. Without infrastructure, no service can be delivered. Without service, a satisfactory outcome is impossible. Without outcomes measured, infrastructure and service delivery cannot improve.” The systems in place, the procedures used to provide care, and the results attained must all be taken into account when evaluating and enhancing the quality of healthcare. This includes methods to assist healthcare institutions in recognising problem areas and putting plans in place to raise the standard of care overall (Moss-Sherman, 2025, p. 9). The structure of the public healthcare facilities, including infrastructure, personnel, equipment, and medical supply availability, influences the process of delivering care to patients, such as handling emergencies, treatment processes, collaboration and resource sharing, and referrals. These processes determine the outcomes of healthcare delivery, including the quality of care, patient satisfaction with services, and

overall health security. These interactions assist in pinpointing gaps that need to be addressed and formulate strategies to improve healthcare delivery in Fetakgomo.

This study was formulated to provide key details for the challenges of public health delivery in an organisational structure using the model, which has three principles that are essential for assessing quality care in health facilities. The primary focus of the study was to explore the service delivery of public healthcare facilities by evaluating the level of quality of health services, based on the following areas presented by Sharew et al. (2020, p. 158):

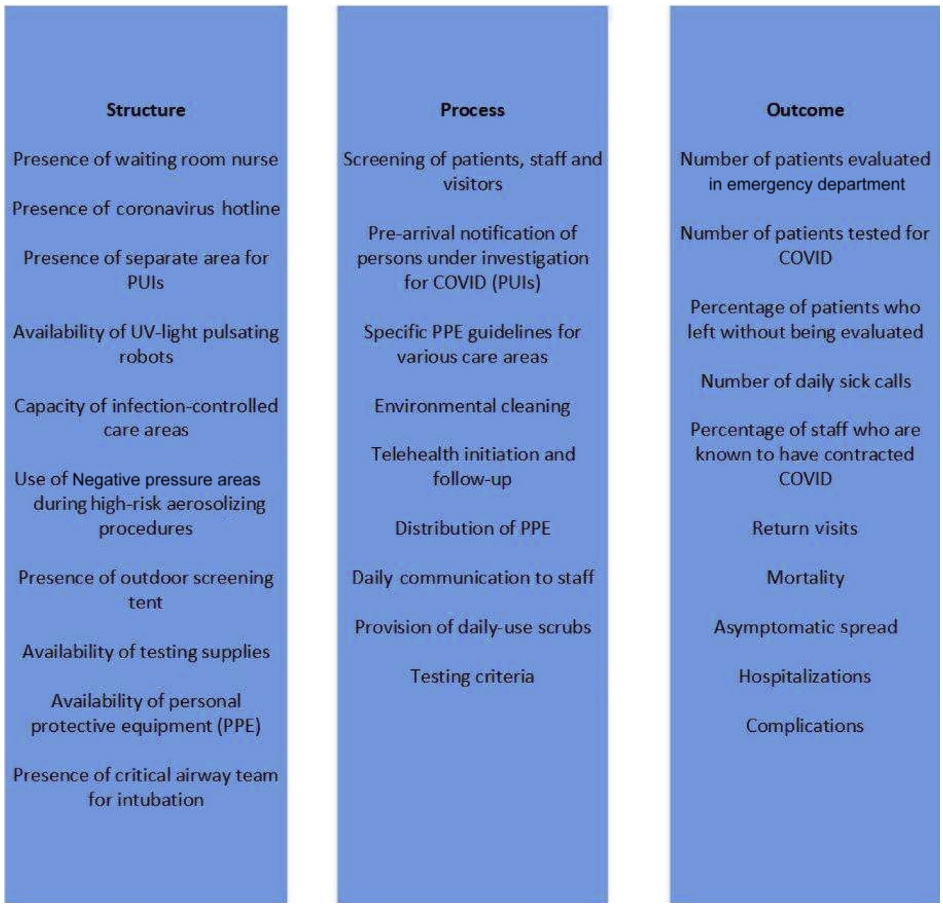
- Facilities' environment and structure
- Healthcare delivery
- Healthcare outcomes

As such, the model was used to examine the challenges of public health delivery in the study area and determine the strategies employed by public health care officials to respond to potential health emergencies.

A study by Binder et al. (2021) applied the Donabedian Model as a guideline for COVID-19 outcomes. The model was applied to respond to COVID-19 related emergencies, guiding the institution to pandemic responses. It enabled an inclusive strategy to evaluate screening methods, set up a supporting mechanism for healthcare workers and patients' outcomes during the critical situation. Binder et al. (2021, p. 241) highlight that the emergency department developed ground-breaking systems to respond to emergency crisis, such as the spike in COVID-19 patients, with measures categorised by the structure, process and outcome analysis. This was carried out through several initiatives, including the process of expanding screening initiatives, changing triage systems, tackling workforce safety, increasing capacity and monitoring practices such as testing and surveillance, as well as remote healthcare services (Binder et al, 2021: 241).

The figure 3 below presents the Donabedian Model in Binder et al study to respond to the COVID-19 pandemic.

Figure 6 : The Donabedian Model



Source: Binder et al. (2021, p. 242)

Furthermore, a study by Sharew et al. (2020) also adopted the model, using it as a framework for quality assessment, with the standard of the structure component determined by the health minister in terms of healthcare resources for facilities. In addition, the healthcare service delivery was a process indicator of several activities such as laboratory investigation and consultations with patients and care providers. The outcome component was determined by patient experiences (Sharew et al. 2020, p. 158). The researchers looked at the availability of resources (i.e., major equipment in facilities), characteristics of the facilities (laboratory, pharmacy unit, delivery unit, emergency room etc.). The findings revealed that the quality of healthcare services was poor due to inadequacies in structural indicators, such as availability of equipment. Despite satisfactory structural component, which is adequate human resources and positive characteristics of health facility setting, which include diverse expertise of human resources, the overall achievement in the outcome component was deemed poor (Sharew et al., 2020, p. 162-163).

A similar study was conducted by Tossaint-Schoenmakers et al. (2021, p. 2). They categorised the structure component in terms of healthcare delivery settings, including resources such as facilities, workforce, equipment and supplies; the process component as the process of providing care, for example doctor-patient engagements and lastly the outcome component as the results of care highlighting affordability, satisfaction and overall wellbeing. Promoting the wellness of patients is a health facility's main objective (Hussain 2019) (in Chrysis, 2023, p. 2) and patients' satisfaction and experience rank highest among a healthcare organisation's priority (Molla et al, 2022) (in Chrysis, 2023, p. 2).

The three components of the Donabedian's Model are in line with the concepts in literature, which are quality healthcare, access to healthcare, and health service delivery. The components are interdependent. If there is insufficiency of the structure component, it will have an impact on how well services are delivered in the process component (Malomane, 2020, p. 26). For instance, if the healthcare facility does not have sufficient numbers of doctors and nurses or financial resources (to pay the staff), there will not be many nurses and doctors available to attend to patients and therefore, this affects the community as a whole in terms of preventative and curative care. This can lead to an increase in mortality. As a result, this impacts negatively on the outcome component, for the quality care has not been met. The mortality rate is one of the outcome measures of patients' well-being, and satisfaction as well as an indicator of their health status

An improved structure component means having enough health facilities, equipment, and staff, which will enhance access to healthcare. Similarly, the improved process component indicates proper preventative care, diagnosis, and rehabilitation, which positively impacts on quality care. Outcomes depend on the elements of the structure and process components. Therefore, the ideal strategy to enhance service delivery quality is to improve the structure and process components (Singer et al. 2016, p. 6).

3.4 The Relevance and Application of the Donabedian Model

The Donabedian Model is extensively used in healthcare to assess the quality of care using the three components (structure, process, and outcomes), which helps to

identify contributing factors of poor quality healthcare. Therefore, the model provides a relevant framework for this study, since the study aims to develop strategies to improve the delivery of quality healthcare. Its relevance lies in the ability to reveal shortcomings of public healthcare facilities. It is especially appropriate for examining how the public healthcare facilities in Fetakgomo contribute to health security because their components strongly align with the fundamental ideas of quality healthcare and service delivery. However, according to Berwick and Fox (2016; cited in Magqadiyane, 2022, p. 50), the model lacks background characteristics that are essential for assessing quality of care, such as environmental factors and patient-related factors. Liu et al. (2011), on the other hand, highlight that the model fails to establish the relationship between the SPO components, making it difficult not to overlap as some factors may not fit into a single SPO component. Regardless of the model being one of the most commonly used for assessing the quality of healthcare, it still has some limitations. However, for this study, it considers the multiple interrelated aspects of health services, such as sufficiency of resources, quality of care delivery, and patient satisfaction with services. It shows how systemic problems in the healthcare system contribute to health insecurity.

Furthermore, the model was used to guide the research design, data collection and data analysis by examining in the relationship between the structure, process and outcome components of public healthcare facilities in Fetakgomo.

3.4. Conclusion

This chapter presented the Donabedian Model of quality care as the theoretical framework that guided the study. The study adopted the Donabedian's Model to explore and clarify the elements used to ease the provision of healthcare in health facilities. The key components of the quality (SPO) were outlined, showing their relevance to evaluating the delivery of quality healthcare in public healthcare facilities. They enabled the study to systematically assess how healthcare is provided, the process of providing care, and the health outcomes experienced by the community members of Fetakgomo. The Model also helped to identify healthcare barriers for each quality component, as well as potential solutions for addressing the challenges.

Moreover, it guided the research design, data collection methods, and data analysis strategies that will be discussed in the following research methodology chapter

CHAPTER 4
RESEARCH DESIGN AND METHODOLOGY

4.1 Introduction

This section discusses the research methodology used in this study, which is the approach used to investigate the drive to gain knowledge (Hesse-Biber & Leavy, 2010, cited in Masaila, 2022, p. 45). As noted by Novikov and Novikov (2019, p. 3), research methodology involves the strategies that a study employs to process, select, analyse, and identify data. It serves as a structured framework for answering research questions and achieving research objectives. The methodology used in this study was shaped by the frameworks Batho Pele Principles and the Donabedian Model, as the researcher considered the importance of collecting data in local healthcare facilities, which are the primary providers of healthcare essential to achieving health security. Therefore, the study adopted a qualitative method to explore and understand the challenges that public healthcare facilities in the Fetakgomo municipal area face in their efforts to improve health security for vulnerable populations. Fieldwork was conducted through semi-structured interviews, focus group discussions and observations. The data collection process enabled participants to share valuable insights into their experiences with healthcare service delivery in these facilities. Participants in the study consisted of primary healthcare providers, patients and members of the community.

The aim was to gain a clear understanding of how public healthcare services are provided in Fetakgomo Tubatse Local Municipality, including identifying any obstacles that may affect their quality and accessibility. The study assessed how healthcare officials prepare for and handle potential health emergencies. Based on this understanding, effective management strategies and practical solutions were developed to address existing problems and strengthen the reliability and safety of healthcare services in the community.

The study explored several key questions related to public healthcare in the Fetakgomo Tubatse Local Municipality. It sought to identify the specific services

provided by public healthcare facilities within the municipality and to understand the challenges these facilities face in delivering effective healthcare. Additionally, the research investigated the management strategies employed by public health institutions to enhance health security, as well as the approaches taken by healthcare officials to respond to potential health emergencies. Finally, the study examined the measures implemented to alleviate existing challenges, ensuring that public healthcare facilities can maintain and improve health security for the community.

Therefore, an overview of the research design and methodology adopted in this study, which includes the study area, the chosen research paradigm, sampling, and approaches to data collection will be discussed.

4.2 Study Area

The study was conducted in Fetakgomo Tubatse Local Municipality, within the Sekhukhune District Municipality. The Sekhukhune District is counted among the five district municipalities in the Limpopo Province. The study area is situated at the Eastern part of the Limpopo Province. Therefore, this study is limited to Fetakgomo Municipal area and excludes the Tubatse Municipal area. The Fetakgomo municipality primarily serves the needs of rural communities and is classified as category B4, primarily consisting of rural areas, and its location is in economically underprivileged areas. The area comprises around 57 settlements, eleven clinics, and one healthcare centre. Like other rural municipalities throughout the country, Fetakgomo is characterised by significant poverty levels, service delivery bottlenecks, a lack of adequate infrastructure, as well as a vulnerable economic backbone (Fetakgomo IDP, 2015/16) (cited in Radingoana et., 2019, p. 21).

The study was conducted in seven clinics and one healthcare centre: Ikageng Clinic, Mohlaletse Clinic, Seroka Clinic, Nkoana Clinic, Phaahla-Manoge Clinic, Nchabeleng Clinic, Mankotsane Clinic, and the Nchabeleng Community Healthcare Center. The clinics are in different settlements and villages, and the communities in each village rely on at least one clinic. The only area with more than one healthcare facility is the Ga-Nchabeleng area, with a clinic and a community health center.

4.5 Research Approach and Design

The research methodology includes both approach and design. There is a variation between research approach and research design, which is often used inaccurately and synonymously, which will be elaborated in the section below:

4.5.1 Research approach

The research approach lays the conceptual groundwork and supports the rationale for the study. This study used a qualitative research approach to examine issues in healthcare facilities to improve the health security of impoverished communities in the Fetakgomo Local Municipality. Qualitative research bases its concern on the development of an explanation of social phenomena, thus its aim is to enable us to comprehend the world around us, as well as the causes of current events (Hancock et al., 2007, p. 6-7). In qualitative research, an understanding of the whole is required. The qualitative approach centers on the significance that individuals attribute to their experiences, the processes through which they understand their environment, and the various encounters they have in their lives (Potokri, 2022, p. 92). Therefore, this study examined insights derived from the experiences of people accessing healthcare services in public healthcare facilities, as well as the healthcare providers, who are the participants in the research.

In choosing the qualitative approach, the researcher considered exploring and understanding the lived experiences of the participants, particularly in relation to access to health facilities and health insecurity, and also took into account the research area, which is a rural setting. Qualitative approach enables an in-depth, grounded understanding of social phenomena that cannot be fully understood through statistical or numerical data. Observation method for data collection was considered to examine the facilities in the area, their geographical distance, the state of infrastructure and maintenance, cleanliness, availability of basic amenities, such as water, toilets, and sanitation. The researcher determined that the basis for the qualitative observation was crucial as it strengthened the probability of rational decision-making. This would have been compromised if quantitative approaches were applied instead.

4.5.2 Research design

Research design comprises a more in-depth component of the entire research process. Creswell (2009, p. 4) refers to research design as “the plan and procedure used by the researcher to conduct a study” and consequently, provides “an appropriate framework for a study” (Jilcha-Sileyew, 2020, p. 2). It assists in achieving the research objectives or answering research questions (Maree & Van der Westhuizen, 2022, p. 33). This study employed a qualitative case study design to examine public healthcare facilities and service delivery in Fetakgomo. This design is appropriate for this study because it allows for detailed examination of facilities, service delivery challenges, and success factors, and response strategies. This qualitative case study design is a method of conducting research that makes it easy to examine a phenomenon in its context by utilising a range of data sources. This guarantees that the problem is examined through a range of perspectives rather than just one, enabling the discovery and comprehension of several aspects of the phenomenon (Baxter & Jack, 2008, p. 544). It also allows the researcher to explore ways in which individuals see their experiences and ways in which they shape their realities based on these experiences (Merriam & Tistell, 2016, p. 6). In support of this, Denzin and Lincoln (2005, p. 3) note that researchers investigate issues in their natural settings to explain them in a way that people convey meanings to them. Merriam and Tistell (2016) further explain that qualitative research design is anchored in the principle that awareness is an ongoing process, shaped by persons through their interaction with the context of various events, experiences, or phenomena.

In this study, the researcher was the primary tool for data collection, and accomplished that through observations, one-on-one interviews, and focus group discussions. Qualitative information on the context of public healthcare facilities, factors impacting health security, and how the delivery of health services was drawn from interviews and focus group discussions with healthcare workers, patients, and community members. During the data collection process, the researcher did not impose any rules or limitations on the study’s outcomes. The researcher observed real-life situations and allowed everything to unfold without interference.

4.6 Research paradigm

Constructivism/Interpretivism to the study

The study followed a constructivism/interpretivism paradigm which is well-suited for qualitative studies. Lincoln & Guba (1989) refer to it as a “naturalistic paradigm”. It is associated with critical reality, realism, and humanitarianism, and focused on establishing how people give a meaning to the world in terms of historical and social perspectives. The study revolved around improving the health security of impoverished people. Therefore, there were interactions with numerous participants in the study including healthcare workers, patients, and community members to understand the struggle for improving health security for vulnerable populations. This was carried out through focus group discussions and one-on-one interviews with the participants. The research paradigm has the following aspects: ontology, epistemology, and methodology, each of which will be discussed below.

Ontology

Ontology deals with the study of the nature of existence. It involves numerous realities and dealing with personal experiences. According to Lincoln & Guba (2013, p. 9) ontology deals with questions such as, “What is the essence of reality?” and/or “What can you know?” These questions are ontological in nature and represent claims about what we can know about reality without distinguishing between separation and reality. Ontology is described as a way for researchers to define what is real (Antwi & Hamza, 2015, p. 218).

Constructivist ontology was adopted for this study to explore the lived experiences of people accessing healthcare in public healthcare facilities of Fetakgomo, as well as health personnel working in these facilities. Nurses are the people who are experienced in the operations, delivery, and management of healthcare provision. For instance, they know of the gaps and shortages in resources, staffing, workloads, and shifts, among others, while patients have direct experience with the services rendered, such as the quality of care; therefore, their experiences and realities are socially constructed. This corresponds with the constructive ontology, which sees reality as being shaped by social interactions and individual experiences rather than existing as a single objective. This qualitative study enabled the researcher to gather the realities

of the patients and healthcare workers as experienced in the healthcare facilities through interviews, focus groups, and observations.

Epistemology

Epistemology refers to knowledge that is sufficient and well-founded. The focus is on how the knowledge is formed and obtained. For example, epistemology addresses the following questions: “What can be known?”, “How can we know?” and “What are the conditions for acquiring existing knowledge?” (Eneanya, 2012, p. 16). Therefore, it is all revealing the truth and what is real or not. According to the constructivism/ interpretivism paradigm, reality is relative. The epistemological aspect of the study is critical in identifying a viable study design that takes into account study goals, types of data collected, study locations, and data interpretation and analysis.

The study was also guided by interpretivist epistemology. This philosophical concept enabled the researcher to gain in-depth insights and understanding of the work of public healthcare facilities in promoting the well-being of underserved communities, as well as the healthcare access indicators, challenges, and service quality. This approach is suitable for this study because it aligns with the aim of the study, which was to gain a deeper meaning and understanding of health service provision. It also informed the selection of data collection methods and data analysis strategies.

Methodology

A methodology is a way of doing research. Researchers choose their preferred method based on a variety of factors, including population, assumptions, experiments or experiences. The research’s ontological and epistemological tenets must be reflected in its methodological aspects. In this study, the researcher chose a qualitative methodology, in which the fieldwork process will be discussed next.

4.7. Data-gathering methods(s) and procedure

4.7.1 Data collection process

The fieldwork process started with the researcher applying for ethical clearance from the University of South Africa (UNISA) Ethics Committee and obtaining approval, followed by submitting the research proposal and the approved UNISA ethics letter to

the National Health Research Council (NHRC) website. After it was approved and the researcher was granted permission to collect data in clinics, the researcher submitted the approval letter to the Sekhukhune Health District, for them to inform the facilities that research was to be conducted in their facilities. The district department provided the researcher with a letter to present to the facilities to prove that permission was granted from both the head office and the district office.

The data collection process required the researcher to travel to Limpopo province to identify the participants the study aimed to engage with for interviews and organise focus group discussions. The process continued with the researcher visiting the clinics and approaching healthcare workers and patients, explaining the research study and its significance, as well as its contribution to the community and the health department. The researcher also went door-to-door to talk to the community members who were the patients in these facilities, as it was not possible to talk to everyone at the clinics. The researcher had asked for consent and arranged dates and suitable times for the interviews because people were very busy sometimes, especially in the clinics. During the data collection phase, observations were made, and photographs were captured to document the condition of the healthcare facilities.

Four qualitative data collection methods were employed in this study, as shown in Figure 7. The desktop research provided the groundwork of the study and guided the development of the interview instrument, focus group discussion guide, and observation checklist. Although each data collection method had its own instrument, they shared core thematic areas. Interviews and focus group discussions were conducted in alignment with the objectives of the study, the Batho Pele Principles, and the Donabedian Model of quality care. Furthermore, the observation method was employed to strengthen participants' insights from the interviews and focus group discussions by capturing the structure and process aspects of healthcare delivery in Fetakgomo.

Figure 7: Data Collection Process

4.7.1.1 Desktop research

The study started with desktop research utilising secondary sources to provide a situational analysis of the role of public healthcare facilities in providing quality care, particularly to impoverished communities. It explored the concept of health security and the significance of public healthcare facilities in achieving health security, drawing both on national and international perspectives. Building upon insights from the literature and document review, the theoretical framework, and research objectives, the researcher developed the data collection instruments.

4.7.1.2 Population

Krieger (2012, p. 634) states that the concept of population is fundamental to population sciences. However, it is widely defined only in statistical terms. Krieger further explains that the definition is characterised by its meaningfulness or meaninglessness, which is important for strategies in population health and health inequalities (Krieger, 2012, p. 634). Within the framework of a research study, the population is defined as the set of individuals recognised as respondents or participants, to which the research metrics and conclusions are directed (Liamputtong, 2019, p.16). Therefore, for this study, the population comprised healthcare workers, patients and/or community members.

4.7.1.3 Sampling and sample size

Sampling is a process of choosing a group of people to represent the whole population of the study area. The selection of a sample that accurately reflects the characteristics of the community was essential, as this would ensure that the conclusions derived from the sample could be extended to the broader population (Bhattacherjee, 2012). The researcher conducted the study in a clinical setting, particularly in primary healthcare facilities, and within the community of Fetakgomo Municipal area. The municipal area comprises the following clinics: Mohlaletse Clinic, Ga-Seroka Clinic, Nchabeleng Clinic, PhaahlaManoge Clinic, Nkoana Clinic, Ikageng and Mankotsane Clinic, and the Ga-Nchabeleng Community Health Center. The study also required the researcher to conduct door-to-door visits within the local communities in different sections of the municipal area. Despite the broad geographical area, the researcher has managed to collect data from the clinics mentioned above, as well as selected regions for community members, including Mashilabela, Mohlaletse Malaeneng, Mohlaletse Ga-Phasha, and Ga-Seroka. These areas were close to one another. This was convenient and minimised transportation costs. Qualitative studies do not favour populations of relatively great size; nevertheless, there was a concern of getting participants who would provide comprehensive and detailed data.

The researcher used a combination of snowball and purposive sampling to choose participants, and this method allowed the sampling process to continue until a sufficient sample size was reached (Creswell, 2013, p. 233). The two methods of sampling were both cost-effective and time-effective:

- Snowball sampling – is a non-probability method of sampling used by qualitative researchers in cases where the chosen population is hidden - for instance, people living with HIV who refrain from disclosing their status.
- Purposive sampling – is a non-probability sampling technique where a qualitative researcher depends on his/her discretion to select variables for the representative population.

The researcher's grounds for choosing snowball sampling were that it was not known which community members visit the clinics regularly, and who had chronic illnesses. As such, people were encouraged to suggest the participants suited for the study.

Furthermore, purposive sampling was chosen to select participants with expert opinions regarding the phenomena explored.

The sample for this study consisted Dataset Group 1 with patients and community members who visited the clinics for healthcare services, and Dataset group 2 with healthcare workers, including auxiliary and assistant nurses, professional nurses, operational managers, home-based care workers, counsellors. The total number of people who took part in this study was thirty eight (38).

Face-to-face interviews were conducted with twenty (20) participants. Ten (10) with patients and/or community members and another ten (10) with healthcare workers (nurses and a counsellor). An additional community member (1) opted to submit a completed questionnaire due to time constraints. The participant was provided with a copy of the interview instrument and it was returned to the researcher after being completed.

Furthermore, four focus group discussions were conducted with healthcare workers. Two focus group discussions with nurses (one with three (3) participants and the other with four (4) participants), and two focus group discussions with home-based care workers (one with six (6) participants and the other with four (4) participants) .

The exclusion criteria for participation in this study were minors (<18), people who couldn't read, or were unable to sign the consent forms, and patients who were severely ill.

As some of the interviews were conducted in Sepedi, the researcher translated those interviews from Sepedi, the native language spoken by the community, to English.

4.7.1.4 Semi structured face-to-face interviews

An interview schedule was designed as a guide, including a set of pre-determined questions guided by the subject of the study, to collect primary data from the different participants of the study. This enabled the researcher and the respondents to have a discussion that flowed freely. Babbie (2011, p. 312) states that semi-structured

interviews are suitable for qualitative research. The interviews were open-ended and allowed participants to be expressive. The researcher followed several stages in the process of doing the interviews. The first stage was to introduce the researcher to the participants and allow them to introduce themselves, followed by explaining the study, stating its objectives, and highlighting that the study would assist in identifying the challenges both patients and healthcare workers face in healthcare and provide recommendations to the Government. The purpose of the interviews was explained in detail. Participants were asked if they were willing to be interviewed and whether they were comfortable with being recorded. The researcher provided them with a consent form for them to read and sign, and explained that the interview would last about 5-10 minutes, depending on how lengthy the participant's response would be. Notes of participants' names, age, and demographics were taken, and they were assured that they would be assigned pseudonyms to protect their identities. The biographic details of the participants were not recorded; the recording started after introductions. The researcher finally expressed gratitude to participants for their time and valued insights and thanked them for being part of the research study.

Challenges with interviews: The biggest hurdle with interviews was time constraints with healthcare workers, particularly nurses. The researcher had arranged to have interviews on certain days at specific times, but the arrangements never happened as planned. Due to nurses' busy schedules, the researcher would wait approximately 4 hours just to speak to them, and some would spare 5 minutes, although the time was enough in some cases. There was one time when the researcher waited 5 hours until nurses' end of the shift to interview them. Due to time constraints and the clinic being in a remote area with limited public transportation, the researcher had to wait that long. Despite these challenges, sufficient key insights were captured from the interviews, as the sample size was adequate.

4.7.1.6 Focus group discussions

Focus group discussions allow the researcher and the participants to have conversations all together (Babbie, 2011, p. 315). This is a type of discussion whereby the researcher prepares a selection of questions posed to participants; they gather together and discuss the subject matter as a group, while the researcher guides them

and ensure that the research topic is covered entirely. In this study, four focus group discussions were conducted, two groups with home-based workers and two groups with nurses. A focus group guide was used to facilitate the group discussions. Focus group discussions with home-based workers explored the perspectives regarding home-based healthcare services. It was recognised that home-based care workers do more than their designated healthcare duties, but also provide personal care, such as cooking for patients. Data obtained from these focus group discussions were used to supplement the interview data.

Challenges with focus group discussions: A major challenge was the lack of engagement from some participants. In certain cases, one or two participants actively participated, and the researcher would have to convince the other participants to share their insights. They would then agree with what was said or raise additional points. This resulted in a dominant participation situation, where a few participants did not engage much in the discussion. However, all key areas were covered.

4.7.1.8 Observations

Ellis (2024, p. 1) states that "… qualitative observation is widely used where the researcher expects the data generated to be both (detailed and in-depth) and plentiful." In this study, the researcher chose to observe the healthcare facilities' infrastructure, cleanliness, and resource availability to explore whether quality care is provided to communities. Observations were conducted in all seven facilities, and photographs were taken.

4.8 Data recording

The researcher used a smartphone to record the interviews to collect information from participants during data collection, and informed the participants about an audio recording and arranged training for the recordings with them. Participants were asked to read and sign a consent form before the audio recording. Audio records were transcribed manually; the researcher would listen to one recording over and over again and transcribe it verbatim. The process took longer and was very tedious, as the recordings had to be translated, because most of the participants responded in Sepedi. For one participant who opted to respond in writing, copies of the consent

form and the interview instrument were provided, and they were returned signed and completed.

4.9 Data Analysis Strategies

Morse and Field (1995) define qualitative analysis as a process that integrates the data as one, showing what has been overlooked and linking the root cause of consequences. Data analysis is a continuous activity that answers the researcher's questions and guides the researcher in terms of approaches for collecting data in the future (Bhattacharjee, 2012, p. 123). Data were analysed based on the main data sources: transcripts and notes. Transcripts were generated from the interview recordings, as well as the completed questionnaire. In addition, data were organised and sorted out into manageable pieces of information that would be easily retrieved. The researcher used ATLAS.ti to analyse the data and followed a six-step process of data analysis, which includes familiarisation, coding, general themes, reviewing themes, defining and naming themes, and writing up (Caufield, 2019). As this was a qualitative study, thematic analysis was used to analyse data using the ATLAS.ti software that enabled the researcher to generate codes, memos, and themes systematically. Thematic analysis is a versatile technique and a useful research tool that provides a large amount of detailed and complex data (Braun & Clarke, 2006). The data analysis process will be explained further in the next chapter (Chapter 5: Data presentation).

4.10 Ensuring rigour: validity and reliability

In terms of trustworthiness and data quality control, this study used the Lincoln and Guba's model of trustworthiness which allows for measures to verify that the data are valid, dependable and reliable (Lincoln & Guba, 1985, p. 289). The model includes four pillars, which are transferability, credibility, dependability, and confirmability. Details of each of these measures are given below:

- Transferability – This refers to the chances that the findings of the study might have similar meanings in similar situations among the selected population. The interviews were equitable to permit thorough exploration and steer clear of superficial information. In this study, transferability was maintained by providing rich amounts of background context on the subject, total participants, a

sampling strategy and transcripts. The researcher collected full-scale data that is relevant to other municipalities in Limpopo Province outside of Fetakgomo Tubatse Municipality. However, the findings cannot be extrapolated to all of South Africa.

- Credibility – Credibility concerns the reality and truthfulness of the study findings. As such, triangulation, peer review, persistent observation, and reflexivity were employed. Measures to ensure credibility were adhered to by following these steps, as outlined by Merriam (1998, in Mafora, 2013, p. 690).
    - Avoided bringing personal viewpoints into the data
    - The literature review themes guided the design of the interview schedule
    - Allowed participants to clarify my interpretation of the data
    - Addressed unclear aspects and confirm the credibility of findings
- Dependability – This indicates that if the same study is repeated using the same design, methods, and population, it will produce similar results. Semi-structured interviews were employed in the investigation to guide the respondents and allow them to express their feelings and emotions. To ensure dependability in this study, a trial run was conducted with two individuals who were comparable to the main study population.
- Confirmability—The aim was to ensure that true and accurate data were collected. Accurate data were the focal point of the study. To aid in confirmability, an audit trail with field notes, audio tapes, and transcripts was kept. The action of inventing the study findings was avoided.

The study's respondents came only from public healthcare facilities and residential areas in the Fetakgomo municipal area. Only data from the participants were used in the study.

4.12 Conclusion

This chapter provided an overview of the research methodology and presented the study area, research design and approach, and research paradigm, which are fundamental to this study. It also discussed in detail data collection processes and

data analysis strategies. Moreover, ethical considerations and ensuring rigor requirements were addressed. The next chapter unpacks the data analysis process.

CHAPTER 5
DATA PRESENTATION

5.1 Introduction

This qualitative study aimed to investigate the nature and scope of public healthcare facilities' work in providing accessible, quality care to underprivileged communities. It involved face-to-face interviews and focus group discussions with nurses, home-based care workers, patients, and/or community members. This chapter will explain the data analysis process used in ATLAS.ti, and the next chapter will present the results.

5.2 Summary of the Dataset

The data were divided into two groups or datasets: a group of patients and another group of healthcare workers.

The first dataset group encompassed transcripts of face-to-face interviews with patients, whom I refer to as community members. This group focused on the services provided by the facilities, including the kind of services generally utilised in the clinics. Dataset group 1 addressed the research question: What services are delivered by the public healthcare facilities in Fetakgomo Tubatse local municipality? Data from this group included 11 transcripts.

The second dataset group consisted of face-to-face interview transcripts with healthcare workers (i.e. nurses) and 10 transcripts. It also included 4 focus group transcripts, 2 with nurses and another 2 with home-based care workers.
Dataset group 2 addressed all five research questions:

- What services are delivered by the public healthcare facilities in Fetakgomo Tubatse Local Municipality?
- What are the challenges of public healthcare delivery in Fetakgomo Tubatse Local Municipality?
- What are the management strategies employed by public health facilities to improve health security?

- What are the strategies employed by public healthcare officials in Fetakgomo Tubatse Municipality to respond to potential health emergencies?
- What measures are in place to alleviate the challenges public healthcare facilities face in order to guarantee health security?

This group was central in this research study because they are at the forefront of providing day-to-day healthcare services. They experience challenges and barriers firsthand in the healthcare facilities.

5.3 Data processing

This phase involved preparing the data. The mother tongue, Sepedi, was most common in the audio tapes. Some participants mixed Sepedi and English, while others spoke only Sepedi. When transcribing, I translated the Sepedi language which I am proficient in, to English. Sepedi is my native language. I went through the audio tapes over and over again for accuracy. Moreover, I took field notes, and they were added to the transcripts; the notes were mostly the names, ages, gender, and demographics. I chose not to include these in the recording to avoid making it too long. the app I used to record offered a limited number of minutes per recording.

The next phase involved assigning pseudonyms to participants. Some facilities had more than one participant while others had only one. When assigning a pseudonym, I identified the healthcare workers as (nurse 1 up to 10) and assigned patients (Patient 1; Patient 2; Patient 3…and so on). For focus group discussions, the two groups with home-based-care workers were identified as home-based care groups 1 and 2, and participants were also assigned pseudonyms: the same applied to the two focus group discussions with the nurses.

5.4 The Software: ATLAS.ti

ATLAS.ti is a software used to analyse qualitative data. In this study , the software was used rather than doing a manual analysis. According to Adelowotan (2021, p. 90) past studies used manual coding as a standard practice to analyse data. However, he emphasised that manual coding is time consuming as it involves paperwork. Therefore, ATLAS.ti provides convenient coding and recording as it simplifies the

generation of codes, themes, and networks which makes the interpretation of the data less complicated (Adelowotan, 2021, p. 190).

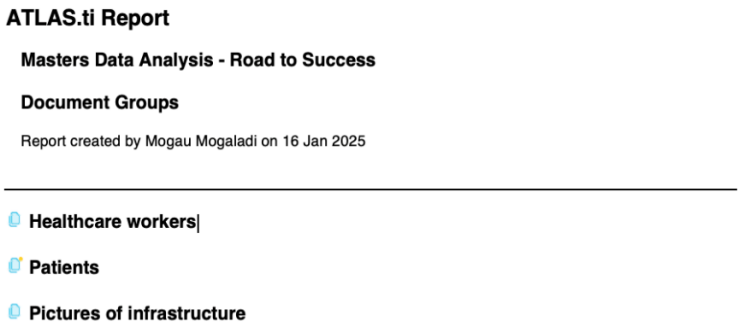
*5.4.1 I**mporting the data into ATLAS.TI***

Upon completion of preparing and labelling of datasets, including the transcripts, and pictures taken during fieldwork, the researcher created a project in ATLAS.ti and named *it "Masters Data Analysis – Road to Success"* and therefore, inserted all the documents she had prepared for the analysis. There was a total of 31 documents added to the project. See (figure 4 below).

Figure 8: ATLAST.ti Document Report

Furthermore, I grouped the documents into three- namely, healthcare workers, patients, and pictures of infrastructure, as illustrated in Figure 5 below. The purpose of grouping the documents is to have shortcut collections (Silver & Bulloch, 2018).

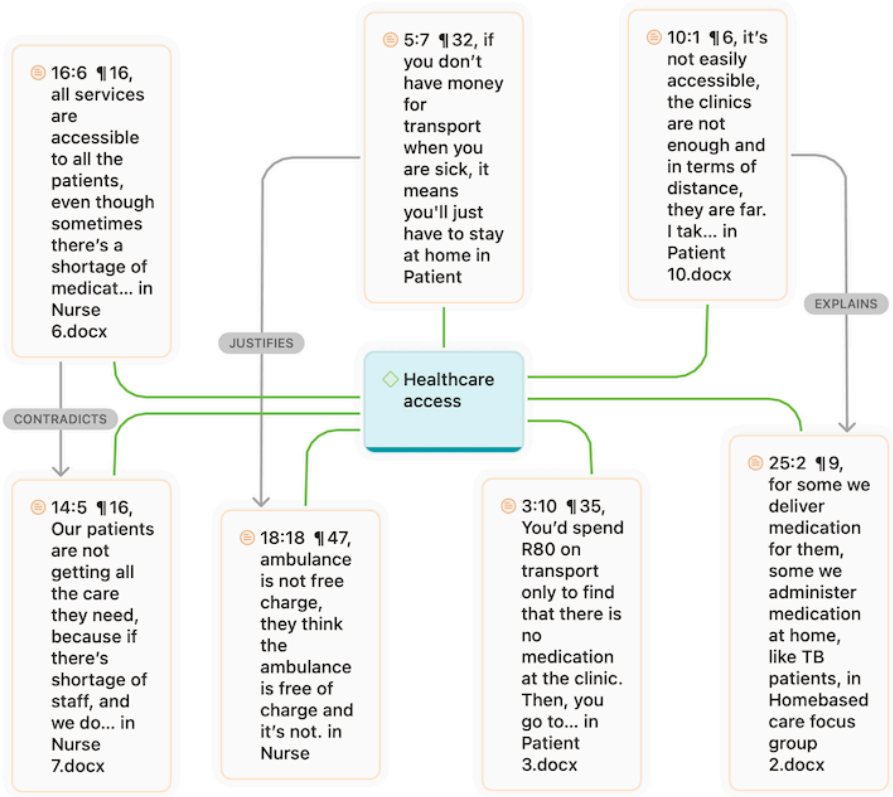
Figure 9 : ATLAS. TI Document Groups Report



5.4.2 Reviewing the data and coding

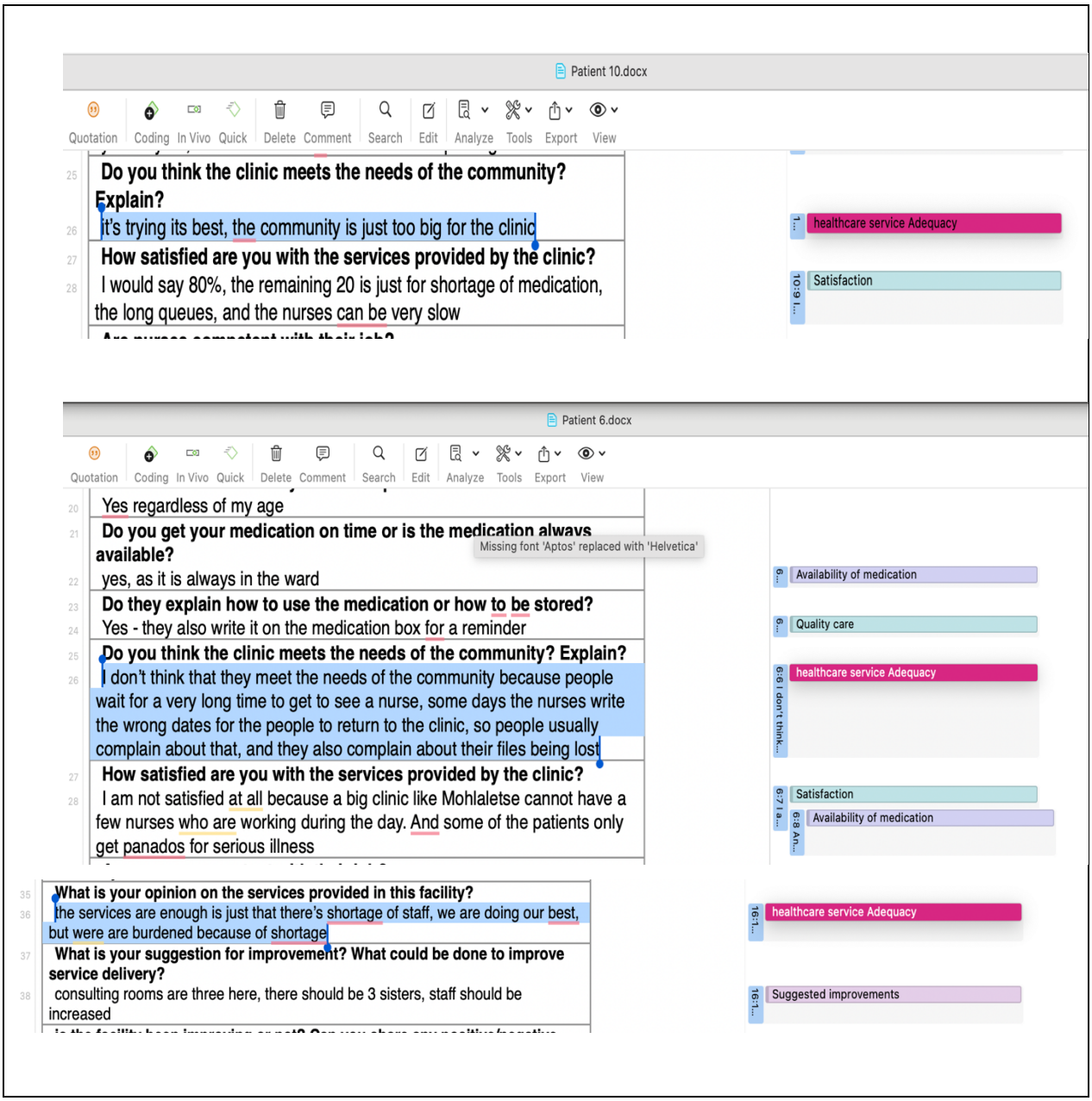
The data consisted of two groups of transcripts and pictures. The researcher went through all the transcripts again, reading them to gain an understanding of the data, and "searching for what's of the data" (Kalpokaite & Radivojevic, 2019, p. 51). In the process of reviewing the data, the researcher developed memos to write down her thoughts and opinions about what the data reveals. As this study investigated the role healthcare facilities play in improving health security, she created a memo about healthcare access, which includes the availability, accessibility, affordability, and acceptability of care. The figure below presents the healthcare access ad hoc network, indicating what the patients and healthcare workers said about accessing healthcare in the facilities.

Figure 10: An Ad hoc Network of Patients and Healthcare Workers Concerning Healthcare Access



Furthermore, the literature review (chapter 2) of this study guided the coding process. Coding is an important tool in the data analysis process to convert raw qualitative data into a "story" that is communicative and credible (Skjott Linneberg & Korsgaard, 2019, p. 3). Therefore, Saldaña (2015) refers to a code as a word or short phrase that conveys the primary idea of a transcript or visual data. The researcher began the coding process by reading the transcripts, highlighted key points, gave them descriptive labels, and therefore, correlated texts with allocated similar codes. The process is illustrated in the Figure 6 below. The process generated numerous codes such as "healthcare adequacy satisfaction, availability of medication, quality care, suggested improvements" among others. As demonstrated in Figure 7, the highlighted content (in blue) was focused on healthcare adequacy, whereby participants explained the extent to which the population meets the required healthcare services.

Figure 11: Coded and Labelled Segments about Healthcare Adequacy



As the researcher progressed with the coding, new codes were developed, and the number of codes increased (see Table 2). Upon examining a few transcripts, the researcher revised them again to verify whether the codes were still relevant or if they required reallocation to ensure consistency and accuracy.

Table 2 below presents an Excel export of 35 codes, including their groundedness density and code groups. Groundedness is the number of quotations allocated to a code, while density indicates the links between the codes. Several codes lacked solid

groundedness due to problems identified by a few respondents (Mncanca, 2022, p. 188). The codes were colour-coded according to code groups.

Table 2: Excel Export of Codes

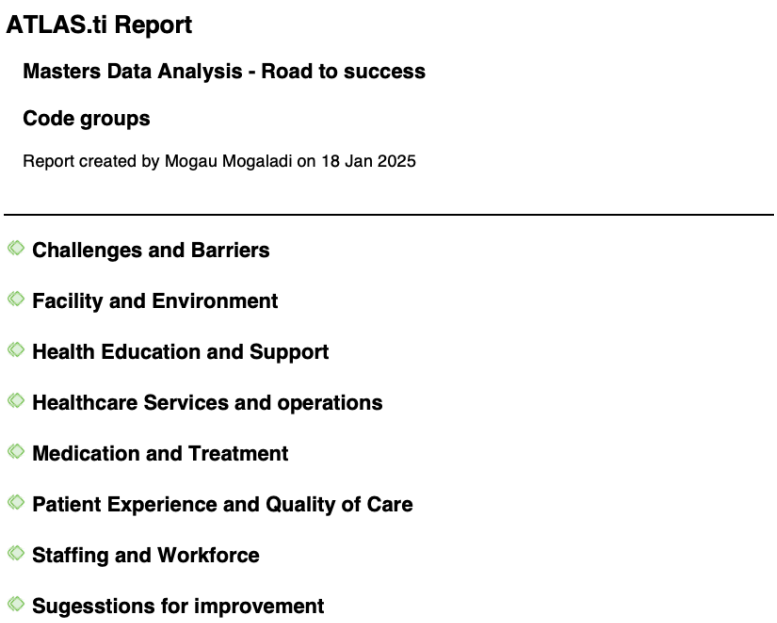
Code	Groundedness	Density	Groups
○ Age, Gender, Demographic	11	0	
● Availability of medication	17	2	Medication and Treatment
● Availability of services (24/7)	13	4	Healthcare Services and operations
● Challenges with community support	4	1	Challenges and Barriers
● challenges with healthcare services	30	5	Challenges and Barriers
● Chronic Illnesses	8	1	Medication and Treatment
● Cleanliness and hygiene	10	1	Facility and Environment
● Delivery of medication in facilities	8	1	Healthcare Services and operations
● Enough Healthcare workers	1	2	Staffing and Workforce
○ Explaining how to store and use medication	1	0	Patient Experience and Quality of Care
● Facilities' collaboration	8	0	Facility and Environment
● Facilities' strengths	4	1	Facility and Environment
● Facilities' weaknesses	4	1	Facility and Environment
● Facility improvement overtime	8	0	Facility and Environment
● Health education and community support	4	0	Health Education and Support
● Health emergency management	11	1	Healthcare Services and operations

Code	Groundedness	Density	Groups
• Healthcare access	32	1	Patient Experience and Quality of Care
• Healthcare service adequacy	14	1	Healthcare Services and operations
• Healthcare workers roles	12	1	Staffing and Workforce
• How challenges affect healthcare workers	9	1	Staffing and Workforce
• Lack of resources	15	1	Challenges and Barriers
• Number of healthcare workers in facilities	10	1	Staffing and Workforce
• Number of patients seen in a day	9	2	Healthcare Services and operations
• Overtime work	11	1	Staffing and Workforce
○ Patients addressed properly	7	0	Patient Experience and Quality of Care
• Poor environment when providing care	1	1	Facility and Environment
• Quality care	9	2	Patient Experience and Quality of Care
• Respectfulness	3	1	Patient Experience and Quality of Care
• Satisfaction	9	2	Patient Experience and Quality of Care
• Service provision and required services	20	1	Healthcare Services and operations
• Suggested improvements	20	0	Suggestions for improvement
• Timeliness and waiting period	13	1	Healthcare Services and operations
• Transparency	9	1	Patient Experience and Quality of Care

Code	Groundedness	Density	Groups
○ Understanding of language used	9	0	Patient Experience and Quality of Care
● working hours	11	2	Healthcare Services and operations

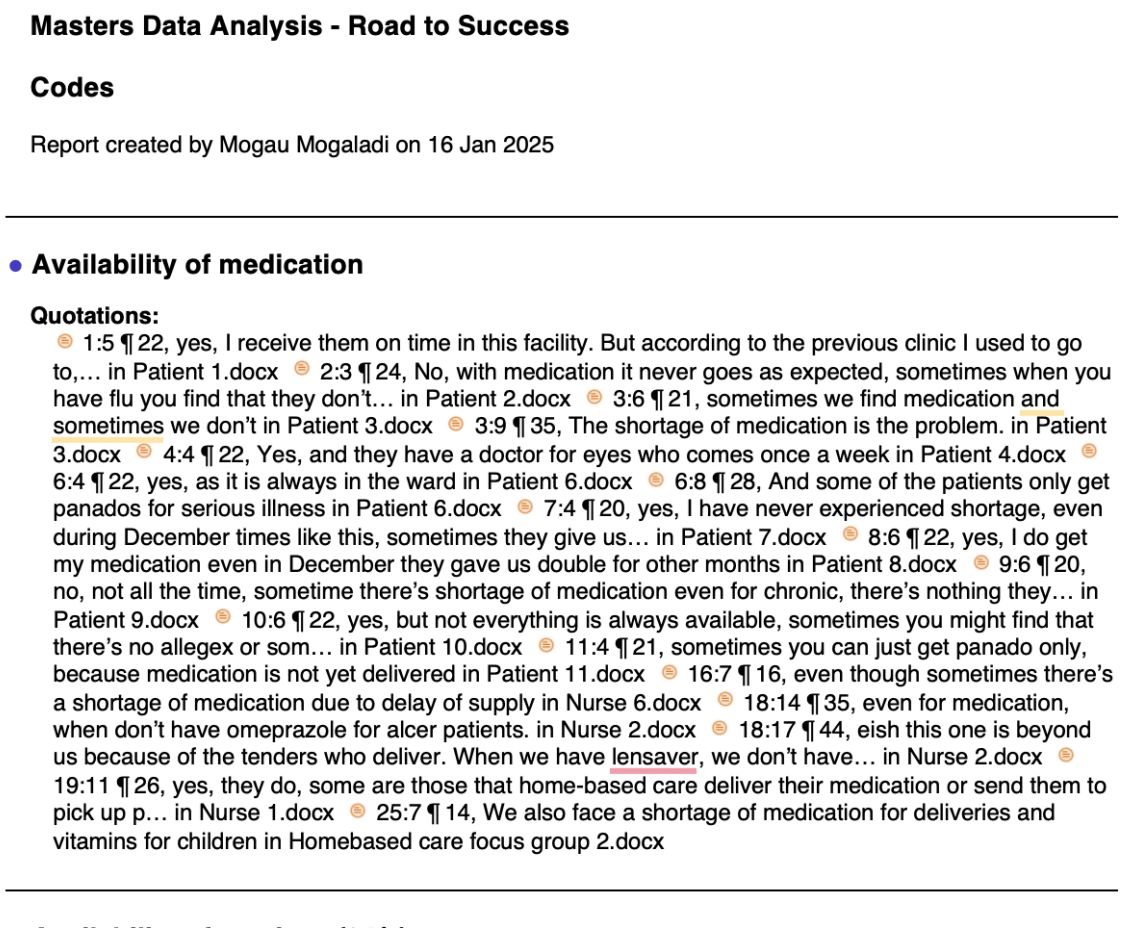
The coding process progressed to the next phase of grouping similar codes. The next figure (8) illustrates the eight code groups created. The code groups allow you to generate grouped short-cuts of codes which can belong to any number of groups (Silver & Bulloch, 2018). Each code group was categorised as a temporary coding category (Maykut & Morehouse, 1994 as cited in Mncanca, 2022, p. 188).

Figure 12: ATLAS.ti Code Group Report



The codes are linked to quotations when assigned to specific segments of texts. A quotation is a segment that is created based on the research objectives or research questions. Figure 9 below indicates the quotations linked to the code labelled “Availability of Medication” in the clinics. Both the patients and nurses shared similar insights regarding medicines being available, but not at all times.

Figure 13: Example of Quotations Linked to a Code



Masters Data Analysis - Road to Success

Codes

Report created by Mogau Mogaladi on 16 Jan 2025

- **Availability of medication**

Quotations:

1:5 ¶ 22, yes, I receive them on time in this facility. But according to the previous clinic I used to go to,… in Patient 1.docx 2:3 ¶ 24, No, with medication it never goes as expected, sometimes when you have flu you find that they don't… in Patient 2.docx 3:6 ¶ 21, sometimes we find medication and sometimes we don't in Patient 3.docx 3:9 ¶ 35, The shortage of medication is the problem. in Patient 3.docx 4:4 ¶ 22, Yes, and they have a doctor for eyes who comes once a week in Patient 4.docx 6:4 ¶ 22, yes, as it is always in the ward in Patient 6.docx 6:8 ¶ 28, And some of the patients only get panados for serious illness in Patient 6.docx 7:4 ¶ 20, yes, I have never experienced shortage, even during December times like this, sometimes they give us… in Patient 7.docx 8:6 ¶ 22, yes, I do get my medication even in December they gave us double for other months in Patient 8.docx 9:6 ¶ 20, no, not all the time, sometime there's shortage of medication even for chronic, there's nothing they… in Patient 9.docx 10:6 ¶ 22, yes, but not everything is always available, sometimes you might find that there's no allegex or som… in Patient 10.docx 11:4 ¶ 21, sometimes you can just get panado only, because medication is not yet delivered in Patient 11.docx 16:7 ¶ 16, even though sometimes there's a shortage of medication due to delay of supply in Nurse 6.docx 18:14 ¶ 35, even for medication, when don't have omeprazole for alcer patients. in Nurse 2.docx 18:17 ¶ 44, eish this one is beyond us because of the tenders who deliver. When we have lensaver, we don't have… in Nurse 2.docx 19:11 ¶ 26, yes, they do, some are those that home-based care deliver their medication or send them to pick up p… in Nurse 1.docx 25:7 ¶ 14, We also face a shortage of medication for deliveries and vitamins for children in Homebased care focus group 2.docx

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Silver and Bulloch (2018) explain quotations as segments of data significant for data analysis. They further describe them as independent entities, which means they can be separately identified and listed from any element. For instance, they can be extracted without being coded (Silver & Bulloch, 2018). The example explains "free quotations." They are segments of texts that are highlighted to show the interesting aspects of primary data for which a group of shared characteristics has not been identified yet (Friese, 2014, p. 16). The software has six different types of quotations, including "text quotations, graphic quotations, PDF quotations, audio and video quotations, and Google Earth (GE) quotations" (Friese, 2014, p. 17-18). The researcher used text quotations to identify and arrange connected segments of data. Furthermore, ATLAS.ti has a code co-occurrence function that enabled me to identify whether codes overlap. Instead of identifying the codes manually, the software assisted in creating a code occurrence table which provided the frequency of co-

occurrences. That enabled me to decide whether to merge the codes, group them, or keep them unchanged. The table below presents the overlapping code co-occurrence matrix.

***Table 3**: Overlapping Code Matrix*

	●Availability of medication Gr=17	●Availability of services (24/7) Gr=13	●challenges with community support Gr=4	●challenges with healthcare services Gr=30	●Chronic Illnesses Gr=8	●Health education and community support Gr=4	●health emergency management Gr=11
●Chronic Illnesses Gr=8	0	0	0	0	0	0	0
●cleanliness and hygiene Gr=10	0	0	0	1	0	0	0
●facilities' collaboration Gr=8	0	0	0	0	0	0	0
●Healthcare access Gr=32	1	1	0	0	0	0	1
●Lack of resources Gr=15	0	0	0	0	0	0	0

The table shows at least one co-occurrence with the codes: availability of medication, availability of services, challenges with healthcare services, and health emergency management. The colours or numbers typically show you the strength of the co-occurrences.

Following the co-occurrence analysis, the researcher clustered the codes, each code was assigned to the eight code groups previously shown in Figure 8. The code groups are illustrated in Figure 10 below, along with the codes assigned to each group.

Figure 14: ATLAS.ti Code Groups and Family Members Report

ATLAS.ti Report

Masters Data Analysis - Road to success (2)

Code groups

Report created by Mogau Mogaladi on 27 Jan 2025

Challenges and Barriers

Created: 2025/01/15 by Mogau Mogaladi, **Modified:** 2025/01/16 by Mogau Mogaladi

Members:

● challenges with community support ● challenges with healthcare services ● Lack of resources

Facility and Environment

Created: 2025/01/15 by Mogau Mogaladi, **Modified:** 2025/01/15 by Mogau Mogaladi

Members:

● cleanliness and hygiene ● facilities' collaboration ● Facilities' strengths ● Facilities' weaknesses ● Facility improvement overtime ● Poor environment when providing care

Health Education and Support

Created: 2025/01/15 by Mogau Mogaladi, **Modified:** 2025/01/15 by Mogau Mogaladi

Members:

● Health education and community support

Healthcare Services and operations

Created: 2025/01/15 by Mogau Mogaladi, **Modified:** 2025/01/16 by Mogau Mogaladi

Members:

● Availability of services (24/7) ● Delivery of medication in facilities ● Health emergency management ● Healthcare service adequacy ● Number of patients seen in a day ● Service provision and required services ● Timeliness and waiting period ● Working hours

Medication and Treatment

Created: 2025/01/15 by Mogau Mogaladi, **Modified:** 2025/01/15 by Mogau Mogaladi

Members:

● Availability of medication ● Chronic Illnesses

Patient Experience and Quality of Care

Created: 2025/01/15 by Mogau Mogaladi, **Modified:** 2025/01/18 by Mogau Mogaladi

Members:

● Explaining how to store and use medication ● Healthcare access ● Patients addressed properly ● Quality care ● Respectfulness ● Satisfaction ● Transparency ● Understanding of language used

Comment:

> 2025/01/18, 14:43, merged with
> Patients addressed properly

Staffing and Workforce

Created: 2025/01/15 by Mogau Mogaladi, **Modified:** 2025/01/15 by Mogau Mogaladi

Members:

● Enough Healthcare workers ● Healthcare workers roles ● How challenges affect healthcare workers ● Number of healthcare workers in facilities ● Overtime work

Suggestions for improvement

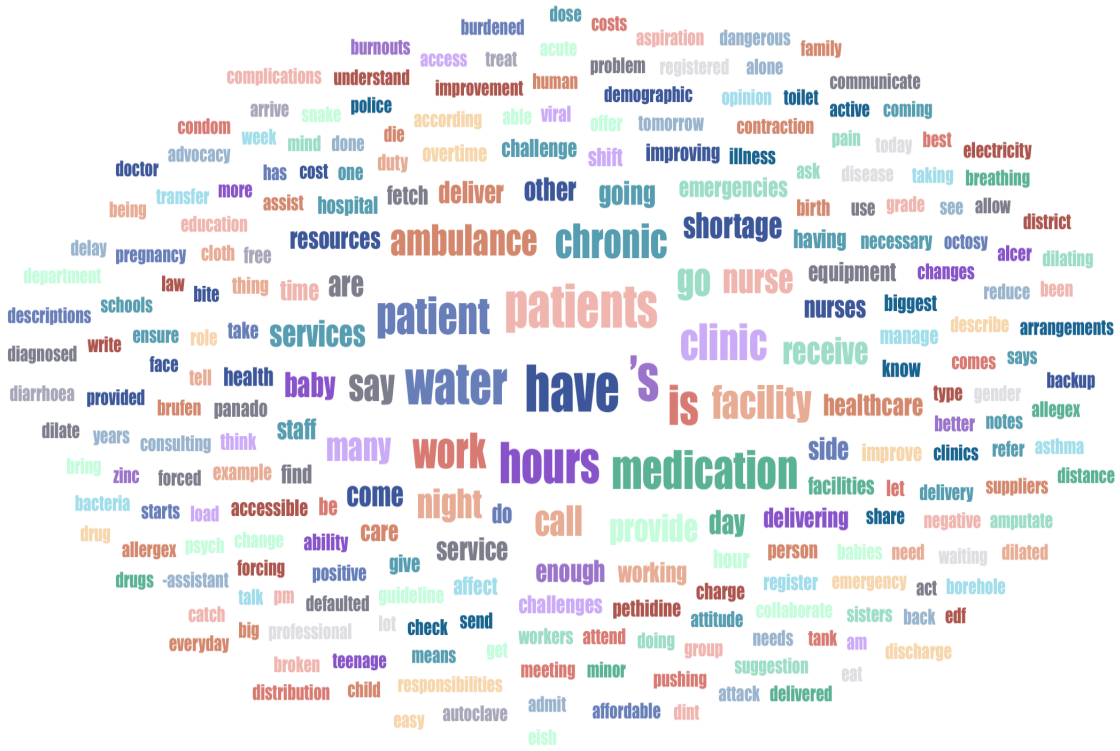
Created: 2025/01/15 by Mogau Mogaladi, **Modified:** 2025/01/15 by Mogau Mogaladi

Members:

● Suggested improvements

After completing the code grouping, the researcher reviewed the data again to re-group and merge similar codes to ensure that all the information was in the appropriate groups to form categories. Categories were formed by the similarities and differences in the data, "… which are generally used to group and compare data by category" (Maxwell & Miller, 2008, p. 462). Therefore, the final process was creating themes that emerged from the categories. Themes highlight abstract ideas, processes, patterns, trends, and concepts in the data (Saldana: 2013). The similarities among codes and categories led to the development of five key themes, namely: access to healthcare; patient centred care and experience; systematic challenges in healthcare; medication and treatment delivery; and strategies for improving healthcare delivery. Furthermore, the researcher generated themes based on the relationships and patterns between categories and codes. What informed the naming of the themes was the content of the data, research questions, and objectives, theoretical/conceptual framework, and participants' voices. The participant's voices are the quotations in the data, Additionally, a word cloud was used to uncover phrases and words that participants frequently used in interviews. Figure 11 below illustrates an example of a word cloud generated.

Figure 15: Word Cloud Showing the Frequency of Codes and Quotations



The word cloud is derived from one interview question about the challenges of healthcare services in public healthcare facilities, and therefore, it presents an overview of participants' insights. It aimed to illustrate the three steps central to the frequency of words, phrases, or quotations in the data. The first step was for knowledge enhancement in terms of study participants; the second step was to describe the participants for the reader; the last step was to analyse the data gathered during interviews (van Rensburg, 2023).

Figure 12 presents the 5 themes generated in memos. Memos reflect on the process of coding, as well as the code categories, subcategories, themes, patterns and data

concept with the possibility of heading toward theory (Saldana, 2013: 41). Therefore, the categories and code groups formed sub-themes.

Figure 16: ATLAS.ti Themes Report

5.5 **Conclusion**

This chapter presented data from a user of ATLAS.ti, a computer-assisted qualitative data analysis software (CAQDAS). The software analysed data, including coding, creating code groups and categories, and generated themes.

CHAPTER 6
DISCUSSION OF FINDINGS

6.1 Introduction

This chapter presents the research findings and draws conclusions from the collected data on healthcare providers and patients including their views on the role that public healthcare facilities play in ensuring quality healthcare access and health security. The study's findings were generated from focus group discussions and one-on-one interviews with key stakeholders, patients, and healthcare workers. As such, healthcare workers played a vital role in this research study as representatives of healthcare facilities. The results will be discussed and presented in this chapter.

6.2 Participants

This study generated data from 38 participants during fieldwork, including 20 interviews, 10 with healthcare workers 10 with patients, and 4 focus group discussions totalling 17 participants. Of the 4 focus group discussions, 2 were with home-based care workers, and two with nurses; one participant opted to respond to the interview questions in writing. The profiles of the participants are presented in Table 4 and Figure 12 to allow the readers of this dissertation to understand who contributed to the data and the participants who provided the information that formed part of the research. All the participants of this research were aged 18 years and above, and most of them engaged in the interviews and focus group discussions on their native language Sepedi. The interviews with healthcare workers took place in public healthcare facilities, while interviews with some patients took place at the clinics, and some were conducted at their homes. The majority of the participants experienced similar issues with healthcare service delivery.

Table 4: Profile of the Patients/Community Members

Patients /community members			
Participants	Age	Gender	Employment Status
Patient 1	41	Female	Self employed

Patients /community members			
Patient 2	42	Female	Unemployed
Patient 3	Not given	Female	Unemployed
Patient 4	34	Female	Employed
Patient 5	Not given	Female	Self employed
Patient 6	21	Female	Student
Patient 7	Not given	Male	Unemployed
Patient 8	60	Female	Unemployed
Patient 9	53	Female	Employed
Patient 10	30	Female	Employed
Patient 11	65	Female	Unemployed

The next figure presents healthcare workers including professional nurses, auxiliary nurses, a counsellor, an acting operational manager, and an acting local area manager who played a vital role in this study.

Figure 17: Profile of Healthcare Workers

Interviews

Nurse 1: is a female professional nurse, and her role is to check pregnant woman, and work with mother and child, minor and chronic illnesses.

Nurse 2: is a 24-year-old female professional nurse grade 1, and her role is to treat the patients and act as an advocacy role to the patient.

Nurse 3: is a 39-year-old female auxiliary nurse; **her** role is patient care - she assesses patients before they are seen by professional nurses. She acts as the first line of contact for patients in the clinic.

Nurse 4: is a female professional nurse, whose roles are patient care and referral

Nurse 5: a female professional nurse and an acting operational manager

Nurse 6: is a 41-year-old female registered nurse and registered midwife, whose roles are consulting of patients and delivering babies

Nurse 7: is a 42-year-old female professional nurse and her roles are professional care, immunisation, family planning, antenatal care, and emergency deliveries.

Nurse 8: is a 52-year-old female PAC trained nurse**,** whose roles are to examine patients, assess, give treatment and refer.

Nurse 9: is a 51-year-old nurse and acting local area manager who oversees all the healthcare facilities in the area.
Counsellor: is a female HIV/AIDS counsellor.

Focus Group1 (Nurses)
Participant 1: Clinical nurse practitioner (patient care and a bit of admin),
Participant 2: Operational manager (Patient care and admin),
Participant 3: Lay counsellor,
Participant 4: Counsellor (HIV, and counselling)

Focus Group 2 (Nurses)
Participant 1: Processional nurse
Participant 2: Professional nurse
Participant 3: Professional nurse

Focus Group1 (Home-based Care Workers)
Participant 1: 56-year-old female home-based care worker from Tswereng
Participant 2: 45-year-old female home-based care worker from Mashilabele
Participant 3: 42-year-old female homebased care worker from Phaahlamanoge
Participant 4: 38-year-old female homebased care worker from Mashilabele
Participant 5: 37-year-old female home based care worker from Ga-seroka
Participant 6: 41-year-old female homebased care worker

Focus Group 2 (Home-based Care Workers)
Participant 1: female homebased care worker
Participant 2: female home-based care worker
Participant 3: female home-based care worker
Participant 4: female home-based care worker

6.3 Themes and subthemes

The data were analysed using thematic analysis. Table 5 illustrates themes and sub-themes which were generated through coding and classification of the data which the

participants provided through semi-structured interviews and focus group discussions. The analysis and interpretation were done using ATLAS.ti.

Table 5: Themes and Sub-Themes

Themes	Sub-themes
Access to quality healthcare	Healthcare services availability and accessibility
	Healthcare facility infrastructure and environmental factors
	Healthcare emergency management/response
Patient centered care and experience	Waiting times
	Respect, transparency and communication
	Satisfaction with services
Systematic challenges in healthcare	Resource limitation
	Healthcare system and operational challenges
	Challenges' impact on staff and services
Medication and treatment delivery	Availability and distribution of medicines
Strategies for improving healthcare delivery	Collaboration and resource sharing
	Optimising service delivery

6.4 Findings and interpretation of the data

This section presents an overview of the findings from the cleaned data of focus group discussions and semi-structured interviews. Therefore, the study findings are validated by the literature in Chapter 2.

6.4.1 Access to quality healthcare

This key theme has generated three sub-themes: healthcare services availability and accessibility, healthcare emergency response, and facility and environmental factors. As such, both patients and healthcare workers shared similar insights concerning healthcare delivery within these themes. They maintain that quality healthcare services are not easily accessible.

6.4.1.1 Healthcare services availability and accessibility

Healthcare access can be characterised in monetary terms, population and the extent to which health services are delivered (WHO, 2007 in Gaede & Versteeg, 2011, p. 101). Gaede and Versteeg (2011, p. 100) further emphasise that, regarding population reach, access in remote areas is determined by the distance to clinics and hospitals, while accessibility to all services includes availability and quality of care at all levels. In terms of the physical presence of public healthcare facilities, a major hurdle is the lack of proximity to access healthcare for a considerable proportion of the population in the Fetakgomo Municipal area. The researcher conducted an observation during fieldwork and identified that there is one clinic in each village, except for one village that does not have a clinic, and another with both a clinic and a community healthcare center. The villages, being big, have sections, and one clinic is not enough to accommodate the communities. Those who find healthcare easily accessible live close to the clinics. In an interview with patient #11, when asked whether healthcare is easily accessible, she answered, *"For me, yes, they are accessible, the clinic is not far."* Furthermore, most of the facilities do not have a 24-hour service, which reveals a lack of full access to healthcare. Patient #8 mentioned:

"The boring thing is that they don't work on weekends and at night."

Therefore, this confirms that healthcare is not always available in terms of operating hours. In support of this, Nurse #7 stated:

> *Our patients are not getting all the care they need because there's a shortage of staff, and we don't have a 24-hour service, a person can get injured there on the streets, and when they have to come to the clinic we are closed. Also, we don't work on weekends, because we don't have staff, so we can't rotate. We only do emergency deliveries because there are just two of us who are working, so if an emergency delivery comes in, both of us have to attend to the patient, so the patients outside suffer because of that, for us deliveries we send them to the hospital.* (#7*).*

Among the seven facilities selected for this study, only two provided a 24-hour service, while three have an on-call system, where the nurses are on standby for emergencies.

Nurse #3 explained the on-call system, stating that, *"we provide an on-call system, if you come to the clinic at night, you will find a nurse who spends a night at the clinic."* In the first focus group discussion with nurses, Participant #1 stated that, *"even those who work on call during the night they just compromise so that patients do not return home."*

Shortage of staff has been highlighted as the rationale for the lack of a 24-hour service. Nurse #1 remarked that, "*We don't provide a 24-hour service simply because we are short-staffed, for a 24-hour service, it needs a certain number of people to be there for day and night, including cleaners and security."*
Another Nurse #4 agreed stating:

> *We had a 24-hour service a long time ago when we had enough staff and when we were still working in this building that is now cracked, so we were forced to cut the building and use half from 2009 until 2015, but after 2015, calling system had to be cancelled because of the structure and shortage of staff*. (#4).

There is one clinic with dilapidated infrastructure in the area, and this poses healthcare service delivery challenges.
Furthermore, distance is another challenge that prevents community members from accessing healthcare services easily. Gaede and Versteeg (2011, p. 99) agree with this, explaining the limited healthcare services in remote areas by highlighting that the distance to the closest healthcare facilities, affordability issues, and lack of transport are among the many obstacles that rural communities encounter. Moreover, numerous studies are in support of these challenges, highlighting the distance, financial burden, and time as significant barriers to healthcare accessibility in rural areas compared to urban areas (Schneider, 2009; Stuckler et al., 2011 & Jackson et al., 2006). Some of the participants stated that they take two taxis to get to the clinics, and it costs about R80 for the round trip. Patient #10 explained that:
"it's not easily accessible, the clinics are not enough, and in terms of distance, they are far. I take about 7 km to get to the facility."

Those patients who do not have money for transport walk to the clinic. Patient #8 noted that, *"Sometimes if you don't have the funds, you have to walk to the clinic." For those*

who are unable to walk long distances are further disadvantaged: Patient #7 stated: *"I have a problem with walking because of my legs; even going to the clinic is far for me because of my legs."* Patient #4 *added* that, *"Sometimes a child is sick you don't even have a mere R10, and to get to the clinic, you have to travel. You'd find yourself sitting with a sick child at home because there is nothing you can do."*

However, Nurse #6 argued that healthcare is easily accessible stating that, *"It is easy to access, we also use home-based care workers, and they visit them at home to deliver medication or at a shop, we call them pick-up points, depending on the conditions."* This nurse emphasised that healthcare is accessible, as the patients do not always need to visit the clinic; they can be cared for in their homes by home-based care workers, or get their medication delivered at home. According to Marshall and Meyers (2014), home-based care workers offer healthcare services for people with physical disability, chronic patients who require support and counselling, such as HIV/AIDS and TB, and patients on routine use of medication instead of them visiting the clinics.

In Focus Group #2 with home-based care workers, participant #1 explained how patients receive healthcare in the comfort of their homes, stating that they *do "screening, health promotion, referral"* and further explained that:

> *We do door to door. For chronic illnesses, some, we deliver medication for them, some we administer medication at home, like TB patients, and for those that are unable to cook for themselves, we assist them.*

Also, in Focus Group#1 participant #1 stated that, "W*e go to creches to check children's clinical cards, to check if they attend their scale appointments properly, they are getting their injections on time, and they receive their vitamins accordingly. When we find that there's a child who did not receive all these services, we refer them to the clinic so that the nurses can provide care for them."*

Participant #2 further emphasised that:

> *For our patients, we collect medications and deliver them, especially those with chronic illnesses and the elderly who are unable to come to the clinic every month, and after six months that's when they come to the clinic and renew their prescription letters. We do assist them at*

their homes those who are sick and can't bathe themselves, we bathe them, cook for them, give them medication until they improve. (#2).

Even though home-based care workers enhance healthcare access, they don't provide all the health services required by the communities. Their main focus is chronic patients and TB patients. I probed further, asking how they care for TB patients at home, and Participant #3 explained:

> *For TB patients because they have to take medication every day, we go to them to ensure that they take their medications. Back then, they used to come to the clinic every day to take their medications, but now they come maybe after two weeks., For TB they not like chronic patients, we don't deliver medication for them, they come and collect their medication, and we just do follow-ups and make sure they take their medication on time*. (#3).

Patients in interviews pointed out that they rely on the clinics for chronic, minor, and acute illnesses, as well as pregnancy and child healthcare. The main chronic illnesses include diabetes and hypertension. In the analysis of healthcare services, below is the list of services provided by the six clinics in the study area:

- Mother and child
- Minor illness
- Chronic illness
- Family planning
- Immunisation
- Antenatal care
- Minor emergencies
- Postnatal care
- Reproductive health
- Adolescence and youth-friendly services
- Emergency deliveries

Among the six clinics, only one provides dietetics services. In an interview, Nurse #3 mentioned that with regard to services offered at the clinic, they deliver "… *almost everything except those that are done in hospitals."*

Additional services provided by the community health centre include:

- Circumcisions
- Dental services
- Dietetics
- Psychiatric services

Therefore, in terms of affordability, nurses highlighted that healthcare is free of charge, and patients don't have to pay for anything. Yet, Nurse #2 noted that, "*The ambulance is not free of charge. They think it's free of charge, but it is not.*" As such, when patients are transferred to the hospital from the clinics, they are required to pay for ambulance services, which the majority of the people are not aware of.

6.4.1.2 Healthcare Facility Infrastructure and Environmental Factors

Quality care has progressively become the main element of health security. As such, people require healthcare that meets their standard of needs. The environment of healthcare facilities is the key component that shows whether people receive or provide care in a healthy environment. Cleaning the healthcare facilities is a form of practising safety and sustaining a healthy environment which is essential for both patients and care providers, as well as for infection and prevention control (IPC) efforts (Patrick et al., 2024, p. 2). In interviews, patients were asked if the facility they receive care in was clean, and their responses are as follows:

Out of the eleven patients interviewed, six noted that the clinics were clean and did not have any complaints. However, four patients stated that they were not always clean.

Patient #1's response was:

> *No, not all of them. Some are very dirty, especially in the toilets, even the cleaners don't clean thoroughly. Back then, cleaners used to clean late after the clinics were closed so that people find the clinics clean in the morning, but nowadays the cleaners come to work at the same time as the nurses when we are already at the clinic, and they start*

cleaning while we are sitting at the waiting areas, asking us to lift our legs so that they can clean. (#1).

Patient #10 noted, *"Some days it's clean and some days it's not, sometimes they just start to clean while you are already at the clinic."*
Patient #4 agreed stating that, "*It's not bad, but sometimes they start cleaning while we are sitting in the waiting area."*
Patient #8 further mentioned that *"The surroundings are poor, cleaners come in late and start cleaning while we are at the clinic, and the nurses won't start working until they are done."*

These responses show that there is a lack of consistency in the cleanliness and hygiene of the facilities, and they expressed concerns regarding the cleaning staff working at the same time as nurses while patients are already at the clinic. This causes disruptions during operating hours, as it delays the nurses from starting their work, further delaying the patients, as it increases the waiting period.
Patient #9 stated very strongly that the clinics were not clean at all: *"No. It's not clean in and out."* She further emphasised that she did not like the facility because "*it is dirty, there's no hygiene, toilets are not clean, and we don't have water."* According to WHO (2019) out of every four healthcare facilities, one does not have a water supply, and out of every five, one lacks sanitation. Not having water has a direct impact on sanitation.

However, during observations, the researcher noticed that the facilities were clean, the waiting areas were clean, the toilets were clean, and the consulting rooms were also clean in all seven facilities. The researcher waited for longer periods in the facilities to interview the nurses. The researcher observed that sometimes, the place was made dirty by the patients. The majority of the population revealed that the environment is healthy; however, we cannot dispute the fact that it's not always the case. The response of patient #9 reveals that sometimes the environment is unhealthy. Figure 14 below illustrates hygiene and cleanliness in a facility. And she was right when she mentioned the lack of water.

Figure 18: Hygiene and Cleanliness in Facilities

Furthermore, from the perspective of infrastructure quality, out of the seven facilities, three clinics have poor infrastructure. There was one facility that did not have a building, as illustrated in Figure 15 below.

Figure 19: Ga-Seroka Clinic infrastructure

When asked if the buildings are user-friendly, a healthcare worker responded as follows:

Nurse #4 *"Not per se, first of all, we don't have a structure, we work in containers, there is no privacy, you have to speak lower so that others don't hear you, whereas patients differ with voices, privacy is a big issue. we have been working in these containers for 15 years."*

Patient #8 supported this statement noting that, *"The infrastructure? All the buildings have cracks, so we use containers. They are small and there's no privacy."*

This clinic has only three containers, which are not big enough to accommodate the community, and it has been like that for over a decade. As such, patients who receive care in this facility are more disadvantaged than the rest of the Fetakgomo community. The waiting area is small, and there is not enough shade for the sun. The containers need to be repaired, and as a result, they pose serious health challenges. Nurse #4 noted that:

> *The structure is a problem because we'd find that the electricity is not working properly, because in these containers, things shift a lot. Some days, one container is not working properly, the next day it's the other one. When it's raining, the water gets inside and damages the cables, and the main switch shuts down. A lot of things work electronically, so it becomes a problem* (#4).

The infrastructure in other clinics also requires attention. Nurse #5 noted that *the building is old, the ceilings are falling off, when it's raining, we have leakages, we have to shift things."*

In Focus Group #1 with Nurses, Participant #1 noted that the challenge they face with infrastructure is *"space,"* and she further explained that *"the building is no longer user-friendly for the community, the community has increased, people are a lot, and we only have 3 consulting rooms."*

Participant #2 added: *"A lot of things are damaged, taps, toilets, doors, floors are cracked, the clinic is cracking in half, this clinic will be closed one day because the crack is very huge."*

According to Sumbana (2024, p. 511), the Limpopo province government pays no attention to the poor infrastructure in healthcare facilities.

6.4.1.3 Healthcare Emergency Management/Response

According to WHO (2019), all populations in the world are at risk of experiencing health emergencies and disasters, along with those related to disease outbreaks, conflicts, natural, technological, and other hazards. As such, public healthcare facilities in rural areas are not well equipped to cope with such cases. This study investigated how the facilities in the Fetakgomo Municipal Area manage health emergencies, with a focus on "other hazards," which are trauma, injury, accidents, obstetric, and violence-related

emergencies. As part of the interview, healthcare workers were asked how they manage such emergencies.

According to Rose et al. (2017, p. 126), public healthcare emergency management utilises distinct knowledge, approaches, and frameworks to effectively respond to multifaceted health events. Therefore, during a focus group discussion #2 with Nurses, Participant #3 explained how they deal with emergencies in their clinic:

> Once they arrive, they see them outside, then they FastTrack them and then get in here and tell us that there's an emergency, we have a room for that, then all the nurses will go there to assess what kind of an emergency is it, and if it needs just two nurses or all of us, it only depends on the severity. If it's an emergency that needs all of us, we stop seeing patients and attend to the emergency until the emergency patient goes to the hospital. (#3).

Furthermore, in interviews with nurses, responses were as follows:

Nurse #6 responded: *"We have an EDF, we can just say it's our doctor; it's the one that tells us how to manage our emergencies, and sometimes we use our descriptions. We have an emergency room with enough equipment, especially medication, and when we do the referral."*

Nurse #8 highlighted that, *"according to protocol, it depends on what type of emergency it is. If it's something that can be handled in the facility, we manage, stabilise and discharge, but if it's something very major, we manage, stabilise and refer to the next level of healthcare which is Jane Furse hospital."*

Jane Furse Hospital is the nearest hospital in the area.

Another Nurse #1 stated:

> *Sometimes during emergencies, I call everyone, including the cleaners, but obviously you won't tell the cleaner to inject the patient, but you can ask them to give you things while you are treating the patient, like 'pass me that bucket with injections', or 'pass that drip' written what what. Yeah, it gets hectic sometimes. Maybe there's an emergency, and I'm alone, I call the cleaners to come to assist*. (#1).

Nurse #4 further explained that *"we deal with them; accordingly, it only depends on when it arrives. We attend to it immediately, but we have a challenge with EMS. It takes too long to get here."*

In support of this, Nurse #8 further explained that they experience challenges during the referral processes, stating that, *"we do have challenges of the ambulance. The system for the ambulance - you just don't go there and tell them I have a patient. The call must go via the call centre because that's how they record and then the call centre report and that's how we get the ambulance."*

Nurse #3 also noted that:

> *We have an emergency room. When a person come here as an emergency, we triage them, meaning that they don't queue, we assist where we can, if they need oxygen we give oxygen, if they need a mobiliser, we give them. We are stabilising the patient, and then we will refer the patient. We had an emergency today. We had a patient who complained about the abdomen, explaining that they might have a kidney problem. We gave her medication to stabilise the pain and referred her to the hospital. The ambulance takes time, but today, because we called in the morning, it didn't take time.* (#3).

Nurse #9 stated:

> *When an emergency arrives, it doesn't queue. We leave our patients and attend to the emergency. When it's a major emergency and we have to do referral we do management first, call the call center in Jane Furse hospital then report our patient and they send EMS, but normally I'm not supposed to call the EMS, I only report to the call centre, then they call the EMS and let them know that in OPD we in need of an ambulance*. (#9).

These discussions show that there is preparedness and competencies to respond to health service needs based on the Office of the Assistant Secretary for Preparedness and Response (2016, in Rose et al., 2017, p. 129), as they include numerous initiatives and procedures to effectively manage health emergencies. Preparedness involves having a plan to respond to the needs of

patients during cases of disasters or health emergencies. Therefore, the healthcare workers have strategies in place even with the limited resources.

The researcher then probed how long the ambulance takes, and she answered, *"it takes +- 15 minutes"*. This posed a further question about the challenge of ambulances arriving late, and she explained that it depends on the day, and sometimes there's an EMS parked there in the Community Health Centre.

Nurse #7 explained that sometimes the ambulances take a long time and sometimes it do not, noting that *"… luckily if you find that it's been on the road and it's headed to the hospital, it will come on time, but if not, you will wait with the patient until they arrive."*

Nurse #6 explained that the ambulance can sometimes take over *"2 to 3 hours"* to come. Even so, she explained that *"… we have a WhatsApp group where we send messages, so the whole district will know that the clinic has been waiting for an ambulance for over three hours, and response in the group is faster."*

The explanation for the prolonged arrival of ambulances at the healthcare facilities during emergencies is highlighted by Rapanyane (2022) that in South Africa, there is a severe shortage of ambulances and EMS.

The participants' viewpoints show that health emergency response in the clinics is moderately effective, as they usually care for minor emergencies. Also, the delay in the ambulance's arrival can affect patients' outcomes, especially in cases of emergencies that need urgent referral. However, according to the Department of Health (2023, p. 8), they manage emergencies competently, based on the following:

- When a patient enters the accident and emergency department, healthcare workers leave everything and prioritise the emergency.
- Healthcare workers, responding with urgency, immediately assess the patient on arrival.
- Healthcare workers follow the Subjective, Objective, Assessment and Planning (SOAP) technique.

6.4.2. Patient-centered care and experience

This study investigated quality healthcare based on patient experiences in the selected healthcare facilities within the study area. The patients' responses uncovered that health security could be achieved for the communities of the Fetakgomo municipality. Despite this, it is impacted by numerous challenges. The experiences stemmed from waiting times, satisfaction with healthcare services, whether patients are being respected, whether healthcare workers are transparent, and whether patients understand the language used at the clinics, as well as health education and support, all of which are sub-themes generated from the main theme.

6.4.2.1 Waiting times

In public healthcare facilities, patients' waiting times are recognised as the most common complaints reported by patients, and they are among the rising concerns measured in the assessment of quality healthcare (Adi Leiba et al., 2002, cited in Department of Health, 2023, p. 3). In interviews with patients, they were asked how long they wait to be seen by a nurse, and they responded as follows:

Patient #8: "We wait for hours; you can go there at 7 am and finish around 1 pm."

In support of this, Patient #9 explained, *"We take a long time waiting to be seen by the nurses, you can take 2-3 hours without three patients being attended, you can go the clinic at 6 am and get assisted after lunch, after 2 pm."*

This response suggests that in 2 – 3 hours, not even three patients would be assisted. The researcher further probed what kind of services she uses to understand the reason behind the long waiting period, as she mentioned that she goes to the clinic very early in the morning. Patient #9 further explained that:

> "*I collect my medication for high blood pressure, in the morning, I am always number three; it's always Ntate Sebi as the first in the queue, then Ntate Phori, as the second, and then myself. Whenever we come to collect our medication after every 3 months, we are always like in the queue. And we come very early in the morning, all three of us*." (#9).

NB: The names provided are pseudonyms to protect the identities of the people mentioned by the participant to ensure confidentiality, privacy, and anonymity.

This participant did not understand why collecting medication should take such a long time, as she does not even go for a diagnosis and/or any other form of treatment.

Patient #8 explains that *"… especially the day that the doctor comes to the clinic, for example, you just came to collect medication, but you will wait long because of the queue, because the doctor is there, and the doctor works alone and must attend to everyone."*

Another Patient #10 stated another issue contributing to long waiting times: *"The issue is that if they misplace your file, you have to wait extra hours until they find it. imagine going there very early in the morning and waiting for way too long because they can't find your file, and you were number 5/6 in the queue."*

Patient #4's response read as follows, *"We wait for a long period, you just have to make sure that you eat at home before you leave for the clinic, even worse if you find that there's a pregnant person in the clinic, we can wait the whole day."*

As such, pregnant patients are treated as an emergency or priority, as Patient #2 noted: *"When there is a pregnant person who is about to deliver, they prioritise that first; we all wait until an ambulance arrives to take her. All the nurses out there focus on her."*

Patient #9 agreed stating that:

> We queue for too long, you'd find that only one nurse is working, and *then an emergency arrives (pregnant woman for delivery), just know that you will leave the facility at night if that happens. And there's no solution; you either go home or wait to be assisted by the night shift staff.* (#9).

Six patients out of eleven mentioned that they wait for too long and highlighted that it takes a minimum of 2 – 3 hours. However, two patients argued that it depends on the days and the number of people one finds at the clinic. Patient #3 noted that *"… it depends, some days you take long some days you are not."*

Patient #2 shared the same sentiment and further explained that:

> *It depends, once you are done with the scale and belt (triage process), you might not wait that long, but they are also slow, sometimes they will receive a phone call, and they would attend to it and take a long when*

they assist you might also take some time to wait for your medication. (#2).

According to Patient #2, there are some factors that cause the slow services such as nurses being on their phones for too long. Patient #8 added that *"sometimes they hold meetings, and we wait for too long."*

The researcher then found that there were three patients who indicated that they don't wait for long periods. One mentioned that she does not take more than 30 minutes and another, Patient #6 noted: *"I wait at least 30 minutes to go take blood pressure and scale and wait for another 30 minutes to an hour to get to the nurse because they are only 2 or sometimes 3 nurses."*

Patient #7 highlighted an alternative to not waiting for too long by stating that *"… I don't wait for long, I don't go in the morning I go in the afternoon when I get there I find that they are almost finished, I avoid going early in the mornings because I know I'd find a queue and I will wait for long.'*

As such, waiting times are always different for all patients depending on the time of the day and the number of nurses on duty. Patients that go the clinics in the early hours of the morning frequently wait for long hours to be seen by a nurse, as compared to those who go in the afternoon. However, it's not always the case for everyone.

During the researcher's observations, she visited one clinic with 24-hour services to conduct an interview. The researcher went there at 6 pm and found a queue that wasn't long, but the people were not there for night services; the timing just overlapped because the clinic was overcrowded during the day. The researcher also asked out of curiosity when doctors visit the clinics, and found out that it is usually on Wednesdays, which are always crowded. Additionally, the day for mothers and children sees longer waits, as those patients tend to take more time in the consulting rooms.

The Department of Health (2023, p. 3) notes that across numerous healthcare facilities, the demand for healthcare services exceeds the operational capacity of the facilities. And all these user experiences from patients proves that the available resources are inadequate as evidenced by the long waiting periods in queues. Patients sometimes leave the facilities without receiving care (Department of health, 2023, p. 3). Therefore, it is critical to minimise the long queues for the purpose of decreasing the waiting periods and overcrowding, which also contributes to the spreading of

infections (WHO, 2009; in Nwagbara et al., 2024, p. 2). They further explain that the long waiting periods are due to patients arriving very early at the facilities prior to the start of services (p5). This implies that patients may feel like they have waited for too long because they have arrived too early. Other contributors highlighted by numerous studies (Daniels et al., 2017 as cited in Nwagbara 2014; Baron & Kaura 2021 as cited in Nwagbara; Makua & Khunou, 2022 as cited in Nwagara; Sokhela et al., 2013 as cited in Nwagbara et al., 2024) include:

- Staff meetings during operating hours
- Shortage of staff
- Healthcare workers arriving late at work
- Lunch breaks are going beyond the authorised times
- Patients not queuing properly

6.4.2.2 Respect, transparency, and communication

Respect in healthcare is key to good service. - The communication between a patient and a healthcare worker should be conducted with dignity and privacy. Both patients and healthcare workers should be addressed properly regardless of age, gender, or race. In addition, patients' information ought to be kept confidential.

In interviews, patients were asked whether they were respected, addressed properly, and if they understood the language used in the facilities. All the patients agreed that they understood the language, which is Sepedi. All the nurses speak the Sepedi language in the facilities. About how they are addressed and respected, all patients responded that they are being addressed properly. However, nurses' attitudes were deemed unprofessional by some patients.

Patient #10 highlighted that they do treat them with respect. However, *"…they do have attitude sometimes when they don't get the information they need, or if you go to a different clinic, they are usually not happy with that, and they behave somehow."*

The researcher understands the nurses' reaction because when you change clinics, it makes their work more difficult. Patients have files with records of their health history at the clinics; thus changing clinics can make the nurse's job more difficult. That could annoy them.

Patient #4 stated: *"These new young nurses address us properly with respect than back then when it was the old ones."* According to Patient #4, since the new batch of younger nurses started working, patients have been treated with more respect.

The above response suggests that the new (younger) nurses are more respectful than the old ones. The researcher believes that this is because in their training, communication skills and emotional intelligence is emphasised. The researcher too had also experienced kindness from the new-age nurses, as compared to the old ones.

Patient #1 initially agreed that the nurses in the clinic treat her with respect and later emphasised that *"… in general with clinics, I don't like how the nurses talk to us, they don't talk to people in a respectful manner, especially to the elderly."* She used to go to a different clinic before she got married, and after her marriage, she had to move to another area. As such, she had different views for different clinics.

The researcher probed further to understand what kind of personal experience she had, and she explained that

> *I once had a verbal fight with a nurse because of her attitude, we were fighting because of the type of words she used while talking to me, you will find that they address us using certain words that don't suit us, so my response to her was that you didn't go to school for our sake, you went to school for yourself, try to talk to us properly, this is your work. Attitude is their problem, but it's not all of them*. (#1)

Jacelon, (2002, p. 232) agreed that the elderly patients are affected by negative attitudes. Furthermore, these patient experiences are supported by several studies highlighting that there are reports of grievances concerning disrespect from healthcare professionals in care, as patients complain and report such remarks (Abdelrahman & Abdelmageed, 2018; Chadwick, 2012; & Reader et al, 2014). However, Abdelrahman and Abdelmageed (2018) emphasise that complaints from patients are often made without proper knowledge of the healthcare systems and understanding how the system operates. Nonetheless, patients have the right to defend themselves.

While some nurses are known to have negative attitudes toward patients, unfortunately, some patients get to experience that at first hand. In Haskins et al (2014) study about nurses' attitude towards patient care, it was reported *that "Patients*

reportedly experienced verbal abuse, rudeness and neglect" (p. 41). Such perceptions were experienced by patient #8, who explained that: *"Sometimes, when they misplace our files, they get angry at us, while they are the ones who misplace them."*
However, the experience described by patient #7 was positive; he stated that *"… the way they treat me, I don't want to lie, they treat me well. When I got here, I didn't know them; they didn't know me, but they never ill-treated me."*
A positive attitude toward patient care is considered good quality healthcare. As such, nurses are required to have positive attitudes towards patients as it is an ethical healthcare principle and contributes to quality care.

In terms of transparency, patients were asked whether the person who is attending to them has a name tag. Five patients responded with a 'yes', while one mentioned that *"… sometimes they do wear them and sometimes they don't"*. Patient #10 further explained that *"… some do, but they sometimes wear them backwards."*
Two patients mentioned that the nurses do not have name tags, and their responses are as follows:
Patient #9 said that *"… the nurses don't have name tags, you won't know who assisted you."*
In support of this, Patient #1 stated that:

> *No, they don't, all of them, including home-based care workers. I even asked for the name of the nurse who was assisting me, and her response was "why do you want it" and I said to her that I want to know so that went I come back, I would know who prescribed my medication and so on, and she said, it's not important for me to know her name. So, she refused to tell me her name, but she assisted me very nicely, and we were communicating very well*. (#1).

This indicates that sometimes there is a lack of transparency in the facilities, particularly in the context of openness, trust, and accountability. A study by Cook (2025, p. 1) suggests the "Hello, my name is…" introductions along with name tags, highlighting that healthcare professionals should have their name tags with their full name, title, and position. He further explains that the introduction campaign was influenced by a cancer patient who required to know who was rendering care for her

and also emphasised that the name tags are not only important for patients but also the clinical team (Cook, 2025).

Therefore, one of the reasons healthcare professionals wear their name tags backwards was highlighted in an interview with Nurse #6. She stated that *"… we work in a high-capacity clinic where you can be reported just like that."* However, if you are being reported, it means that you did something wrong. Patients have the right to stand up for themselves when they don't receive the care they need. This is for their safety and quality of care. As such, in healthcare, transparency is fundamental because it fosters a culture of respect for patients and enables them to be informed and be proactive in their overall health and well-being (Fukami, 2024, p. 1).

6.4.2.3 Satisfaction with services

In several public healthcare facilities, the demand for healthcare services exceeds the capacity available, and this can be the reason why there are long waiting periods that sometimes result in patients returning home without receiving the care they need (Department of Health 2023, p. 3). The facilities in the study area are not adequate; they are overwhelmed by the large population. The study investigated satisfaction with services by asking patients how satisfied they are with the services provided by the clinics, whether nurses are competent with their work, and whether the clinics meet the needs of the community. Some patients were on a neutral stance, some replied with 'yes,' whereas others responded with a 'no' and elaborated on their responses.

Patient #7 best describes his satisfaction with service delivery. He seemed very confident about his response and noted, *"Yes, I am satisfied, even for us, they are those that get their medication delivered in the residence of the chief and then come to collect them there, it's nearby. It's just that I need to make arrangements so that I can collect them there."* According to Hlongwane and Gray (2022), South Africa has commenced re-establishing the healthcare reforms by means of implementing the CCMDD program intended to achieve the NHI. This program enables patients to collect medication at pick-up points near their place of residence, saving them the time to visit the healthcare facilities and queue for long hours just to collect their medication. However, Sekopa and Netangaheni (2025, p. 1) stressed that, majority of the primary healthcare facilities in Sekhukhune District encountered significant implementation

challenges regarding the CCMDD programme, while simultaneously benefiting from the program.

Therefore, Patient #7 further explained how satisfied he was, but also highlighted the issue of queuing for too long:

"The service delivery is right; the only issue is the long queues. I never get confused when I get to the clinic. When I get there, I always find people ready to assist me."

Patient #4 narrates her experience as follows: *"Their services, I think they are okay, except for the fact that you would wait for a long time, and then they would say there's no medication, or it's finished."*

Patient #2 added that *"the slow service, and if they don't have medication, if possible, they should tell us that they don't have medication for 123 so that we can leave instead of queuing for long hours, that time you are hungry, but they are looking to just check the vitals and fill in the file."* And this takes us back to Abdelrahman and Abdelmageed's (2018) argument, which was mentioned previously, where they emphasised that patients are not fully informed about how the healthcare system works. There are protocols that need to be followed in healthcare, and nurses cannot just send patients back home because there is a shortage of medication.

However, Patient #2 noted that *"I'm neutral, I don't blame them for some of the poor services."*

Patient #10 supported the above acknowledgment by stating that *"I would say 80 per cent, and the remaining 20 per cent is just for the shortage of medication, the long queues, and the nurses can be very slow."*

Patient #6 noted that she was satisfied with the services at the clinic. However, she emphasised that the clinic does not meet the community's needs due to the long queues and also highlighted some mistakes that the nurses often make, stating: *"The problem was when a nurse wrote the wrong date when I took my 1-year-old for a scale and injection." She added that "people usually complain about that, and they also complain about their files being lost" (#6).* Files in healthcare are medical records that are described by Thomas (2009, p. 384) as documents that have a patient's health history, as well as notes on daily operations, distribution of medications, clinical findings, and test results. As such, if a patient's file is lost, that means their medical history is lost, and this could have consequences in the long run. The aim of keeping records is to facilitate proper care for patients in case they relocate or for future reference.

However, Patient #3 was happy with the services, although she elaborated that *"the problem is that they are far."*
Patient #6 stated that the services did not meet her needs. She argued that *"I am not satisfied at all because a big clinic like Mohlaletse Clinic cannot have a few nurses who are working during the day. And some of the patients only get Panados for serious illness."*

The shortage of medication results in poor service delivery. However, that does not necessarily mean that nurses are not doing their job. The same reason goes for slow services. The shortage of staff has been highlighted as a major issue (*see 6.4.1.1)*. Patient #10 noted: *"I believe they are, some of the things are beyond their control, there's a shortage of staff, we can't really expect them to be that effective."*
Other patients emphasise that nurses do their job, they are trying their best, and they take care of their patients. Patient #10 stated that "*The fact that they don't send patients home after their knock-off time, they attend to all of them, that shows that they do compromise."*

Therefore, in terms of the clinics meeting the needs of the community, the findings reveal that the clinics are not fully functional in meeting the needs of the community.
Several issues have been highlighted by patients, with the first being a lack of adequate infrastructure. Patient #2 supported this by stating that *"… the clinic doesn't have a structure, so we wait outside in a shelter."*

According to Patient #10, the clinic is trying, but the community is just too big. For instance, there are pick-up points for medications, which are convenient for most people, but others still have to queue for longer periods at the clinics.
In interviews, patients highlighted the good and the bad services provided by the clinics; they acknowledged that the clinics are making great efforts to provide good service. However, they are not big enough to serve a growing community.

6.4.3 Systematic challenges in healthcare

There are numerous challenges in the healthcare system. According to the Department of Health (2013) significant concerns include healthcare workers' negative

attitudes towards patients, long waiting times, unclean environment in health facilities, shortage of medicine and stock-outs, and insufficient infection control that threatens the safety and security of both staff and patients. Some of these critical issues have been discussed in the previous sections as challenges experienced by patients and facility and environmental factors. Therefore, sub-themes that emerged from this key theme include resource limitation, structural and operational challenges, and how these challenges impact healthcare workers and service delivery.

A question was posed to the healthcare workers was whether the facilities had been improving or deteriorating. This was a general question, and they were given an opportunity to share any positive or negative changes with the facilities overall. As such, some challenges are highlighted below.

Nurse #7 stated, *"It's just up and down. Sometimes we have enough staff, we used to work on weekends, sometimes we don't, and we have stopped working on weekends. There were times when staff was much more than it is now, but we never had more than 6 professional nurses."*

Nurse #6 noted:

> *From 2016, so far I didn't see any improvements, because of shortage of staff, the clinics are always full, especially this one, it's like they call each other to come here, we have patients from Ga-Sekoka and Seroka village has a clinic when you ask them why they didn't go to the clinic there, they say that the nurses are not working there, they are just lazing around, but we know that it's just what patients say, the clinic is stagnant.* (#6).

Nurse #3 seemed confident with their facility improvement, and said:

> *We improved a lot. We have resources. The government tried to bring this thing called ideal, we have home-based carers, our patients can take time without coming to the clinic, home-based carers deliver their medication at home, and when patients come to the clinic, because it's not always packed, they are happy, they receive fast services.* (#3).

Another Nurse, #2, noted that their facility was improving as well. However, she shifted the focus to service delivery in relation to teenage pregnancy, stating that *"… we are*

improving because teenage pregnancy, according to statistics, it's been low this side because we are doing follow-ups, but the services are better than before, I think we are improving."

The nurses emphasised that the clinics are improving in terms of service delivery. However, resource limitation hinders progress due to poor water supply and a shortage of staff. However, there was one nurse who strongly opposed their clinic improvement, noting that:

> *It's deteriorating, things are getting worse, the staff keeps decreasing, lack of maintenance, nurses are resigning, some are going on pension, but they are not hiring staff.*

Therefore, the Batho Pele principle is not followed by the facilities. Umbana (2024, p. 509) reported that the shortage of staff does not comply with the principle. This also applies to the next section on resource limitation.

6.4.3.1 Resource limitation

Resource shortages have been identified in the section above, and to get a deeper understanding of the resource limitations, healthcare workers were further asked whether they had all the necessary resources to provide care in their facilities, and what the biggest challenges were they face when delivering care. Their responses mentioned that not all resources were available. Resource shortages were provided by nurses and home-based care workers in interviews and focus group discussions below:

- Shortage of staff
- Shortage of medical equipment, supplies and technology
- Shortage of medication
- Shortage of batteries for equipment and/or devices
- Lack of water
- Lack of electricity backup
- Lack of infrastructure
- Lack of stationery
- Emergency Medical Services (EMS) response delay
-

As such, 83 per cent of the South African population receiving care at primary healthcare facilities experience medication shortages, lengthy waiting periods, overcrowding, insufficient staff, and poor-quality care (Nwagbara et al., 2024, p. 1).

Therefore, the shortage of staff has been the biggest challenge faced by all facilities selected for this study. In support of this, Sumbana et al. (2024) state that "… the shortage of healthcare workers, particularly in remote, rural areas is a challenge"(p. 511). All facilities examined in this study have no more than three nurses per shift, with some having just two per shift. Nurse #1 noted that *"… we are short-staffed. Sometimes you'd find that there's only 2 or 3 people working, so we get stuck."* Nurse #6 agreed stating that *"… while we have a shortage, they can call a meeting, and you would find that we are 3 during the shift and it's a must, we must attend the meeting, and maybe there's 1 nurse left to attend to the patients, and that's a challenge."* Nurse #7 elaborated that *"for example now we are just two, if one of us get sick, it means there will only be one nurse available and maybe there are 50 patients outside, so it's a challenge."* Furthermore, in focus group #1 with nurses, Participant #1 repeated the same reason of Nurse #7 stating that *"… for example, now we are working and it's just the two of us, if one of us gets sick it means there's only going to be one professional nurse, whereas we have to be at least 2 or 3."*

Other staff shortages include pharmacists, as noted by Nurse #7:

> *"We don't have a pharmacist or pharmacist assistance, which means ordering and receiving medication is done by us, physical count, SVS, and reporting of medication every week.*

The above responses emphasise that some nurses are doing the pharmacists' work at the clinics, which falls outside of their scope of work. They compromise a lot for patients to receive the care they need. Another issue that has been raised is that when nurses transfer or resign, they are not being replaced. This burdens the one remaining in the facilities because they have to fill the gap of the person who left.

The nurses expressed several experiences with resource limitations. Nurse #2 shared a detailed explanation of some of the challenges she faces as a professional nurse who works the night shift in a maternity ward and how resource shortages affect patients:

> *We don't have the necessary equipment, for instance, we don't have linens, when I'm delivering a baby, my pack doesn't have that green*

> *cloth inside (sterile drape), there's a sterile procedure but now I don't have the cloth, the linen when the baby comes, they can catch infections, but I'm forced to deliver. On this side, we don't have pethidine, but the guideline says we must have pethidine. We tried to talk about it, but it's not there. I don't even have naloxone, which is a drug that helps the baby to wake up, so the resources are not enough. We have to improvise. After giving birth, we just give them Panado and Ibuprofen; we don't have strong drugs for pain.* (#2).

Nurse #2 further emphasised the shortage of water in the facility, noting that: *"there's no water, I have to fetch water from the tank"* (#2).

Nurse #2's narrative on resource limitation points out a significant risk to patient health and safety, which can lead to serious complications or risks during childbirth, including enduring severe pain during and after labour. As such, the patients' health is compromised. In my view, this also affects the nurses because if anything goes wrong, someone is going to be blamed in the end. Healthcare workers get sued for malpractice. Although, in this case, it can be due to inadequate resources. These resource limitations are among the many reasons why people lose trust in public healthcare systems. As such, Nurse #2 emphasised that *"… a lot of patients don't come to the clinics, they are saying nurses have an attitude, and that's true, nurses have a lot on their plate."*

Nurse #2 further elaborated on the challenges, stating that:

> *The biggest challenge is that we don't have medication. When we are delivering the baby need zinc for diarrhoea and I don't know when I last saw zinc, I think it was in January.*

This resource limitation is one of the risky factors in healthcare. Therefore, funding is required for healthcare facilities in Limpopo Province to get the necessary equipment and supplies (Sumbana, 2024, p. 511).

The shortage of medication proves to be another significant challenge, as it greatly affects service delivery. According to Nurse #1, the facilities sometimes run out of medication, and Nurse#6 agreed, highlighting that *"… sometimes there's a shortage of medication due to delay of supply."*

Nurse #2 mentioned that it has been a long time since she last saw Zinc, and that when Panado is available, Ibuprofen is not, and vice versa. Nurse #1's narrative seems to align with the above account as indicated below:

"The biggest challenge is that when there is no medication, we can't deliver services, and sometimes medication is not available."

The shortage greatly affects patients, not only health-wise but also financially, as noted by patient #4*: "Shortage of medication is the problem, you'd spent R80 on transport only to find that there is no medication at the clinic, and go to another clinic the next day and still don't get medication."*

Modisakeng et al. (2024, p. 5) highlighted supplier performance and buy-outs that contribute to shortage of medication in facilities below:

Table 6: Supplier performance and buy-outs

Buy-Outs	**Supplier Performance**
Lengthy complex process	Lack of capacity to deliver
Essential medicine not on tender	Withholding stock
Long turn-around time	Delayed payments
	Incorrect information about stock availability

Source: Modisakeng et al., (2024)

Furthermore, a lack of water is another critical issue that arose in interviews. Not having water in healthcare facilities is a great challenge. Without water, many of the operations which are taken for granted stop functioning.

Nurse #2 noted that *"… we do not have water, today there is water running, and tomorrow there's no water, and mind you there's no pit toilet, so it's your responsibility as a nurse to go fetch water at the water tank and it's a distance, what if a snake bites you because there are snakes this side or scorpions, it is not my duty do you understand?"*

A response from Nurse #9 corresponding to views shared by Nurse#2 regarding the lack of water reads as follows: *"We don't have water, our pipes have been damaged since winter 2024."*

Nurse #3 shared the same sentiments, noting: *"We have a problem of water; our machines are sometimes leaking, even though we compromise, we come to work because the patient is the priority."*
Nurse #7 added: *"We don't have backup for water; some have a JoJo tank as backup, but we don't, we only have a borehole, and sometimes it doesn't work."*
I probed further to get a deeper understanding of how they work without water, and Nurse #1 responded, "*They provide water tanks but it's not enough, you can smell the toilets, so what about those bacteria's?"*
Nurse #3 stated: "*Then we compromise and use Degerm. Water is a big issue."* As such, they use Degerm to wash their hands when there is no water.

In terms of medical equipment, supplies, and technology, there are a lot of essential resources that are lacking in the clinics. Nurse #9 shared the following challenges:

> *We don't have a sonar machine; the hospital took our sonar machines because theirs is not working, so we have stopped seeing pregnant patients who are 26 weeks and above, so we don't do the procedure where we check if there an insure with the baby, so our patients are now suffering, we don't have a portable small X-ray. Since I got here, they make us write things we need and don't have. It's been over 10 years of writing those things, but nothing has happened. Our theatre is not working*. (#9).

It has been highlighted that raising the issue does not solve the problem. The nurses have been communicating their cries with management; however, there has been no change. They have been complaining for 10 years about the same thing. The department is failing both the healthcare workers and the communities.
Nurse #7 expressed: *"We don't have the equipment in the delivery room, we don't have an incubator, baby warmers, back-up generators."* She further noted that *"… our ENT (Ear, Nose, and Throat) machine is broken, also the autoclave to sterilise instruments."*
Another issue that arose from the findings is that, when equipment is damaged or broken, it is not being fixed. They could stay with broken or damaged equipment for years in the clinics.

In support of the above statement, Nurse #5 had the following say: *"We don't have all the necessary equipment, it's just that some gets damaged and not replaced. And we have a shortage; we don't have an HP meter, and it's very important."*
An HP meter is a Health Parameter meter that is used for measuring vital signs. Nurse #5 is absolutely correct when she said the HP meter is important, because the clinic will not be able to triage patients without the HP meter. Chronic patients will not be able to be checked for vital signs. The triage process involves prioritising severely ill patients.
Nurse #7 also mentioned: *"We only have one computer, and now these are all my files for the day, I have to go store all of them in the computer later, and I knocked off. So, if I go now to record these, I will knock off at 9 pm."*

In Focus Group #1 with nurses, Participant #1 mentioned: "We don't have a cholesterol machine, some equipment is available, but there are no batteries, the sugar machine doesn't have batteries, scales don't have batteries, especially for adults, BP machines, and we don't have an autoclave to sterilise equipment."

In Focus Group #2 with nurses, participants shared resource shortages and experiences related to the shortages. Participant #1 expressed that *"… usually the things that we are short of are batteries for testing the sugar machine, and by protocol, we are supposed to test each and every patient, but we are short of batteries so we can't test every patient."* Participant #2 added that they don't have batteries for *"… the machine to check babies' hearts and for maternity patients."* Participant #3: noted: *"We are short of stationery."*

An additional challenge is the delay in EMS arrival and a lack of backup generators. Nurse #2 shared critical concerns regarding those challenges, stating that:

> *You can call the ambulance; it will take 3 hours, and with psych patients, I cannot treat the patient when the police are not there. When you call them, they say they only have one van. Sometimes they are forcing us to work without backup generators. How can you resuscitate a baby without a backup generator? How can you switch a piscatory with those small lights, so they were forcing that it's just 2 hours, but in*

those 2 hours, a person can die, five minutes a person can die if there is no electricity. (#2).

Participant #1 from Focus Group discussion #1 with nurses agreed, stating that "… *patients wait for a long time for an ambulance to arrive."*

However, Nurse #9, who works at the Community Health Centre, noted: *"For us, we are lucky because the ambulance it's in the yard, but if it's not available in here, we have to report to the call centre, and it can take time."*

Furthermore, the only counsellor interviewed in this study noted the following resource shortages: *"Sometimes you will find that there are no test kits, consent forms are not available - they have to sign consent forms."*

To sum up the resource shortage, particularly equipment and medical supplies, below is a list of essential resources that are lacking in the facilities:

- Sonar machines
- X-ray machines
- ENT (Ear, Nose, and Throat) machine
- Autoclave (for sterilising instruments)
- Incubators (for newborns)
- Baby warmers
- Back-up generators
- Health parameter meter machine
- Computers
- Water tanks
- Linens
- Sterile drapes
- Cholesterol machine
- Batteries for equipment

Moreover, with the load shedding, load reduction, power cuts and constant cable thefts happening in the country, it is disturbing that healthcare facilities in rural areas do not have back-up generators. The issue of equipment not having batteries is concerning because batteries are easily replaceable.

6.4.3.2 Healthcare system and operational challenges

The scope of nursing responsibilities and duties includes efforts to protect and promote health, enhance individual abilities, as well as to prevent illnesses and injuries, relieve suffering, diagnose and treat conditions, and promote healthcare for individuals, families, and communities (American Nurses Association, n.d). The nurse participants of this study include professional nurses, auxiliary nurses, Midwife nurses, PAC-trained nurses, registered nurses, acting operational managers who are also professional nurses, and an acting local area manager who is also a nurse.

Furthermore, each clinic operates with one operational manager, two or three professional nurses depending on availability, one or two auxiliary nurses, one or two lay counselors,15 to 60 home-based care workers, at least one pharmacist and/or pharmacy assistant, and sometimes peer educators who distribute condoms to the community. There is only one clinic with a dietician available, and the Community Healthcare Centre (CHC) has two doctors, seventeen professional nurses, four enrolled nurses, six emergency nurses' assistants, twenty-six community health workers (home-based care), two dentists, one dental assistant, one dental therapist, one pharmacist and one pharmacy assistant, two lay counsellors, and two dietitians. The CHC is staffed with a broad range of professionals, ensuring that they provide a variety of health services for the community. Nevertheless, being the only facility providing all those services limits its ability to serve the whole community.

In this study, there are notable challenges in terms of healthcare delivery systems and daily operations, including "… resource allocation, patient flow and waiting times, data management and technology integration, staffing and workforce management, supply chain management, patient engagement and satisfaction, emergency preparedness and disaster management" (Khatib et al., 2024, p. 2266).

The duration of working hours for nurses in the selected facilities ranges from 7 to 12 hours each day, with shifts alternating between day and night for only two facilities, and weekly hours for all facilities vary between 40 to 44 hours. Most of the shifts are 11-12 hours long; yet, some nurses adhere to the standard 8-hour shift. As such, nurses work long hours and sometimes work unpaid extra hours. According to Igumbor

et al. (2016, p. 2), there is a study conducted by Hontelez et al. (2012) on rural public healthcare facilities in the KwaZulu-Natal Province. The study established that nurses spend 83 per cent of their time on direct patient care, 9 per cent on indirect patient duties, and 9 per cent on other duties, and on average, they work 7.1 hours a day. For this study, nurses were asked if they work overtime, and their responses were 'yes', 'no', and 'it depends." Their narratives are as follows:

Nurse #3 noted:

> *I work overtime because I am working on Sundays, and Sunday it's not a normal workday. I work overtime if there's an emergency. If an emergency arises, I will stay because I can't leave an emergency at the clinic, which means I am going to stay until the person is assisted or until the ambulance arrives if the person needs referral.* (#3)

Nurse #7 added: *"Yes, and we don't get paid for overtime because our clinic does have an on-call system, but when there are too many patients, we just continue to work until they all get assisted, we don't return them and say it's knock off time."*

Participant #2 in focus group 2 with nurses also agreed that they work overtime, supporting Nurse #7's narrative regarding working extra hours so that the patients do not return home unattended in the clinic. Her statement reads as follows: *"Yes, during the week we work until a patient is picked up by an ambulance or when we are done with patients, and during holidays as well."*

Nurse #5 mentioned that because they don't have a night shift that *"… yes, some work overtime and some don't, after 6 pm, a patient that comes around that time, the nurse works overtime."*

Another participant #1, in focus group #1 noted that *"… some work overtime but they are not here, their overtime is calling system, which is overnight."*

Mmamma et al. (2015, p. 5) support these findings as highlighted in their study that nurses complain a lot that they are overworked. One of the reasons is that their extended working hours aim to address staff shortages (Olds and Clarke, 2010; in Mogale et al., 2015, p. 3).

Nonetheless, three nurses, all from different clinics, noted that they do not work overtime. Nurse #6 indicated *that: "We don't have overtime at the clinic. They don't allow us to do it even though there's a shortage; they can never call you from home*

and say a sister is alone at the clinic, you must come to work with her/him." It should be noted that this nurse works in a clinic that has a 24-hour service. As such, they don't work overtime because they change shifts.

Nurse #2 also mentioned: *"We don't work overtime, but if there's a shortage, they call you and give you a day off, and you will for those hours."* Similar to Nurse #6, their community healthcare centre has a 24-hour service. However, there is one nurse who indicated that she does not work overtime, even when their clinic does not have a night shift. In addition, of the two that stated: 'It depends,' one mentioned it can just be an hour, whereas Nurse #4 explained further, stating that: *"… because I can't leave the patient in the clinic if I call an ambulance. But I don't claim it as overtime, I take hours."* Furthermore, nurses were asked how many patients they were able to see in a day. One Nurse #9 explained that, per protocol, a nurse should see a maximum of 35 patients a day. Notwithstanding this, there are days when they exceed this number due to a shortage of staff and overcrowding in clinics. She further explained that "… *most patients are for chronic, they come to see a doctor to renew prescription medication."*

In most cases, the average number of patients that nurses see in a day is 50. During holidays (public, school, and festive) the clinics are overcrowded and the number increases to between 70 and 80. In one instance, there's a clinic that becomes extremely busy during those seasons and exceeds 300 patients a day,
Nurse #6 noted that they can attend to *"… around 300 in a day, and sometimes it's more, you'd find that we didn't record some on the system, so it could be more than 300, or maybe 200."* It's important to note that this clinic has a 24-hour service, and it is at the centre of the study area. Therefore, it provides care to a more extensive community. Nonetheless, it only has two or three nurses per shift. The day and night shifts vary in terms of patient numbers. Nurse #2 noted that *"for night shift maximum can be 10, sometimes you can spend the night without seeing a patient at all."* Day shifts are busier in this clinic, and this indicates that during the day, a single nurse can see a minimum of 90 patients. This, however, depends on the availability of nurses on duty. This exceeds the 35 patients per nurse protocol. Not even the healthcare centre with a large number of nurses and consulting rooms can attend to such a huge number

of patients. According to Nurse #8, the health care centre attends to a maximum of 175 patients on a busy day, including both day and night shifts.
Igumbor et al. (2016, p. 5) note that clinics with heavier workloads, as per patient headcount and staff levels, have fewer consultations in general as compared to those that have smaller workloads.

Furthermore, the clinics use an Electronic Tracking System (ETS) to record and manage headcount, ensuring accurate data. Despite this, Nurse #6 highlighted that sometimes they don't record all patients in the system; this is due to the lack of adequate computers or malfunctioning computers in the clinics.
Moreover, in focus group discussions with home-based care workers, it was noted that they are not always welcomed when they are on duty doing door-to-door services. Participant #3 in Focus Group #1 stated:

> *Challenges that we face are when we do door-to-door and find kids or teenagers, they give us attitude, some ensure that the elderly don't give us attention, some close the door and keep quiet, some chase us away or make their dogs chase us, or they tell us not to open the gate. Sometimes there's a sick person in the house, and you don't know when you initiate talking about HIV and educate one another, they just say in our house, we don't have an HIV patient, even when you try to educate, they refuse.* (#3).

In Focus Group #2, Participant #1 agreed, stating that *"… some don't welcome us nicely in their homes."*
According to Jacobs (2019; in Heggestad et al., 2020, p. 5), as a healthcare worker, when providing care to patients in their homes, you have to respect their autonomy by respecting their wishes.
Participant #2 added that "*another challenge is that some of our patients default, they just leave the area for some time and return in poor health, and we start from scratch."*
On the other hand, she narrated a different experience, highlighting that: *"We need transport because we walk long distances doing door to door. We walk for about 2 hours to get to some houses. We also have a shortage of medication for deliveries, vitamins for kids."*

Therefore, one of the indicators of defaulting related to TB patients is that clinics are 10 km or more from patients' place of residence (Elbereer et al., 2011; in Obeagu et al., 2023, p. 23). Home-based care workers visit patients' homes to ensure that they are taking their medications properly.

6.4.3.3 Challenges' Impact on staff and services

As much as the healthcare challenges affect patients, healthcare workers face even greater hurdles in delivering care, which negatively affects service delivery. The listed resource shortages (*see 6.4.3.1)* and the healthcare system and operational challenges mentioned in the previous section are among the contributing factors to the obstacles healthcare workers encounter during healthcare delivery. As such, they were asked how these challenges affect their ability to provide care, and the responses are as follows:

Nurse #2 narrated how the lack of water affected her personally:

> *They affect me because fetching water is not my scope of practice. The government needs to provide me with water, but it affects me because if I don't go to fetch the water, it means the patient won't take the scheduled doses. The person who is going to suffer is the patient. As a nurse, when I arrive, I have to go fetch the water, and mind you, when the patient has delivered, they need to go to the toilet to relieve themselves. For patients, it's not their duty to go fetch water to flush, do you understand? So that's the problem that we have on this side.* (#2).

Nurse #3 added that *"It affects us because after every 5 patients you must hand wash, so we compromise and use we use Degerm when we don't have water."*

The long working hours and attending to a significant number of patients per day have been highlighted as a major issue leading to burnout. Healthcare workers are notably the primary occupational group that is at high risk of developing burnout syndrome (Grochowska et al., 2018, p. 190). In support of this, Nurse #8 noted: "*Ratio of patients to staff is affected, one professional nurse sees more patients, that's overworking."*

Participant #1 in Focus Group 2 with nurses noted that "… eish, because we don't rest when you're supposed to knock off at half past 4, but there are still patients you can't knock off and tomorrow still you are required to be in on time, so you see you might end up not being effective."

The consequences of burnout affect healthcare workers physically, mentally, emotionally, and professionally, and also impact their family life. As a result, their environment is affected when they are experiencing burnout (Lewandowska & Letwin, 2009). Nurse #9 narrates how her mood changes when she is tired:

> *I get really tired when I have to come back to work the next day, my heart becomes heavy, I am too tired, and every small mistake annoys me, I become impatient, and am not effective. When a patient gets in here and forgets to close the door, I just look at them, and they would be surprised as to why I looked at them like that. It's because I am tired. The noise outside is too much. They talk too loudly, and they're going to say we don't talk to them with respect, we have an attitude, sometimes some patients visit other clinics, not this one, and decide to come here on a random day, and when you ask them why they came here, they tell you stories. That time, I was working alone, and I was tired*. (#9).

In my view, this is among the reasons why people say nurses have negative attitudes. An exhausted person can be easily irritated. Also, the prolonged work hours result in nurses being fatigued and being ineffective (Geiger-Brown & Trinkoff, 2010a; in Trinkoff et al., 2010, p. 1).

Participant #1 In Focus Group #1 with nurses shared a personal challenge that affects her life, stating that:

> *Another challenge is that for some of us who are not from the area and you want to transfer, that's a challenge, they are refusing to give me a transfer, it's a challenge for me because I have to sacrifice for my kids, but It means my kids are growing up without their mother being present, so I am raising the community whereas my kids are suffering, physiologically is affecting me*. (#1).

Furthermore, in Focus Group discussion #1 with home-based care workers, they mentioned that when they are doing door-to-door in Mashilabele village, which is the

only village that does not have a clinic in the area, they sometimes get stranded because they don't have a clinic nearby to go to. Participant #3 noted that:
"We don't have a place where we can sit, we were using the old Home Affairs, but now the Home Affairs is dilapidated, there's no roofing, no chairs, and when it's raining, we get stranded." This response indicates that the health and safety of the community workers is compromised.
Furthermore, in support of all these challenges that hurt healthcare professionals, Higuchi et al. (2002) state that the limited resources hinder healthcare workers' ability to provide care and meet patients' needs.

6.4.4 Medication and treatment delivery

South Africa's healthcare system has grappled with major challenges in the provision of medicines, as evidenced by the recurring stockouts across all nine provinces. This is emphasised by interprovincial discrepancies in the incidence, duration, and impacts of these stockouts, indicating the differences in the province's effectiveness in preventing, managing, and coping with these shortages (Hwang et al., 2019). According to the World Health Organisation, in public healthcare, the effectiveness of service delivery processes plays a role in shaping the pathway whereby medicines reach patients, along with the appropriateness of their prescription, dispensing, and usage (Bigdeli et al., 2014). They further emphasise that medication should always be available, affordable, and safe to consume (Bigdeli et al., 2014).

6.4.4.1 Availability and distribution of medicines

In interviews and focus group discussions with healthcare workers, they were asked questions regarding the supply of medication and whether the facilities receive medication on time. The responses varied; there were mixed perspectives on the delivery of medication. Nonetheless, the majority of the responses reflected that medicines are largely delivered on time, usually on Fridays or every fortnight. One interviewee mentioned that their clinic gets medication from Jane Furse Hospital, which is the nearest hospital in the area, and is responsible for the supply of medicines. A few respondents mentioned that medicines were not always delivered on time. Nurse #6 noted that:

Sometimes we receive them on time, and sometimes we don't. It's not an everyday thing where we receive them on time.

In terms of availability, Nurse #1 explained that "*they do deliver on time, but when a specific medication is not there, it means it's not there, and there's nothing we can do."* This confirms that there is an inadequate stock of certain medicines. Nurse #2 supported this by stating that:

> *Eish, this one is beyond us because of the tenders who deliver. When we have Lensaver, we don't have Panado; when we have Panado, we don't have Allergex, or we don't have the other medication, so they just change because the suppliers are not the same*. (#2).

Nurse #6 shared the same views, noting that:

> *Those without chronic illnesses receive treatment and medication. But sometimes you will find that the patient needs both Panado and Allergex, but we only have one item. We never send patients home, so we have some arrangements with other sisters. If we send you home, we'll definitely tell you to come back tomorrow, and you will get your medications*. (#6).

Moreover, nurses were also asked whether chronic patients receive their medication on time, and the same question was also directed at the patients to get insights from both the healthcare workers and patients. The non-chronic patients were not excluded. According to nurses, most patients receive their medication on time. Nurse #5 noted that: *"They do. The only challenge is that sometimes you will find that they are not all available - there is a shortage of one or two items for the patients."*

Nurse #2 added that *"… for medication, when we don't have omeprazole for ulcer patients."*

There is a process called Central Chronic Medicine Dispensing and Distribution (CCMDD), which is a type of medication delivery package for patients, allowing them to collect it at the nearest pick-up points (Louw et al. 2020, p. 51). Louw et al., in their study, explained this process, as illustrated in Figure 16 below.

Figure 20: The CCMDD (Centralised Chronic Medicine Dispensing and Distribution) Process

Source: Louw et al., (2020, p. 52)

Nurse #6 explained the chronic patient's medication treatment and the CCMDD process as follows:

> *Chronic patients start to receive their medication in the clinic, and we check their vitals. If they are stable, then we register them for CCDMDD. For example, the law says that for HIV-positive patients, before we register them on CCMDD, they must have three undetectable viral loads. We do a viral load every year, so for three years, it must show that the viral load is suppressed before we can register them for CCMDD*. (#6).

Nurse #9 added that:

> *Those who are not stable collect their medication in the clinic. Those who are stable - they deliver their medications in selected areas, which are shops or different pickup points. The nurses and home-based care deliver their medication. For non-chronic patients, they receive treatment and medication in the clinic, and since we have a pharmacist, we always have medication*. (#9).

However, Nurse #7 highlighted a challenge with the treatment of chronic patients due to inadequate staff, stating that:

> *When it comes to chronic, it becomes a challenge because we have to prioritise, and if there's just the two of us, we are unable to prioritise chronic patients. But with CCMDD, they get their medication and get their vitals checked. But sometimes, the elder ones get satisfied when they see the nurses, and according to the CCMDD, they are not even supposed to get their vitals checked - they just have to come to collect their medication and then come back after six months. For non-chronic, they get the care they need, and there's not always a shortage of medication*. (#7).

The CCMDD program reduces the long queues in clinics, and it also saves travel expenses for patients. As such, Nurse #8 highlighted that *"… the queues are not increasing because of the CCMDD procedure, and a booking process for chronic patients, even though our day-to-day patients come in numbers, but it's not bad. The doctors attend to patients with chronic illness, so it reduces the workload."* The healthcare centre has two doctors who take away some responsibilities from nurses and consult with chronic patients.

Therefore, according to patients with regard to medication and treatment, the responses reveal mixed perceptions related to medication availability, with some respondents receiving their medication regularly on time, while others encounter shortages.

Patients' responses to shortages of medication are as follows:

Patient #9 has hypertension and noted that:

> *… sometimes there's a shortage of medication even for chronic. There's nothing they do. Here is my medication, and it's not complete. There's one box I did not receive, so I only take these two for now. Sometimes they replace it with something else, sometimes they don't because of a shortage, so now I take only these two for my chronic. How will I get better?* (#9).

She further emphasised that *"… the department is failing us with our health. We don't have medical aids; we rely on these public clinics, but our chronic medications are not always complete."*

Patient #10 agreed on the lack of available medications, noting that: *"Not everything is always available, sometimes you might find that there is no Allergex or something else."*

In support of this, Patient #11 stated that: "Sometimes you can just get Panado only, because medication is not yet delivered."

Patient #2 added that

> *With medication, it never goes as expected. Sometimes, when you have the flu you will find that they don't have medication, and they will send you back home and advise you to use home remedies. And sometimes you would regret going to the clinic and could have used the money for transport to buy some medication*. (#2).

Two patients shared contrasting experiences, with patient #7 stating, *"I have never experienced shortages, even during December times like this. Sometimes they give us extra for January, so I will go to collect end of January."*

Patient #9 shared a similar experience, noting that *"I do get my medication even in December. They gave us double for other months."* Even so, this seems to be something that only happens in December.

Therefore, this is supported by Ndzamela and Burton (2020) who state that rural healthcare facilities experience frequent medicine stockouts. They further emphasised that medication for pain, dermatological and psychiatric conditions, chronic illnesses, antibiotics, and vaccines was often reported as not available (Ndzamela and Burton, 2020).

Furthermore, patients were asked whether the nurses explained how to store and use the medications, and they all responded with "Yes." And others highlighted that the descriptions are written on the packages for a reminder.

6.4.5 Strategies for improving healthcare delivery

6.4.5.1 Collaboration and resource sharing

The study area comprises eight healthcare facilities, and data were collected in seven facilities (six clinics and a community healthcare centre). Therefore, the study investigated how these facilities collaborate in terms of resource sharing and referrals. Collaboration between the facilities ensures that the communities receive quality care. As such, sharing of medication has been the key highlight, as medicine shortages have been identified as a significant challenge. The facilities have communication channels where they report the issues they are experiencing in order to get support from others. Nurse #9 shared her narrative as follows:

"We have SVS groups where we report availability or drugs and refer patients."

Nurse #8 further explained the communication channels and the referral process, stating:

> *We have WhatsApp groups for the local areas, and Geographic Service Area (GSA), GSA means if the clinics fall under Jane Furse hospital, they fall under the same umbrella. If there's a patient I have to refer to another clinic, I give the patient a referral letter, call the colleague and let them know I'm referring a patient, and also, I do a follow-up to check if the patient got there*. (#8).

In terms of medicine sharing, Nurse #7 highlighted that *"we ask for medication, and every week we report our medication. If we have extra, we rotate the stock. If they have a mass supply, they give us medication."*

Nurse #2 agreed, stating that

> *We communicate. Last Tuesday night, the other clinic was working and didn't have Oxytocin. They called us and said, "Do you have Oxytocin? We want to deliver, and we said yes. Let me call the EMS and ask if they can bring it that side, so we can share.* (#2).

The collaboration between the facilities is important for patients to receive care at all times.

6.4.5.2 Optimising Service Delivery

Healthcare workers were asked to share suggestions for service delivery improvement. The increment of staff was a recurring highlight. As such, the nurse's narratives were as follows:

Nurse #1 noted:

> *To have more staff so we can render a 24-hour service. There are some services that we would like to render, but we are unable to because, for instance, if a pregnant woman arrives at 4 pm and we knock off at 6 pm, it means we have to call the ambulance to come to take the patient to the hospital. So, you no longer prioritise the patient because now you are also exhausted, and you want to knock off at 6 pm. You see, for the facility to have improvement, they must hire more staff, so that services will be improved*. (#1).

Nurse #5 added that they should *"… increase the staff for our 24 hours to be sustainable because sometimes you will find that there's no one on standby for overnight. And midwives, there's a huge shortage".*

Nurse #6 agreed that the staff must be increased. She noted that *"… consulting rooms are three here, there should be three sisters, staff should be increased".*

Nurse #8 further highlighted that the department should

> *…fill the posts because people are leaving, but when it comes to replacement, there is no balance. Another thing is that they should increase our nurses because our patients in here suffer; our nurses do on call at the hospital, they look at the fact that we have doctors in the healthcare centre, but our doctors don't work at night* (#8).

Despite all the suggestions, one nurse in a focus group discussion shared that *"We don't have hope anymore. We have unions, so our suggestions are communicated through unions, but it means they are failing, because how do we function with this shortage?"*

Her narrative revealed that nurses are raising concerns, but there is still no improvement.

Nurse #2 noted that there is a need to increase staff, and further expand on health education, stating that:

> *For patients with chronic, let's say you are diagnosed with HIV and you are taking the medication properly, and they told you there is this pastor, and you no longer taking the medication, when you come back this side you have defaulted, so one thing I have realised is that, if we had enough staff, we could go to the villages and tell them about health education. We could go to schools because, in grade 9, they are active, you know. We were going to improve; we were going to kill this disease. Sometimes people don't have food or money, so we can intervene and refer to social workers. For patients with chronic conditions, when they default. There's a reason behind it; they don't have the knowledge about the disease.* (#2).

The importance of healthcare education is vital for achieving health security. It is a lack of knowledge that prevents people from making informed decisions about their well-being. Teaching people about diseases, infections, gestation periods, among others, enables them to adopt healthy lifestyles. Therefore, this will decrease the rate of teenage pregnancy, as well as the HIV infection rate, especially among teenagers. It is rising at an alarming rate. As the nurse mentioned, parents do not talk to their children about sexual and reproductive health, so having people to teach these teenagers about teenage pregnancy and HIV/ AIDS will raise awareness. It commonly appears as if people know these things, but there are still people who are clueless about such topics.

Patients were also asked what changes they would like to see in the facilities to improve service delivery. They highlighted that more staff is needed, but not only the nurses, but also the need to hire more cleaners, as well as at least one doctor per clinic. Patients noted the need to have a doctor present in the clinics, not only to visit on certain days. In addition, more clinics are needed.

Furthermore, home-based workers highlighted the importance of having transport for door-to-door services, as well as having cell phones. These are the resources they need to enhance their community work.

To sum up, in the context of healthcare, healthcare workers, infrastructure, and other essential resources are limited (Khatib, 2024, p. 2267). In terms of healthcare workforce per capita, South Africa is outpacing the rest of the African continent (Solidarity Research Institute, 2009, p. 3). Even so, the shortage of healthcare workers in the country is a key issue. The National Department of Health (n.d, p. 4) highlights the following factors that contribute to the shortage:

- A growing population
- Retirement of experienced nurses
- Persistence of undesirable working conditions
- Average salaries

6.5 Conclusion

This chapter presented the findings from semi-structured interviews and focus group discussions with healthcare workers and patients concerning access to quality healthcare, challenges with healthcare systems, and how they affect service delivery. Key themes were interpreted, and major challenges in healthcare were elaborated on through narratives of resource shortages in the facilities by healthcare workers. How these shortages hinder their abilities to provide quality care was discussed in some detail. Therefore, the lack of adequate resources in the healthcare facilities and the lack of adequate healthcare facilities, affect the healthcare systems to achieve comprehensive health security for the people

CHAPTER 7
SUMMARY OF THE FINDINGS, CONCLUSION AND RECCOMMENDATIONS

This chapter presents an overview of the study, which aimed to explore the role public healthcare facilities play in improving the health security of impoverished people of the Fetakgomo Municipal area. The research focused on healthcare access and service delivery, including quality of care, availability of equipment and medical supplies, staffing, and infrastructure. The purpose of the study was to assess healthcare access, the challenges faced by healthcare facilities and their impact on service delivery, as well as the strategies in place to address these challenges, and how they affect the population, to recommend possible solutions.

The chapter summarises the research findings that are aligned with the objectives of the study. Recommendations are made to inform future research, and conclusions are drawn from the literature and insights from the study's participants.

7.1 What services are delivered by the public healthcare facilities in Fetakgomo Tubatse Local Municipality?

This research question addressed the first research objective, which was to explore and describe the delivery of healthcare services in facilities in Fetakgomo Tubatse Local Municipality. Health service delivery is defined as the provision of services in terms of human resources, funding, supply chain, and procurement that results in direct output of different inputs into the healthcare system (WHO, 2010). Papanicolas et al. (2022) further explain that the intermediate objectives of health services are "… effectiveness, safety, user experience, efficiency, and equity of service delivery."

Health services offered in the healthcare facilities include maternal and childcare, minor and chronic illnesses, immunisation, family planning, antenatal care, reproductive health, treatment of minor emergencies, health and related issues common to adolescents and youth, and emergency deliveries. Other services that are not offered in the clinics but in the community healthcare centre include circumcision, dentistry, psychiatry, and dietetics although one of the clinics in the area has a dietician

providing dietetic services. The facilities provide general services for the communities except for those more serious cases, such as specialised and major emergency care, which are treated in hospitals.

The service delivery in the seven facilities selected for this study while remaining effective, shows potential for improvement. One of the challenges that emerged from the interviews was the geographical distance to healthcare services. Travelling to the clinics did pose challenges for the majority of the people. This indicates that there is a sufficient number of facilities in the area, with one clinic in each village and one village without a clinic. The residents of the village without a clinic are required to go to the nearest clinic in another village. Those who live closer to the clinics have convenient access to healthcare services. Others who live further away incur transport costs. Yet there are others walk long distances to access care because they cannot afford the transport costs. This is extremely difficult for those who are not physically well.

Another primary issue is the limited availability of a 24-hour service facility. The majority of the clinics are not operational day and night, on weekends, and during public holidays. The two facilities that have a 24-hour service are moderately close to one another; people from areas that are far from these two facilities do not have easy access to a 24-hour healthcare service. Therefore, this results in a gap in healthcare service delivery. Nonetheless, three facilities have an on-call system where a nurse is on standby in the clinic at night. According to Hospicare (2016), the principal duty of an on-call nurse implies working after hours, night shifts, during weekends and public holidays, performing standard responsibilities such as attending to patients and caregivers, referring patients when needed, and responding to injuries. In contrast, based on the findings of this study, the on-call nurses only work at night, and some nurses are requested to work on weekends and public holidays during the day as overtime duty.

In the interviews and focus group discussions, the nurses explained that the staff shortage is the cause of the gap in service delivery because there are not enough nurses to rotate for different shifts. Other reasons include infrastructure challenges as one nurse explained that in their clinic, they had to reduce operational capacity over the years owing to poor infrastructure.

Despite encountering these challenges, each healthcare facility has a minimum of 15 community workers, known as home-based care workers, to enhance healthcare service delivery. The availability of home-based care workers enhances the accessibility of healthcare services, particularly for people living with chronic illnesses. They also play a vital role in child immunisation as they ensure that their records are in order. Although their scope of services is limited to these specific health issues, they enhance access to services for some individuals.

Public healthcare is free of charge; however, it was discovered that there were unforeseen expenses, such as ambulance fees. It seems that people are not aware that ambulances are not free, and this is a high, unexpected cost for patients to incur when they need the services.

7.2 What are the challenges of public healthcare delivery in Fetakgomo Tubatse Local Municipality?

The study's objective in this section was: To examine the challenges of public health delivery in Fetakgomo Tubatse Local Municipality.

The findings of the research revealed numerous systematic and operational challenges that healthcare facilities face in the Fetakgomo Municipal area. It was discovered that insufficient resources are a major constraint to providing quality care for the people. The availability of nurses in facilities determine the standard of service delivery. As such, the shortage of staff, particularly nurses and pharmacists has been the greatest hurdle. The demand for healthcare services is rapidly increasing and therefore, this places a lot of additional pressure on the nurses on duty. The issue becomes worse when nurses are transferred or resign; The department does not replace them and their posts remain unfilled. This results in the workload of the remaining nurses being increased. It reaches a stage where one nurse can see twice the number of cases during peak seasons such as festive seasons or school holidays. This results in nurses working overtime. Often, they are not remunerated for their overtime. Owing to their working long hours they experience burnout. This affects their physical and emotional well-being, the quality of patient care, and it often appears as though they have a negative attitude. An exhausted person cannot work effectively. They do not have enough time to rest and rest for the next day of work. They are constantly tired.

It is not only that these nurses work long hours, but they also work with limited medical equipment and supplies, shortages of medicines, stationery, and computers, which are often faulty, resulting in inaccurate patient records.

Some work in environments where there is a lack of water, poor infrastructure, which might be dilapidated, and no electricity. The lack of water at a facility impacts on its ability to maintain hygiene as per protocol. Nurses should wash their hands after every five patients, but they cannot observe this protocol. To make matters worse, sometimes they see between 50 to 90 patients daily, placing themselves and their patients at risk. t This situation is unacceptable.

Therefore, this resource limitation affects patient care and hinders service delivery. This becomes evident in the patients' feedback as many are dissatisfied with their services. Nevertheless, patients understand the driving force behind the poor services as they mentioned that they were aware that it is beyond the nurse's control. For instance, the time that the ambulance takes to get to the facility when it has been called out may be too long, and they know that the nurse's fault. Ambulances taking too long to arrive at the facility puts people's lives and well-being at risk. Also, these inefficiencies worsen the burden on the nurses. The home-based carers are included as they also experience challenges with medication shortages, poor working environments, and have to buy their own stationery, which many patients may not be able to afford.

7.3 What are the management strategies employed by public health facilities to improve health security?

The objective: To develop management strategies for public health facilities to improve health security.

During interviews and focus group discussions with healthcare workers, the strategies aimed at improving healthcare delivery were investigated. As such, collaboration and resource sharing among healthcare facilities were identified as pivotal approaches.

This study revealed that the healthcare facilities worked together to fight the challenges they encountered to ensure that they provided high quality services for their patients. They shared resources, particularly medicines, and assisted one another in patient referrals.

One of the primary management strategies that was identified included methods of communication, such as WhatsApp groups, which allowed healthcare workers to report issues such as medication shortages, or when a clinic had a mass supply of medicine to share with other clinics that were low on medicines. They themselves rotated medications internally to address the issue of medication shortages. As such, these collaborations indicate that their priority is to improve their capacity to offer quality care to the people and maintain good service delivery. This contributed to the overall advancement of health security.

7.4 What are the strategies employed by public healthcare officials in Fetakgomo Tubatse Municipality to respond to potential health emergencies?

The healthcare facilities have adopted strategies to respond to emergencies, and these strategies were explored in this study.

As such, protocols to manage health emergencies were discovered, as well as the challenges healthcare workers faced during those emergencies. Interviews and focus group discussions with nurses identified potential health emergencies such as minor and major injuries, violence or trauma-related emergencies, childbirth, and accidents.

The facilities have emergency rooms; however, only a few of them have adequate medical equipment. In the event that handling the emergency was beyond their control, they focused on stabilising the patient(s) and referring them to a hospital of their own. Therefore, they assessed each emergency and treated it depending on its severity. The facilities have a triaging system, which is explained by the Western Cape Health Government and Emergency Medicine Society of South Africa (EMSSA) as patient-to-triage and triage-to-patient. Patient-to-triage is when a patient arrives at a clinic stable but is assessed as being urgent, and triage-to-patient is when a patient requires an urgent medical response and may need to be referred to a resuscitation

area (Western Cape Health Government & EMSSA, 2012, p. 3). As such, the resuscitation area in the facilities is the emergency room.

The nurses also use an emergency department file to consult for guidance on how to deal with different emergencies. This allows them to know whether it is an emergency they can handle or if it needs a referral. In cases where it is an emergency within their capacity, sometimes all nurses are required to attend to it. This may be due to the lack of adequate staff. In some cases, when there is a shortage of nurses, they are required to request assistance from general workers to assist them in an emergency. Another major issue is the shortage of ambulances, which results in delays during an emergency crisis. This is alarming because the ambulance can take up to three hours, which poses a threat to lives for emergencies that require immediate medical attention.

Another challenge in dealing with emergencies is that other patients are neglected. This results in people leaving the clinic without receiving the care they need. Therefore, the strategies to respond to health emergencies have weaknesses and strengths. The findings show that emergency management is moderately effective.

7.5 What measures are in place for alleviating the challenges public healthcare facilities face in order to guarantee health security?

Another objective of the study was to develop measures to alleviate the challenges public healthcare facilities face to guarantee health security. As such, the clinics have doctors doing rotational visits. Although it was highlighted that there is a need for a full-time doctor in each clinic. In my view, this is unrealistic because the Department of Health might not have a budget for that. They are already struggling to hire more nurses in the clinics; therefore, hiring doctors full-time might not work as doctors earn more than nurses. A substitute method would be to train nurses for specialised healthcare services. In addition, home-based care workers who are already employed to provide care for patients at their place of residence can also be trained to offer more services. One of the hurdles that home-based care workers face is that they are required to walk long distances, covering a wider community when doing their residential visits. Having a means of transport would be beneficial to them, and they are also required to have cell phones for communication.

An additional initiative would be to introduce health education campaigns, for example, an integrated HIV/AIDS program, or on teenage pregnancy. These will assist in raising awareness. The programmes could be executed in schools, community centres, or through handing out pamphlets.

The findings of the study have significant implications for both public healthcare and Development Studies. From a public healthcare perspective, the challenges that facilities encounter, as identified in the study, such as shortages of resources, dilapidated infrastructure, and a lack of medical equipment and supplies, reveal weak public health systems, particularly in Fetakgomo, undermining the quality of healthcare service delivery. These barriers point out areas that require immediate intervention to enhance service delivery and ensure better healthcare access to underserved communities. To improve service delivery and the allocation of resources, collaborative management initiatives are needed in developing and implementing interventions that will enhance service quality (Malematja et al., 2025, p.1).

In terms of Development Studies, the findings contribute to the discipline by providing Insights on how public healthcare measures can address social challenges. For instance, access to quality healthcare for all influences equality and equity, promotes well-being for vulnerable populations, and supports poverty alleviation and sustainable development.

The findings are expected to contribute to the advancement, awareness, and comprehension of the role management of the facilities play in ensuring effective healthcare provision and that vulnerable populations have access to public healthcare services. Furthermore, this study greatly contributes to the achievement of public health and provides nuances and understanding on the strides, challenges and way forward for attaining health for all and ultimately contributing to broader discussions on public healthcare, sustainable development and poverty alleviation in South Africa, as well as to the current policy dialogue and serve as a foundation for proven methods aimed at enhancing healthcare security for the impoverished people and assisting the country to achieve universal health coverage.

7.6 Recommendations

The recommendations presented are formulated from the findings of the study and are directed to the Government, the Department of Health, the District, and Local Municipalities. These recommendations are in line with the Republic of South Africa's National Health Insurance (NHI), which aims to:

> … *achieve universal access to quality health care services in the Republic in accordance with section 27 of the Constitution; to establish a National Health Insurance Fund and to set out its powers, functions and governance structures; to provide a framework for the strategic purchasing of health care services by the Fund on behalf of users; to create mechanisms for the equitable, effective and efficient utilisation of the resources of the Fund to meet the health needs of the population; to preclude or limit undesirable, unethical and unlawful practices in relation to the Fund and its users; and to provide for matters connected herewith*" (The Republic South African's NHI Bill, 2019, p. 2).

The recommendations are detailed as follows:

7.6.1 Recommendations for expanding staff in healthcare facilities

It is recommended that the government and/or the National Department of Health hire more nurses in the healthcare facilities to reduce the heavy workload on nurses in order to enhance service delivery. Efficient service delivery yields health security.

It is also recommended that the district health management hire a pharmacist and/or pharmacy assistant in each facility for the purpose of ordering and dispensing medication. This also reduces the workload on the nurses, as some of them perform the duties of a pharmacist in the clinics.

7.6.2 Recommendations for mobile clinics

It is recommended that the Limpopo Provincial Department of Health and/or Sekhukhune district health officials ensure that underserved areas have mobile clinics to cover the broader population. This will alleviate financial burdens for people who travel long distances to reach healthcare facilities.

7.6.3 Recommendations for Emergency Medical Response (EMS) and ambulance services

It is recommended that the Limpopo Provincial Department of Health (EMS Division) increase ambulances to cater for the Sekhukhune District, which is considerably big, with several healthcare facilities. The shortage of ambulances results in low response rate during critical emergencies, putting people's lives at risk. The whole District relies on a few available ambulances.

7.6.4 Recommendations to build more healthcare facilities in underserved areas and improve facility structures

It is recommended that the National and/or Limpopo Provincial Department of Health build more clinics, especially in Mashilabele village because the area does not have a clinic. This area must be a priority. Moreover, additional clinics must be built in the villages; having at least two clinics in each village would cover the population and alleviate the financial burden of travel costs and community members needing to walk long distances to access healthcare services.

It is also recommended that maintenance be prioritised in the healthcare facilities. Some clinic buildings are dilapidated. The poor water infrastructure should also be fixed.

7.6.5 Recommendations for community outreach and health education

It is recommended that the Limpopo Department of Health and Sekhukhune district officials implement health education programmes. Community workers are available for door-to-door services; therefore, their services can be expanded to teach communities about teenage pregnancy and HIV & AIDS prevention and management for those who are already positive. They already have programmes for TB and sometimes HIV; however, they are focused mainly on adults. These services could be expanded to teenagers as well. The outreach programmes should be done in schools as well by both the community workers and nurses.

7.6.7 Recommendations for Medical Equipment

It is recommended that the Limpopo Provincial Department of Health, including supply chain units, supply each with at least an X-ray and a sonar machine. These two equipment are needed the most in the clinics, and having them in the clinics will assist in minimising referrals that do not require specialist medical attention. For example, referring a pregnant patient solely for a sonar scan will incur financial costs for the patient.

7.6.8 Recommendations for healthcare funding

It is recommended that the National and/or Limpopo Provincial Treasury provide funding to healthcare facilities in Fetakgomo to assist with infrastructure improvement, medical equipment, and medicines, as well as hiring more staff.

7.6.9 Recommendations for future research

Widen the geographical scope of the study: Future research could include additional provinces or regions to determine whether the challenges identified in this study are consistent across different contexts.

Investigate new or unresolved issues: Some themes that emerged during data collection were beyond the scope of this study. These could be explored further to develop a more comprehensive understanding of healthcare access.

Adopt alternative research approaches: While this study used a qualitative method, future research could incorporate quantitative or mixed-method designs to validate findings or uncover new patterns.

Examine specific population groups: Further studies could focus on how certain groups such as the elderly, youth, or people with disabilities, experience access to public health services.

Reapply or extend the theoretical framework: The theoretical lens used in this study could be applied to different sectors or policy areas, allowing researchers to test its relevance and adaptability.

Evaluate practical interventions: Research could be directed toward assessing the effectiveness of specific interventions, such as transport initiatives or extended clinic hours, aimed at improving service delivery.

Strengthen policy-related insights: Future work may explore how policy decisions influence the availability and quality of public healthcare, particularly in underserved areas.

7.7 Conclusion

The study analysed the role of public healthcare facilities in improving the health security of impoverished people within the Fetakgomo Tubatse Municipality, with a focus only on the Fetakgomo Municipal area. The study area was rural in nature, and therefore, challenges related to healthcare accessibility and service delivery were examined. Therefore, this research adds to the body of knowledge by offering empirical findings focused on systematic and operational challenges encountered by healthcare facilities within rural communities to achieve health security for their people. Distinct from other national studies conducted on achieving healthcare, this research provides a comprehensive analysis of how challenges to access and service delivery in healthcare emerge in environments with limited resources, such as rural areas, as which are given less attention than townships and cities. As such, the findings of the study will inform policymakers in healthcare to develop measures that will enhance rural healthcare in terms of systematic operations, infrastructure development, and funding.

The Batho Pele Principles were used as an analytical tool to support patient-centered care, exploring whether healthcare is accessible, equitable, available, and affordable. Therefore, the findings identified ‘access’ as a significant challenge due to inadequate healthcare facilities. In addition, service standards were defined by the lack of resources, which affects service delivery. The findings indicated that the level of quality care provided in the facilities is moderate due to challenges with medication availability, long waiting periods, and a shortage of staff that results in inconsistent 24-hour service provision. Therefore, there is room for improvement. Furthermore, the Batho Pele Principles’ concepts of openness and transparency were not followed by some of the nurses who did not wear their name tags or turned them back to front, so patients did not see their names. This showed a lack of transparency in the facilities.
Moreover, the study utilised the Donabedian Model, which outlined the framework for healthcare facilities in terms of the structure, which outlines the resource availability;

the process, providing an overview of the consultations, treatment, and referrals, among others; and lastly the outcome, which is patient care satisfaction. The findings presented valuable insights into the role these facilities play in providing quality care for underprivileged populations. They indicated numerous challenges, including infrastructure issues, such as dilapidated buildings and container usage to provide care, as well as limited medical equipment and supplies, which fall under the structure component. As such, infrastructure development and resource allocation are required to enable the facilities to provide quality care. Furthermore, the long waiting times indicate poor management. This is due to inadequate staff, poor file management which delays patients, nurses spending a considerable amount of time on phones calls, as well as team meetings that take place while patients are waiting to be attended.

Therefore, the structure and process components of the facilities are proven to have weaknesses that affect both healthcare workers and patients, ultimately leading to poor health outcomes. Despite the weaknesses, the study encountered high patient satisfaction with the service delivery. Although they raised concerns, they did not entirely blame the nurses for poor services but rather provided encouraging feedback for the department, such as hiring more nurses in the facilities.

The biggest shortfall of the healthcare facilities was the workforce shortages, which greatly affected service delivery. Therefore, these emerged as recommendations, and implementing the interventions will enable the facilities to provide communities with the required healthcare needs.

Furthermore, there is a need for policy interventions in healthcare systems to enable facilities to narrow down the quality care provision gap that already exists. This study contributes to the current policy dialogue and serves as a foundation for proven methods aimed at enhancing healthcare security for the impoverished people and assisting South Africa to achieve universal health coverage.

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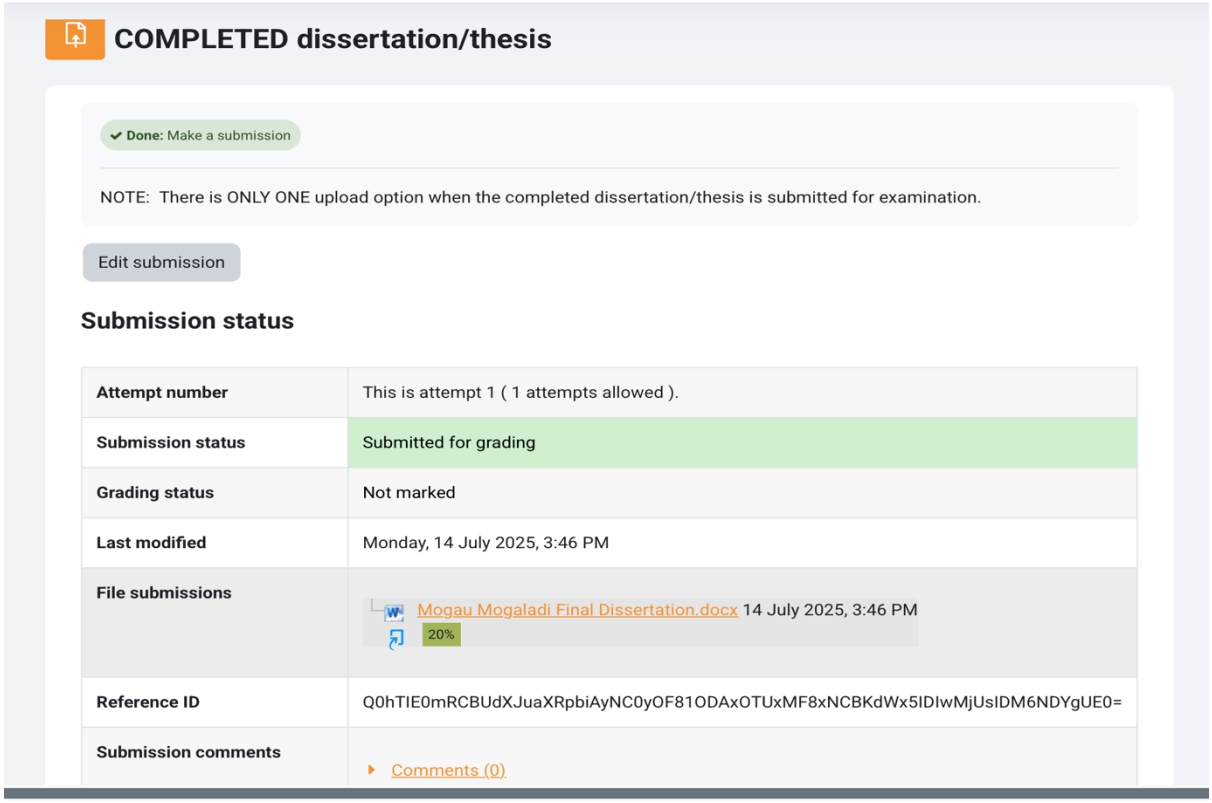
APPENDICES

Appendix A: Turnitin Similarity Index Report



COMPLETED dissertation/thesis

Done: Make a submission

NOTE: There is ONLY ONE upload option when the completed dissertation/thesis is submitted for examination.

Edit submission

Submission status

Attempt number	This is attempt 1 (1 attempts allowed).
Submission status	Submitted for grading
Grading status	Not marked
Last modified	Monday, 14 July 2025, 3:46 PM
File submissions	Mogau Mogaladi Final Dissertation.docx 14 July 2025, 3:46 PM 20%
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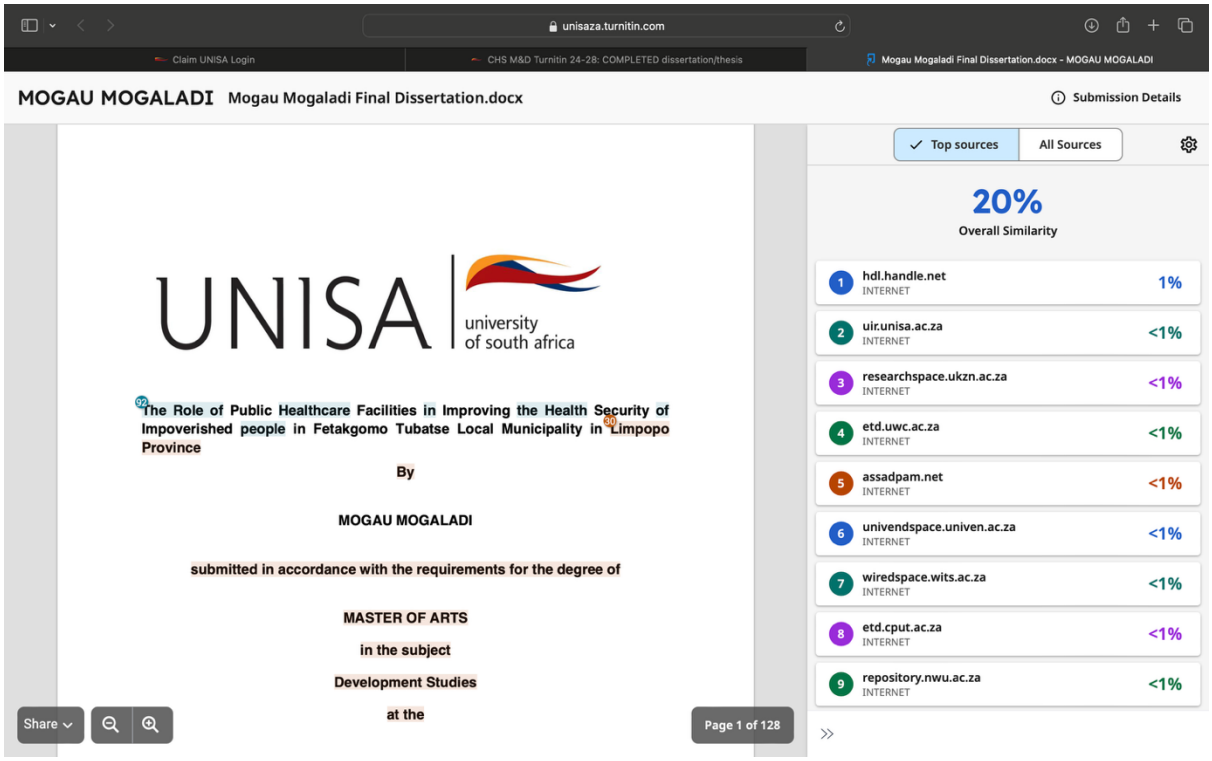


Appendix B: Interview Instruments and Focus Group Guide

Interview Instrument: HealthCare Workers

Name of Interviewee/s	
Designation	
Age	
Gender	

Interview Questions

Background:

1. Can you describe your role and responsibilities in this facility?
   1.1. How many hours do you work?
   1.2. Do you work overtime? If yes for how many hours?

Facility:

2. What type of services do you offer in this facility?
   2.1. How does the facility ensure healthcare is accessible?
   2.2. Do you have 24-hour services?

3. How many healthcare workers are working in this facility?
   3.1. How many patients are you able to assist in 1 day at maximum?

4. Does the facility receive medication orders on time?
   4.1. How do you manage chronic patients, including those enrolled in the CCMDD program, compared to non-chronic patients? Can you describe any specific processes, challenges, or strategies involved in providing care to these different groups of patients?

4.2. Do you have all the necessary resources? (Human resources, equipment, infrastructure, water, etc)

4.3. How do you collaborate with other facilities to ensure continuity and quality of care for patients? Can you describe the methods of communication, coordination, or resource sharing that are involved in these collaborations?

Healthcare emergencies:

5. How do you handle minor and major healthcare emergencies from the moment they arrive at your facility until the referral process is initiated, if required? Can you explain the protocols, resources, or challenges involved in managing these situations? Are there any specific strategies you use to prioritize care or ensure timely referrals?

   5.1. What challenges do you face during a health emergency? (E.g. ambulance, lack of resources)

Challenges:

6. Were there any challenges or barriers that limited your experience or outcomes when providing care?

   6.1 How did those challenges affect you as a health professional?

Personal insights or recommendations:

7. What is your opinion about the services provided at your facility? share your views of the quality of care

   7.1. Looking back, is the facility improving or not? Can you share any positive or negative changes?

8. What are your suggestions for improvement, or any recommendations you have to enhance the quality or accessibility of care?

Interview Instrument: Patients/community members

Name of Interviewee/s and demographics	
Age	
Gender	
Employment Status	

Interview Questions

Background:

1. is healthcare/ healthcare facilities accessible?
    1.1. How much time do you take to get to the facility?

Facility:

2. What kind of services do you use?
    2.1. Do you understand the language used?
    2.2. Is the facility clean?
    2.3. Do you get addressed properly by your name?
    2.4. Does the person attend to you have a name tag?
    2.5. How long do you wait to be seen by a nurse?
    2.6. Do healthcare workers (nurses, doctors, councillors etc.) treat you with respect?
    2.7. Do you get your medication on time or is the medication always available?
    2.8. Do they explain how to use the medication or how to be stored?
    2.9. Do you think the clinic meets the needs of the community? Explain?
    2.10. How satisfied are you with the services provided by the clinic?
    2.11. Are nurses competent with their job?

Challenges:

3. What problems/challenges have you experienced in the clinic(s)?

   3.1. how did these problems affect your health or access to services?

Personal Experience and Health Emergencies:

4. Can you share a personal experience you had in this facility, positive/negative?

   4.1. How do you think the clinic handle health emergencies?

Perceptions and Recommendations:

5. What do you like/dislike about the facility?

   5.1 What changes would you like to see in this facility? Suggestions for improvement? ?

Focus Group Discussion Guide

1. Introductions and demographics
   - Number of participants and names
   - Age
   - Gender
   - Designation
   - Location/name of facility

2. Roles and facility
   - Working hours (including overtime) and workload
   - Roles and responsibilities
   - Number of healthcare workers are working in the facility
3. Access and service delivery
   - Services offered (including 24-hour services)
   - Availability of necessary equipment
   - Affordability of care and access

4. Medication and chronic care
    - Arrival of medication on time and distribution
    - Availability of medicine for chronic patients, and timely distribution
5. Challenges and Emergency Care
    - Biggest challenges when delivering care
    - Impact of challenges on healthcare personnel and service delivery
    - Health emergency response/management
6. Collaboration and resource
    - Collaboration with other clinics when in need or resources/referrals etc.
    - Type of resources needed to improve service delivery
7. Options and Recommendations
    - Opinions on the service delivery provided in the facility
    - Suggestions for improvement
    - Share any positive/negative changes you have observed in the facility - whether its deteriorating or improving

Appendix C: Consent Form

CONSENT TO PARTICIPATE IN THIS STUDY

I, _____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the <insert specific data collection method>.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname…… (please print)

Participant Signature……..Date……

Researcher's Name & Surname……(please print)

Researcher's signature……..Date……

Appendix D: Ethical Clearance Certificate

UNISA university of south africa

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

06 June 2024

NHREC Registration # :
Rec-240816-052
CREC Reference # :
58019510_CREC_CHS_2024

Dear Ms Mogau Mogaladi

Decision:
Ethics Approval from 06 June 2024 to 05 June 2025

Researcher(s): Name: Ms. M. Mogaladi
Contact details: 58019510@mylife.unisa.ac.za
Supervisor(s): Name: Dr. S. Ehiane
Contact details: stanleyehiane@yahoo.com

Title: The Role of Public Healthcare Facilities in Improving the Health Security of Impoverished People in Fetakgomo-Tubatse Local Municipality in Limpopo Province.

Degree Purpose: Masters

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for one year.

The ***low-risk application*** *was reviewed by* College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date **(05 June 2025).** Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

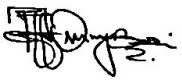
Note:

*The reference number **58019510_CREC_CHS_2024** should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signature: 

Prof. KB Khan
CHS Research Ethics Committee Chairperson
Email: khankb@unisa.ac.za
Tel: (012) 429 8210



Signature: PP

Prof ZZ Nkosi
Exécutive Dean: CHS
E-mail: nkosizz@unisa.ac.za
Tel: 012 429 6758

Appendix E: Limpopo Provincial Department of Health Approval Letter

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
HEALTH

Ref : LP_2024-09-013
Enquires : Legodi P
Tel : 015-293 6028/6410
Email : Malesela.Legodi@dhsd.limpopo.gov.za

MOGAU MOGALADI
CC: UNIVERSITY TO ENSURE COMPLIANCE WITH CLAUSE 2d OF THIS APPROVAL LETTER

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below**;**

THE ROLE OF PUBLIC HEALTHCARE FACILITIES IN IMPROVING THE HEALTH SECURITY OF IMPOVERISHED PEOPLE IN FETAKGOMO TUBATSE LOCAL MUNICIPALITY IN LIMPOPO PROVINCE

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
    a. Present this letter of permission to the office of District Executive Manager a week before the study is conducted.
    b. This permission is **ONLY** for Ikageng Clinic; Mankotsane Clinic; Mohlaletse Clinic; Nchabeleng CHC; Nkoana Clinic; Phaahlamanoge Clinic; Seroka Clinic
    c. In the course of your study, there should be no action that disrupts the routine services or incur any cost on the Department.
    d. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
    e. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
    f. **The approval is only valid for a 1-year period.**
    g. If the proposal has been amended, a new approval should be sought from the Department of Health
    h. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.

pp **Head of Department** 5/11/2024 **Date**

Appendix F: Sekhukhune District Department of Health Approval Letter

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
SEKHUKHUNE DISTRICT

Ref: 5/3/1
Enq: Mogano K.N.M
Tel: 0156332353
E-mail: Norman.Mogano@dhsd.limpopo.gov.za

DEPARTMENT OF HEALTH
SEKHUKHUNE DISTRICT OFFICE
HRD SECTION
08 JAN 2025
PRIVATE BAG X04
CHUENESPOORT 0745
LIMPOPO PROVINCE

TO : DISTRICT EXECUTIVE MANAGER

FROM: HUMAN RESOURCE DEVELOPMENT

SUBJECT: PERMISSION TO CONDUCT RESEARCH OF PUBLIC HEALTHCARE FACILITIES IN IMPROVING THE HEALTH SECURITY OF IMPROVISHED PEOPLE ON FETA KGOMO TUBATSE LOCAL MUNICIPALITY IN LIMPOPO PROVINCE

The above matter bears reference.

1. The Head of Department of Health, Limpopo Province has approved a request to conduct research in our institution in respect of **Ms M Mogaladi** and therefore we request District Executive Manager for Sekhukhune District to grant approval to the applicant to collect data.
2. The research is valid for a period of 1 year and the collected findings from your facilities will be kept confidential and also will not be made available for public use by the researcher.
3. During assumption of research, **Ms M Mogaladi** will present her scope of work and the schedule on how she is going to collect data to the Local Area Manager.
4. The District Human Resource Development request that approval be granted for above mention to Conduct Research at Ikageng Clinic, Mankotsane Clinic, Mohlaletse Clinic and Nchabeleng CHC, Nkoana Clinic, Phaahlamanoge Clinic, Seroka Clinic.

APPROVED | NOT APPROVED

District Executive Manager
Mrs Ralefe MS

Date

Appendix G: Certificate from a professional editor/proof-reader

Barbara Dupont Editing Services

37A Hilltop Road
Hillcrest
KwaZulu-Natal
South Africa
3610
Cell No: 0846668351

25th July 2025

To Whom It May Concern

EDITING OF ACADEMIC THESIS

I hereby confirm that I, Barbara Dupont, edited the master's thesis written by Mogau Mogaladi titled '**The Role of Public Healthcare Facilities in Improving the Health Security of Impoverished people in Fetakgomo Tubatse Local Municipality in Limpopo Province**' and commented on the grammatical anomalies in MS Word Track Changes and review mode by the insertion of comment balloons prior to returning the document to the author. Corrections were made in respect of grammar, punctuation, spelling, syntax, tense, and language usage as well as to sense and flow. Reference guidelines and additional comments were provided to assist with corrections.

I have been teaching English for the past 13 years and have a Cambridge CELTA diploma in teaching English as a foreign language. I am also employed by the British Council as an official IELTS speaking test examiner for their Global Hub. I have been editing academic and other documents for the past ten years, regularly editing the research dissertations, articles and theses of the School of Nursing, Environmental Studies and various other schools and disciplines at the University of KwaZulu-Natal and other institutions, as well as editing for publishing firms and private individuals on a contract basis.

I trust that this document will prove acceptable in terms of editing criteria.

Yours faithfully

B Dupont

Barbara Dupont

Address: 37a Hilltop Road, Hillcrest, 3610
Contact Number: 0846668351