

**THE RIGHTS-BASED APPROACH TO DEVELOPMENT: ACCESS TO HEALTH  
CARE SERVICES AT RATSHAATSHA COMMUNITY HEALTH CENTRE IN  
BLOUBERG MUNICIPALITY OF LIMPOPO**

BY

**CHUENE WILLIAM THABISHA RAMMUTLA**

Submitted in fulfillment of the requirements for

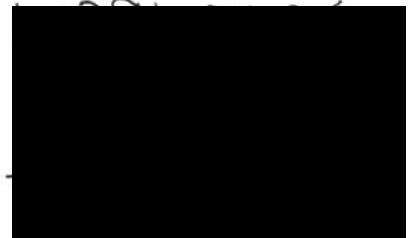
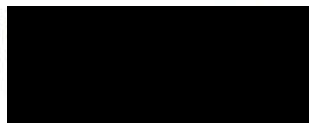
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SUPERVISOR: PROF O MTAPURI

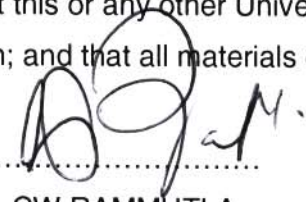
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DECLARATION

I declare that the dissertation hereby submitted to the University of Limpopo for the degree of Master of Development has not been previously submitted by me for the degree at this or any other University; that it is my own work in design and in execution; and that all materials contained herein had been duly acknowledged.

SIGNED.....



CW RAMMUTLA

DATE:

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## **ABSTRACT**

Section 27 of the Constitution of the Republic of South Africa, 1996 provides that everyone has a right to have access to health care. South Africa embraces the concept of universal health care coverage. Access to health care has four dimensions: geographic accessibility, availability, financial accessibility and acceptability. If there were barriers to access to health care, the stake-holders would be duty-bound to design interventions requisite to address those barriers. The aim of the study was to establish whether health care users enjoy the right to have access to health services at Ratshaatsha Community Health Centre (RCHC). The study used a combination of quantitative and qualitative research designs. While a questionnaire was used to collect quantitative data, focused group discussions and participant observations were employed to collect qualitative data. The following are the main findings of the study. Human rights instruments clearly spell out the indivisible and mutually supportive rights that persons have. There are barriers that often affect the rights to have access to health services at RCHC. For instance, the RCHC is not within a 25 km radius of some of the consumers of health care. The roads that link up the health care users and RCHC are in poor condition. The community is generally poverty-stricken. Many cannot afford, among others, the costs of basic needs, transport fares and opportunity costs. Travelling distance and time, scarce skills and lack of medication and equipment rank among demand-side and supply-side barriers to access to health care. Health care users often choose to consult churches and traditional healers. It is recommended that government should, among others, co-ordinate primary health care services in collaboration with churches and traditional healers; commission research into traditional health medicine and healing procedures and protocols of other health care providers; develop policy on cross-referral of patients; improve community participation; set minimum norms and standards for the delivery of alternative health care services; establish health care management guidelines for churches and traditional healers; integrate health care provisioning into IDPs; and provide health care in an integrated intergovernmental manner.

## **ABBREVIATIONS**

AU	African Union
CESCR	Committee on Economic, Social and Cultural Rights
EMS	Emergency Medical Services
ICESCR	International Covenant on Economic, Social and Cultural Rights
LMICS	Low-Middle-Income Countries
HICS	High-Income Countries
MDGS	Millennium Development Goals
MEC	Member of the Executive Council
NHS	National Health System
RCHC	Ratshaatsha Community Health Center
SADC	South Africa Development Community
SAHR	South African Human Rights Commission
UNDP	United Nations Development Program
UN	United Nations
UDHR	Universal Declaration of Human Rights
VDPA	Vienna Declaration and Plan of Action
WHO	World Health Organisation

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## **CHAPTER 1: INTRODUCTION**

### **1.0 Background to the study**

The National Health System (NHS) is based on, among others, the basic principles of universal access; comprehensive primary health care (PHC) and hospital system; capacitated district-based health care system; the public-private mix in health care provision and distribution of resources between public and private sectors; improved community participation in the governance of the health care system; outcomes-driven health care system; and a health system organised and functioning on the basis of decentralised management (Department of Health *Restructuring the National Health System for Universal Primary Health Care* 1996: 5; White Paper for the Transformation of the Health System of South Africa (1997); Nadasen 2000: 23-24).

### **1.1. Introducing issues**

The World Health Organisation (WHO) member-states endorsed the concept of universal coverage as early as 2005 (Currin *et al* 2008: 857-63; Jacobs *et al* 2011: 2). South Africa has also embraced this concept of universal access to health care. There are four dimensions of access to health care, namely geographic accessibility, availability, financial accessibility (affordability) and acceptability (O'Donnell 2007: 2820-34; Peters *et al* 2008: 2-8; Jacobs *et al* 2011: 3). Health care barriers can stem from both the demand side and supply side of access to health care (Ensor and Cooper 2004: 69-79; O'Donnell 2007: 2820-34; Jacobs *et al* 2011: 3).

The Constitution divides the country into 'national, provincial and local spheres of government which are distinctive, interdependent and interrelated' (section 40). This is a middle course between a federal system and a unitary system of government. Sections 40 and 41 of the Constitution establish a co-operative intergovernmental system in the country. This co-operative intergovernmental system is manifest in the shared functional areas. There are functional areas of concurrent national and provincial legislative competence (schedule 4 of the Constitution), on the one hand, and functional areas of



exclusive provincial legislative competence (schedule 5 of the Constitution), on the other.

The health care system comprises public sector and private sector health care. Private sector health care complements public sector health care (Regulation 158 under the National Health Act, 61 of 2003). The Department of Health may approve the applications for licenses of private health care facilities. While the primary objective of the public health care sector is to meet public health needs, the primary objective of the private sector health care sector is to make and maximise profit through health care provisioning. As a result, the private health care sector primarily serves the health care needs of the haves and insured (Nadasen 2000: 37-49; SAHRC Report 2009: 1-4). On the other side, the public health care sector primarily serves the health care needs of the have-nots and uninsured (SAHRC Report 2009: 1-4). This differentiation between public health care users and private health care users underscores the inverse relationship between health and poverty. According to Nadasen (2000: 5), there is a direct correlation between the prevalence of diseases and socio-economic status. Poverty contributes to, among others, suffering, burden of illness, disability and death (Nadasen 2000:5; Todaro and Smith 2009: 399-400).

Generally, Southern African Development Community (SADC) member-states provide health care within and by a hierarchically organised and structured delivery system. With his focus on the Zimbabwean health care delivery system, Agere (1990: 31) puts it as follows -

Health care is provided within and by a hierarchically organised and structured system. The system includes the production, distribution and consumption of health services. Within the system, there are a number of major actors such as physicians, nurses, paramedics, pharmacists and the pharmaceutical industry, insurance companies, hospitals and clinics, through which curative and preventive services are administered, delivered and consumed.

There are two principles that define the operation of health care delivery system: the principle of complementarity (Todaro and Smith 2009: 179-184) and the principle of

subsidiarity. Government must not only provide health services in an inclusive manner but must also decentralise health care delivery to a sphere of government or level within a sphere of government that has the optimal capacity to improve service delivery. According to Agere (1990: 31) there are three critical elements of health care delivery system, namely quantitative adequacy, geographical distribution and the absence of political, economic and cultural barriers to health care access. Quantitative adequacy implies that the health care delivery system must have the right numbers and skills to produce and distribute health care services to the health care users at the right times and service points. Geographical distribution means that health care delivery system must distribute the right levels of health care services in all provinces, districts, municipalities and localities. The health care distribution system should not unfairly discriminate on the grounds of, among others, race, social class and gender. The gap between urban and rural areas must be progressively closed.

South Africa has nine provincial health departments and one national health department. Each province has one health department. Although, constitutionally speaking, health services are a functional area of concurrent national and provincial legislative competence (Schedule 4 to the Constitution), national health department is mainly responsible for law-making, policy-making and co-ordination. A provincial health department is responsible for the provision of health care services in a province. A municipality is responsible for the provision of municipal health services (schedule 4 Part B to the Constitution). However, a province has more than one district municipality as well as numerous local municipalities. A district municipality comprises more than one local municipality. Gauteng, Kwazulu-Natal and Western Cape have one or more metropolitan municipalities and numerous subsidiary local municipalities respectively. The rest of the provinces have district municipalities and local municipalities. A national government may intervene in a provincial government in terms of section 100 of the Constitution and a provincial government may intervene in a municipality in terms of 139. In other words, only a higher sphere may intervene in a lower one.

Limpopo Province has five districts, namely Capricon, Mopani, Vhembe, Sekhukhune and Waterberg. Capricon District is made up of five local municipalities, namely Polokwane, Molemole, Lepelle-Nkumbi, Aganang and Blouberg. A local municipality is demarcated into wards. There are district hospitals, regional hospitals, a hospital complex, community health centres and community clinics. Ratshaatsha Community Health Centre is situated within Blouberg Municipality.

### **1.2. The duty to provide health care**

The state has a duty to fulfill its human rights obligations. The right to health care imposes a burden on the state to provide health care facilities, human resources, roads and transport, communication services, medical instruments and equipment and medicines and drugs, among others.

### **1.3. The location and relations of the area of study**

South Africa is a member of international organisations such as SADC, African Union (AU) and United Nations (UN). It has signed bilateral agreements, established bilateral commissions with a number of world countries and agreed to some of the international treaties. It has, therefore, international, continental/regional and national human rights obligations. As the world has become a global village, every country exists in an inescapably interrelated and interdependent world system. South Africa, therefore, is locked up in this integrated international and continental system.

The International Bank of Reconstruction and Development (the World Bank) and International Monetary Fund (IMF) develop and reconstruct countries. Of course, the structural adjustment programs of the World Bank failed to lift third world countries out of underdevelopment for such various reasons as corruption and lack of government accountability (Uvin 2007: 598-601). What are now in vogue are the principles of good governance (Uvin 2007: 600-601).

#### **1.4. History of health services in the study area**

Before 1994, the Republic of South Africa had buffer zones adjoining the borders that separate it from neighbouring countries. These were security zones. The northern buffer zone comprised the area to the north of the former Lebowa nation-state and to the south of Zimbabwe and Botswana. It was made up of the expanse of white-owned farms and state land. It was heavily guarded by the army. The white communities in the buffer zone did not share the health-care facilities with their black counterparts. They used the services of, among others, Messina Hospital, Louis Trichardt Hospital, and Voortrekker Hospital. These institutions were better resourced. On the other hand, the neighbouring black village communities used the Kibi Community Clinic which provided only primary health care.

The Provincial Government has, since, established a few other community clinics at, among others, Gideon, *Makgafela* and Kromhoek. Community clinics provide primary health care (PHC) services. In addition, government has established Ratshaatsha Community Health Centre at Eldorado village. A community health centre provides PHC, occupational therapy, speech therapy and dental services. There is only one hospital in Blouberg Municipality, namely Hellene Franz. Blouberg Hospital has been downgraded to a status of community health centre.

#### **1.5. Population and access statistics**

According to the results of the 2007 community survey by Statistics South Africa (Stats SA), Capricon District has a population size estimated at 1,243,168. The population statistics, for the period in question, were disaggregated (in accordance with gender distribution) as follows: males 572,718 and females 670,450. Obviously, the population has since grown over the period 2007–2010. On the other hand, the population statistics in respect of Blouberg Municipality were as follows:

- a) total population = 194,116
- b) males = 85,046; and
- c) Females = 109,070.

The official statistics indicate that for the financial year 2009/10, the PHC headcount data of the consumers who received health-care services at Ratshaatsha Community Health Centre and the health-care services provided by mobile clinic in the corresponding area are as follows (the district PHC data are bracketed) –

- a) Ratshaatsha CHC: PHC headcount data for children under five years: 8,818 (District: 805,865).  
Ratshaatsha Mobile clinic: 607.
- b) Ratshaatsha CHC: PHC headcount for children 5 years and older: 43,613 (District 2,789,533).  
Mobile clinic: 2,233.
- c) Ratshaatsha CHC: PHC headcount for patients seen between 7 pm and 7 am: 558 (District 104,887).

The headcount data represent the number of visits by a patient and not the number of patients who visited the health-care facility. In other words, every visit by a patient is counted and added as a single headcount. This being the case, one person may be counted more than one time depending on the number of times he or she consults at the facility.

On the face of the headcount data, only 8,818 (children under five years) had access to PHC services at Ratshaatsha Community Health Centre as against 805,865 and 43,613 (for children 5 years and older) and as against 2,789,533 children in the Capricon District during the period under review.

#### **1.6. Access to other socio-economic rights**

Human rights are inherent and indivisible. Yacoob J, in the *Government of the Republic of South Africa v Grootboom and Others 2000 (11) BCLR 1169 (CC)* stated that human rights (civil and political rights, economic, social and cultural rights and the rights to development, environment that is not harmful the health and well-being of communities and self-determination) are interrelated and mutually supportive. The denial of one

affects access to the other rights. For instance, the right to have access to health care is interrelated and interdependent with the rights to have access to food, shelter, clean water and sanitation (section 27 of the Constitution). Section 27 provides that everyone has the right to have access to health services, food and water, social security and emergency medical care subject to the available state resources. Section 27 rights are, therefore, socio-economic rights. Scarcity of resources bars access to socio-economic rights. In any view, the entire Bill of Rights provides a prism through which section 27 must be construed. This interpretive approach takes into account the competing rights of other health care users as well as the rights of the entire citizenry in relation to their general public needs.

### **1.7. The alternative health-care services**

For purposes of this study, health care is divided into orthodox, complementary and alternative health care. Some community members still use alternative health care services for their health and well-being (Matsepe (2004: 27-50); Mbiti 1969: 162ff). Both the traditional health practices and the healing and prophetic ministries of the African Initiated Church are examples of the alternative health care services. The Traditional Health Practitioner Act, 2004 (35 of 2004) recognises traditional health practitioners. In addition, sections 8, 30-31 of the Constitution recognise the rights to practise religion and culture.

### **1.8. Statement of the problem**

Human rights instruments clearly spell out the indivisible and mutually supportive human rights. The Constitution of the Republic of South Africa provides that everyone has the right to have access to health care (section 27). However, there are demand-side barriers and supply-side barriers that impede the rights of health care users to have access to health services.

### **1.9. The significance of the study**

The significance of the research is that it may identify the barriers that impede access to health care at RCHC and propose policy measures necessary to optimise universal coverage.

### **1.10. Aim of the study**

The aim of the study is to investigate whether people have access to health services at Ratshaatsha Community Health Centre

### **1.11. Objectives**

The objectives of this study are –

- a) To determine whether individuals have *de facto* access to health care services at Ratshaatsha Community Health Centre;
- b) To establish if there are any violations of the right to have access to health care services;
- c) To establish the rationale for the limitations of access to health care services;
- d) To determine whether some people still make use of the alternative health care services and
- e) To propose solution(s) to the stated research problem.

### **1.12. Research questions**

The study will attempt to address the following questions:

- a) Are there gaps between human rights in principle and human rights in practice?
- b) Are there any violations of the rights of individuals to have access to health care services?
- c) Why do some people in the study area still make use of alternative health care services?
- d) What policy interventions are necessary to make health care services accessible?

### **1.13. Outline of the research report**

The research report outline is as follows -

Chapter one deals with (a) introduction, background and significance, (b) statement of problem, (c) aim of the study, (d) objectives and (e) research questions. Chapter two reviews literature. Chapter three selects, and justifies the selection of, a combined quantitative and qualitative research approach. It also identifies the target population, population sample size and sampling method. It states data collection methods used. Chapter four analyses and interprets data. Chapter five make conclusions and recommendations.

### **1.14. Definitions:**

Unless the context indicates otherwise, the following concepts are defined as they are used in their everyday meaning -

**1.14.1 'African Initiated Churches':** the home-grown churches which were initiated by indigenous African people in protest against the marginalization of African culture and belief systems by euro-centric Christian churches. The majority of them blends Christianity with African culture, in particular the indigenous knowledge system. African Initiated Churches are interchangeably called African Independent Churches.

**1.14.2 'Alternative health care services':** health care services rendered to the members of the public by, among others, the traditional health practitioners and African Initiated Churches or just African or Black Churches. These are alternative therapies which are provided in lieu of orthodox health care (British Medical Association 1993: 6-7).

**1.14.3 'Ditaelo':** Prescriptions issued by Zion Christian Church or St. Engenas Zion Christian Church for faith-healing and spiritual purposes.

**1.14.4 'Sewasho':** the spiritual purification ritual prescribed by the Apostolic Church.



**1.14.5 'Diagelo':** the healing schools operated generally in accordance with *ditaelo* but which are not authorised by either Zion Christian Church or St Engenas Zion Christian Church.

**1.14.6 'Health system':** all activities requisite for the promotion, restoration and maintenance of health. The components of the health system are, largely, national and provincial health departments, hospitals, community health centres, community clinics, offices of health professionals in public and private sectors.

### **1.15. Conclusion**

The study determines whether or not the health care users have access to health services at RCHC. Besides the RCHC, the Department provides clinic and mobile services. It may be that, even though that the public health facilities are there to offer services, some people still do not have optimum access to health care.

## **CHAPTER 2: LITERATURE REVIEW**

### **2.0. Introduction**

Literature review is aimed at contributing towards a clearer understanding and meaning of the research problem (Fouche & Delport 2005: 123). It builds a logical framework for the research and sets it within the tradition of enquiry and a context of related studies (Marshall & Rossman 1999: 43). It includes credible literature that provides information about the research problem/question and that enables the researcher to draw relevant and material conclusions from the epistemological base (Yegidis & Weinbach 1996: 57). According to Fouche & Delport (2005: 127-129), the writers generally agree on the following credible sources of research literature – scientific books, articles in professional journals, standard reference materials, research reports, dissertations and monographs, specialised index publications, presentations at conferences, symposia and workshops, internet, radio and television broadcasts, newspapers, magazines and periodicals. This chapter reviews literature that deals mainly with the concepts of human rights and access to health care.

### **2.1. Expounding human rights**

Human rights are referred to, interchangeably, as, among others, fundamental rights, basic rights, natural rights, subjective rights and sometimes even common rights (Mubangisi 2004:2). These are the rights that belong to a person because he or she is a human being (Mubangisi 2004:3). The United Nations (UN) defines human rights as 'those rights which are inherent in our nature and without which we cannot live as human beings' (United Nations: 1987:4).

The denial of human rights dehumanises human beings and unacceptably and inescapably seeks to reduce them to the plane of sub-humans or non-humans. Differently put, the denial of human rights abstracts the fundamental rights from the immanent nature of human beings. In other words, there cannot be a human being without human rights and *vice versa*. According to Mubangisi, human rights are the components of a democratic society (2004:7). Human rights and democracy are

interconnected and interpenetrative. The foundational values of democracy are human dignity, equality and freedom. Human rights are therefore protected for democracy (Mubangisi 2004:7). The UNDP User Guide (UNDP 2006: 4) categorises fundamental rights into civil and political rights (blue rights), social, cultural and economic rights (red rights) and rights to healthy environment and development (green rights) (see also Mubangisi 2004:10). These rights are also known in the academic world as first-, second-, and third-generation rights. Olowu (2009; 17) submits that economic, social and cultural rights are not hierarchically below civil and political rights. However, these two categories of rights are on equal footing (Olowu 2009: 17). In any view, human rights are interrelated and mutually supportive (Government of the Republic of South Africa v Grootboom and Others 2000 (11) BCLR 1169 (CC)).

At face value, human rights empower individuals and groups. However, they are, in their written form, merely paper rights which cannot *per se* actualise their own enjoyment by individuals and groups unless the duty-bearers discharge their obligations in commensurate with the rights involved (UNDP 2006: 7-8). The above-mentioned three categories of rights are, in their dormant paper form, described as *human rights in principle* (UNDP 2006: 4) as opposed to *human rights in practice*.

## **2.2. The sources of human rights law**

The South African human rights law is sourced, mainly, from international law, constitution, legislation, common law, court cases and custom. Section 39(1) (a) of the Constitution provides that a court, tribunal or forum must consider international law and may consider foreign law when interpreting the Bill of Rights. The Constitution provides, furthermore, that the 'Bill of Rights does not deny the existence of any other rights or freedoms recognised or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill' (s 39(3)). There are scholarly writings such as text books, articles and reports that provide information on human rights.

### **2.2.1. The International Human Rights Documents**

The UN, the World Bank and International Monetary Fund (IMF), the regional organisations such as AU and SADC and national organs of state are responsible for the promotion, protection and fulfillment of integrated and mutually supportive fundamental human rights in the Bill of Rights and its concomitants. These organisations are involved in various and diverse 'development assistance programs throughout the world' (Davids, Theron and Maphunye 2005: 90). International and regional organisations play a role in national development. Globalisation makes this role more pertinent.

The international community has set standards, conventions and protocols to which member-states must adapt or modify their legislative and other measures. The study samples a few of these human rights instruments in order to make it plain that there are international, regional and national human rights frameworks that guide law-making and policy-making and that the gap exists regarding the correspondence between law and policy, on the one hand, and implementation of law and policy, on the other. In the event where the executive branch of government is keen to enforce implementation, monitoring and evaluation often reveal that there is a huge disjunction between the top-level plans and delivery-points operations. The UNDP enjoins UN member-states to integrate human rights into development programs (UNDP 2006: 4).

#### **2.2.1.1. Universal Declaration of Human Rights (UDHR)**

The UDHR is the foundation-stone of a multiplicity of international, continental and national human rights instruments. Almost all United Nations member-states use the UDHR as the baseline or benchmark for human rights practice and culture. The influence of the UDHR is manifest in, among others, the African Charter of Human and Peoples' Rights (the Banjul Charter) and the Bill of Rights enshrined in the Constitution of the Republic of South Africa. Of course, the constitution of the United States of America, the constitution of Canada and the Basic Law of the Federal Republic of Germany have shaped the Constitution of the Republic of South Africa in no small way. Although the constitution of the United States predates the UDHR, its subsequent

amendments reflect a confluence between the two documents. The constitution of Canada and the Basic Law of the Federal Republic of Germany post-date the UDHR and, therefore, manifest the influence of the UDHR in an incontrovertible way. Article 25 of the UDHR provides as follows –

- 1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sicknesses, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
- 2) Motherhood and childhood are entitled to special care and special assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Doubtless, the language of article 25 of UDHR is not gender-neutral. It reflects a patriarchal mind-set. Gender-equality aside, critical scrutiny of article 25 reveals a socio-economic bias. However, the political and civil rights and the right to development are irremovable from the web that conceptually and functionally binds all rights together.

#### **2.2.1.2. International Covenant on Economic, Social and Cultural Rights (ICESCR)**

The ICESCR provides for the right of a person to have access to health care. A person is entitled to the 'enjoyment of the highest attainable standard of physical and mental health conducive to living a life of dignity' (article 12).

#### **2.2.1.3 World Health Organisation (WHO)**

In its constitution the WHO provides that health is a 'state of complete physical, mental and social well-being and not just the absence of disease or infirmity'. This definition of health underscores the indivisibility and mutual supportiveness of rights.

#### **2.2.1.4. Committee on Economic, Social and Cultural Rights (CESCR)**

The CESCR in its definition of health care states that health care is 'fundamental to the physical and mental well-being of all individuals and as a necessary condition for the exercise of other human rights' (General comment No 14 of the CESCR).

### **2.2.1.5. Vienna Declaration and Plan of Action (VDPA)**

VDPA provides that human rights and fundamental freedoms are the birthright of all human beings and are universal, indivisible and interrelated (A/CONE 157/23(12 July 1993), articles 1 and 5).

### **2.2.2. Regional Human Rights Documents**

The African Union has enacted a number of human rights instruments. The following is a classical example -

#### **2.2.2.1. African Charter of Human and Peoples' Rights (the Banjul Charter)**

Taking a cue from the international community the African Union has adopted African Charter of Human and People's Rights (the Banjul Charter). Each member-state is expected to incorporate the agreed rights, standards, conventions and protocols into its legislative and other measures. Article 16 of the African Charter on Human and Peoples' Rights provides as follows –

- 1) Every individual shall have the right to enjoy the best attainable state of physical and mental health.
- 2) States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

Article 24 provides as follows –

All people shall have the right to a general satisfactory environment favourable to their development.

On its face the African Charter on Human and People's Rights does not adopt the integrated approach to health care. It does not make reference to 'food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sicknesses, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control'. However, section 27 of the Constitution gives effect to articles 16 and 24 of the Banjul Charter.

### **2.2.3. South African human rights documents**

South Africa has enacted a number of human rights instruments. The following are classical examples -

#### **2.2.3.1 The Constitution of the Republic of South Africa**

The rights-based approach to development coincides with the humanist approach to development. Both put the people at the fore and, therefore, are directly or indirectly etched on a human rights system. Needless to state, the 1990s saw the intensification and acceleration of development by and through development projects and programs. Previously, the development practitioners designed and implemented development projects and programs which did not take human rights into account. However, the development thinkers and practitioners in the 3<sup>rd</sup> World did not take kindly to the exclusion of human rights from development theory and practice. While the evolution of the notion of the right to development has been equally important, the entire human rights system has become a significant debate on the conceptualisation and operationalisation of the humanist approach to development. Human rights indicators need to be worked into development projects and programs. Unavoidably, human-rights paradigm of development requires a study of the interlinking of human rights and theories of development.

Section 27 of the Constitution provides as follows -

- 1) Everyone has the right to have access –
  - a) to health care services, including reproductive health care;
  - b) Sufficient food and water;
  - c) Social security, including if they are unable to support themselves and their dependents, appropriate social assistance
- 2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.
- 3) No-one may be refused emergency medical treatment.

Defining access to health care through the prism of the Bill of Rights reveals that the provision of health care includes the availability of water, food, social security and other basic needs such as clothing, housing, education and employment. The right to have access to health services is a socio-economic right. The duty-bearers such as the state can only provide health care within their available resources. The section 27 rights must be realised progressively. It follows, therefore, that there is an inverse relationship between access to health care and resources. The lack of resources, therefore, affects access to health care and provides section 27 with a context (Nadasen 2000: 85-88). Section 27 provides internal limitations which limit the right to health care and imposes an obligation on state to enact legislative and other measures that implement the constitutional right to health care.

The right to health care of a person must be construed against the competing rights of others to health care and all other socio-economic rights which compete for the limited resources (*Soobramoney v Minister of Health, KwaZulu-Natal* 1997 (12) BCLR 1696 (CC); *B v Minister of Correctional Services* 1997 6 BCLR 789 (C); *AZAPO v President of the RSA* 1996 8 BCLR 1015 (CC)).

#### **2.2.3.2. The health-related legislative and other measures**

The democratic government has enacted laws and other measures, for instance, the Interim Constitution (1993), Reconstruction and Development Programme (1994), the National Health Plan for South Africa (1994), the Constitution of the Republic of South Africa, 1996, White Paper for the Transformation of the Health System of South Africa (1997) and National Health Act for purposes of ensuring, among others, access to health-care services.

### **2.3. Access to health care**

According to Oliver & Mossialos (2004: 655-658), there is no universally accepted definition of access to health services. Peters *et al* (2008: 161-171) define access to health care as 'the timely use of service according to need'. There is a causal relationship between access to health care and poverty. People in poor countries have



less access to health services than those in better-off countries. Within a country, the poor have less access to health services than the rich. According to Todaro and Smith, the health care facilities in poor rural areas are underequipped and understaffed (2009: 399-400). Higher-quality health care facilities are concentrated in urban and richer areas than in rural and poorer areas. Developing countries face much more crippling disease burden than developed countries. The poor are significantly less healthy than the more affluent. The children of the poor are much more likely to die than those of the rich.

South Africa is an unequal country. The Executive Summary of the South African Human Rights Commission Report (2009:6) put it thus –

Access to health care services, especially for the poor, is severely constrained by expensive, inadequate or non-existent transport, by serious shortages with regard to emergency transport [ambulance vehicles], and by long waiting times at clinics and other health care service providers.

The right to have access to health care is fundamental to the physical and mental well-being of all individuals (SAHRC 2009: 17). It is the necessary condition for the exercise of other human rights including the pursuit of an adequate standard of living (SAHRC 2009: 17 *ibid*). In order to realise the right to have access to health care for all, the state has decided to introduce a system of National Health Insurance (NHI) (SAHRC Report 2009: 1-4). While the medical aid schemes insure, mainly, the middle-class in society, the NHI aims at providing universal health care coverage for all. However, NHI appears to be an expensive, long-term policy subject to progressive implementation. According to Discovery Health, it took Australia 30 years, United Kingdom (UK) 37 years, Switzerland 90 years and Germany 127 to fully implement the NHI (SAHRC Report 2009: 1-4). South Africa needs NHI urgently. As from 2012, government is piloting NHI in randomly selected districts.

#### **2.4. The concept of universal access to health care**

The right to health care is equal access, based on the principle of non-discrimination, to health care facilities, goods and services (General comments No 14 of the Committee on Economic, Social and Cultural Rights (CESCR.)). The General Comment states,

furthermore, that health care facilities, goods and services must be available in sufficient quantity; must be physically and economically accessible to everyone; must be culturally and ethically acceptable; and must be scientifically and medically appropriate and of good quality (General Comment No 14 of CESCR para 1; SAHRC Report 2009: 10). The SAHRC Report (2009: 10) states, furthermore, that, in terms of the General Comment No 14 of CESCR, the right to health care includes the following –

- (a) The state must refrain from denying or limiting access to health care services to any individual.
- (b) Health care services should be available to all on a non-discrimination basis;
- (c) The obligation to protect include, *inter alia*, adopting legislation and other measures to ensure equal access to health care facilities provided by third parties; to ensure that privatization does not constitute a threat to the availability, acceptability and quality of services provided; and to control the marketing of medicines by third parties;
- (d) The State must disseminate appropriate information: foster research and support people to make informed choices.
- (e) The State must facilitate and implement legislative and other measures in recognition of the right to health care and must adopt a national health policy with detailed plans on how to realise the right; and
- (f) The State must provide the right for people in disaster situations or in dire need when an individual or group is unable, for reasons beyond their control, to realise that right themselves with the means at their disposal.

The health care delivery system is divided into curative (hospital-based) and preventive health care (primary health care). The apartheid government preferred the curative, hospital-based health care to preventive health care.

## **2.5 The dimensions of health care access**

Access to health care, in its true sense, involves more than the presentation of a patient at the premises of a health care facility. Quality of care is a component of each dimension of access to health care (Peters *et al* 2008: 2-8). According to Jacobs *et al*, 'utilization of health care is used as an operational proxy for access to health care' (2011: 2-3). There are demand-side barriers and supply-side barriers to access to health care (Ensor & Cooper 2004:69-79). Jacobs *et al* state, furthermore, that barriers to access to health care can stem from the demand side and/or the supply side (2011:3). Both demand-side barriers and supply-side barriers have to be addressed concurrently (O'Donnell 2007). Demand-side non-monetary interventions and supply-side non-monetary interventions and demand-side financial interventions and supply-side financial interventions are requisite to eliminate or reduce demand-side and supply-side health care access barriers (Ensor & Cooper 2004:69-79).

### **2.5.1. Geographic accessibility of healthcare**

The geographic accessibility alludes to the distance between the place of abode of a user (or any pick-up point) and the location of the health care facility. It encapsulates travel distance and traveling time. Peters *et al* define geographic accessibility as 'the physical distance or travel time from service delivery point to the user' (2008: 4). Furthermore, it takes into account the modes of transport and status of the roads (hard infrastructure) to and from the health care facility. The communication system plays a critical role in the facilitation of transportation of patients to and fro the health care facility. The lack of communication services limits access to health care (Peters *et al* 2008: 11). Roads, transport and communication services in Low-Middle-Income Countries (LMICs) and rural areas are worse off than in High-Income Countries (HICs) and urban areas respectively.

Peters *et al* (2008: 11) correctly point out that geographic access is an important part of accessing health care in LMICs. Access to health facility is not a sufficient proof of the actual access to health care, utilisation and realised need. In other words, health care use together with realisation of health care need is also an important input. The

provision and utilisation of health care must be consistent with all pertinent norms and standards. It is noteworthy that access to health care consummates at the point where a patient receives medical treatment of the right quality on time. Access to health care and utilisation is contingent upon the protection, promotion and fulfillment of patients' rights enshrined in human rights instruments including but not limited to the Patients' Rights Charter.

According to Peters *et al* (2008), an inverse relationship between distance or travel time to health facilities and use of health services is an important barrier to access to health care. Good roads are necessary for both the demand side and supply side of access to health care. On the one hand, the health care users use roads to and from the health care facilities. On the other hand, the health care providers use roads to distribute drugs and other supplies to health care facilities, for timely referrals in emergencies, and for better supervision of health care workers (Peters 2008: 11).

Peters *et al* point out that road and communication infrastructure and transport costs are higher in LMICs and rural areas than in HICs and urban areas respectively. The radius between health care facilities in LMICs and rural areas is bigger than in HICs and urban areas respectively. Remote health care facilities mean that more travel time and money are spent on travel-related expenditures in LMICs and rural areas than in HICs and urban areas. There is a causal relationship between travel time and money and access to health care, especially by the poor.

### **2.5.2. Availability of healthcare**

Availability of health care alludes to, among others, the existence and reachability of the health care facility, its institutional capacity, the availability of health care workers, the right numbers and competencies of the workforce, the availability of medical instruments and equipment, the business hours (opening and closing times), treatment of emergencies outside working hours, the length of waiting periods and the availability of the right quality and quantity of medication and drugs. According to Peters *et al* (2008: 12), availability is measured in terms of the opportunity to have access to health

care as and when needed. He defines availability as 'having the right type of care available to those who need it, such as hours of operation and waiting times that meet demands of those who would use care, as well as having the appropriate type of service providers and materials' (2008: 5).

### **2.5.3. Financial accessibility of healthcare**

Health care is costly. The dimension of financial accessibility recognises that socio-economic rights are onerous and prohibitive. It divides the health care users among the haves and have-nots. Health care costs are a barrier to access to health care. Indeed, financial accessibility is one of the most important determinants of access to health care (Peters *et al* 2008: 13). It is most directly associated with the dimensions of poverty. The exclusion of users from health care or high-quality health care on the grounds of affordability amounts to social and economic exclusion. Nothing is further from poverty-based discrimination.

Financial accessibility takes into account the GDP (income) within the study area (i.e. the standard of living and cost of living), direct costs such as treatment costs, drug and medication costs and indirect costs such as transportation costs, opportunity costs of time of both the patient and those accompanying him or her and expenses on food and lodging. Peters *et al* defines financial accessibility as 'the relationship between the price of services (in part affected by their costs) and the willingness and ability of users to pay for those services, as well as be protected from the economic consequences of health costs' (2008: 6).

The causal *nexus* between poverty and health care is a significant factor. Health budget is part of public social sector budget. The health sector comprises public and private facilities. While the public health sector is reliant on Treasury (public finance) and relatively small per cent of user (patient) fees (SAHRC 2009: 29), the private health sector is dependent on private finance. The user fees are usually used where public financing is scarce, the public system plays a prominent role in the essential health care, government fails to allocate adequate budget for the public health system, the

salaries for health workers are low, public control over pricing practices by public providers is limited and there is lack of key medical supplies such as drugs (Peters 2008: 12). The user fees or price increases lead to decreased utilisation. In Uganda the abolition of user fees led to the increase in the use of curative, preventive and promotive health services.

#### **2.5.4. Acceptability of healthcare**

Acceptability of health care takes into account the universally accepted legal, ethical, social, cultural and other norms and standards. Peters *et al* define acceptability as 'the match between how responsive health services are to the social and cultural expectations of individual users and communities. The Declaration of Alma Ata points out that primary health care (PHC) must be in line with prevailing cultural norms (Peters *et al* 2008: 13). It must also take into account patients' perception of quality, price and other dimensions of access. Staff attitudes, cultural acceptability and quality of health care are important parts of health care access (SAHRC 2009: 45-46). Peters *et al* point out that the studies in Bangladesh, Burkina Faso and India demonstrate that the patients' perception of quality can be an important determinant of utilisation (2008: 14).

South Africa has the features of the 1<sup>st</sup> and 3<sup>rd</sup> World. It has, therefore, a pluralistic medical system (public sector and private sector health care systems). The country is poised to depart from the unjust past of discriminatory health care service delivery system and embrace an equal, non-discriminatory health care delivery system for all. To achieve this, it needs to determine where it comes from, where it is and where it is going. There is no luxury of Alice in the Wonderland approach. Commenting on the nature of the apartheid-era health care system, SAHRC said the following –

The South African health care system, prior to 1994, resembled the fragmented and failed system that apartheid was. As such, the health care system was characterised by abject discrimination, unequal distribution of resources, unethical execution of responsibilities by health practitioners and large scale complicity in upholding the system of apartheid. A lack of coordination and lack of accountability was also common. Apartheid South Africa offered a co-existence of first-world and

third-world health care services (often operating just meters apart), with the first-world experience being the almost exclusive preserve of whites (SAHRC 2009: 12)

On the average 5 million health care users are members of medical aid schemes. Others but a relatively small per cent even have hospital insurance plans. The 3<sup>rd</sup> World comprises mainly black workers and peasantry and vulnerable groups: women, children and people living with disabilities. The 1<sup>st</sup> World category of patients enjoys the right to choose health care providers in the public or private sector. Generally, the 3<sup>rd</sup> World category of patients has a limited choice cut out for them: public health system or traditional medicine.

## **2.6. The barriers to health care**

The concept of health care access incorporates universal coverage. The notion of universal coverage alludes to the access for all to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost (Jacobs *et al.* 2011: 2). Health care access is a prerequisite to the right to health care. The impediment to access to health care leads to the limitation of the unfettered enjoyment of the right to health care. Barriers impede or limit health care access and, therefore, obtrude the right to health care. As stated in chapter 1, in 2005 the WHO member states adopted a resolution to provide universal coverage (Carrin *et al.* 2008). The resolution recommended actions to alleviate barriers to access to health care. However, the recommended actions related only to financial interventions. The resolution ignores the fact that multiple factors bar access to health care. For instance, the following impede access to health care: poor roads and transport, distance, travelling time, lack of equipment, scarce skills, staff attitude, lack of medication and drugs and prohibitive costs. Financial interventions alone can, therefore, not sufficiently and suitably optimise access to health care. The effective access to health care requires a combination of the non-monetary and financial interventions. Jacobs *et al* (2008: 3) put it thus -

Demand-side determinants are factors influencing the ability to use health services at individuals, households or the community level, while supply-side determinants are aspects inherent to the health system that hinder service uptake by individuals, households or the community.

There are two main categories of the barriers to access to health care, namely the demand-side barriers and supply-side barriers (Ensor & Cooper 2004:69-79). According to Jacobs *et al* (2011: 4), demand-side interventions and supply-side interventions relate and affect the dimensions of access to health care. In 1978, the WHO member-countries endorsed primary health care (PHC) as a paradigm designed to reduce inequities in health through enabling universal access to health care. Without strategic interventions, the new health system almost always initially reaches the haves and insured, while the have-nots and uninsured only start to benefit in later years. This phenomenon is known as 'inverse equity' hypothesis (Jacobs *et al* (2011: 4).

## **2.7. Alternative health services**

These are the services provided to the community by either the churches or traditional African religion. The alternative health care services complement public health-care services. In his Master of Theology degree dissertation (UNISA) (2004), Matsepe conducted a research into the provision of health care services among the African communities by African Initiated Churches. According to Mbiti (1969) religion and traditional health care practice play a significant role in the life, health and death of an African.

### **2.7.1. Main-line churches**

The main-line churches are the churches such as the Roman Catholic Church, Anglican Church, Dutch Reformed Church, Presbyterian Church, Lutheran Church and Methodist Church.

### **2.7.2. Pentecostal and charismatic churches**

The Pentecostal and charismatic churches subscribe to the so-called 'Born-again Movement' principles. They claim to speak in tongues and conduct faith-healing ministries.



### **2.7.3. African Independent (Initiated) Churches (AICs)**

These are the churches initiated by the African people. Some of the African people, after engaging in the ministries of Main-line churches, resolved to form African Independent Church movement that blends Christianity and African customs that are not necessarily incompatible with the tenets of Christianity. Most of the authentic and original AICs prescribe, among their injunctions, water, earth (soil), salt and fire for healing purposes. The classical examples of AICs are -

#### **2.7.3.1. Zion Christian Church and St. Engenas Zion Christian Church**

Engenas Barnabas Lekganyane founded Zion Christian Church (ZCC) in 1924 (Bishop BE Lekganyane: The Foreword to ZCC Family Bible 1994). However, God commissioned him to found a healing and prophetic church in 1910. He was baptised by Elias Mahlangu of the Zion Apostolic Church (ZAC) through three-time immersion in the river in the name of the Father, the Son and the Holy Ghost. He was ordained as a priest in the ZAC. His membership of the ZAC was short-lived owing to differences over, among others, interpretation of prophecies. He joined and became a priest in Zion Apostolic Faith Mission (ZAFM) of Edward Motaung (Lion). ZAFM was headquartered in Lesotho. He resigned from ZAFM and founded his own church which he named Zion Christian Church. The present-day headquarters of ZCC are at Moria, Boyne, outside Polokwane in Limpopo Province in the Republic of South Africa.

Engenas passed on on the 31<sup>st</sup> of May 1948. After the death of Engenas Barnabas Lekganyane, the founder of ZCC, his eldest son, Barnabas held the fort. Sadly, he too passed on within six months of his father's death. A leadership dispute arose. In the result, the church split into two congregations, namely Zion Christian Church led by the second son to Engenas, named Edward Engenas Marobathota Lekganyane and the fourth son, named Joseph Engenas Mahlakanye Lekganyane. In the 1960s, Edward registered his branch of Engenas' church as Zion Christian Church and Joseph his branch of Engenas' church as St Engenas Zion Christian Church (St Engenas ZCC). Zion Christian Church adopted the Star of David as an emblem, while the St Engenas ZCC adopted a dove as an emblem.

Notwithstanding the split, the similarities abound. The most important common features are the healing and prophetic ministry, the three-times-a-year annual conferences (i.e. Easter Conference, September Conference and December (Christmas) Conference), liturgical prayer meetings (*Mpoho*) and spiritual injunctions (*ditaelo*).

### **2.7.3.2. Apostolic Church**

There is a multiplicity of brands of apostolic churches in Africa. Prominent examples are St John Apostolic Faith Mission, Twelve Apostolic Church and United African Apostolic Church. The Botswana-born African prophet, Christina Nku, (MmaNku) founded St John Apostolic Faith Mission St John Apostolic Faith Mission church in or about 1908. From the outset, the church conducted the healing and prophetic ministry. According to respondents, MmaNku was blessed with the healing powers and prophecy and could heal the sick and expel the demons and curses. Multitudes flocked to her in need of spiritual help. Sadly, as from the 1970s the church experienced leadership dispute after dispute and split into rival groupings. However, it is still recognised for the healing and prophetic ministry. Apostolic churches prescribe, inter alia, *sewasho for healing purposes*.

## **2.8. The scholarship on access to health care**

According to the constitution of the World Health Organization, health is 'a state of complete physical, mental and social well-being and not merely the absence of disease'. Health is the object of a fundamental constitutional right. There is an interconnection between human rights and the basic social conditions in which people live (Currie and de Waal 2005: 567). In other words, basic social conditions affect human rights negatively or positively depending which way the pendulum turns. If the basic social conditions were bad the rights of people who live in them may be violated and if the converse were the case, the rights may be fulfilled. Without derogating from the indivisibility and interdependence of rights, the recognition of the interconnection of human rights and the basic social conditions led to the inclusion in the modern

constitutions of the socio-economic or second-generation rights (Currie and de Waal 2005: 1ff).

There are a number of socio-economic rights in the South African Bill of Rights, for instance, the right to have access to housing (s 26), health-care, food, water and social security (s 27), children's rights (s 28) and education (s 29). These socio-economic rights are so closely connected such that they are pillars of the human development index adopted by the World Bank. According to Todaro and Smith, the three indices that are the touch-stones of human development index are education income index, index and health index. The underlying theory of human development indicates that the rights in sections 26, 27, 28 and 29 are mutually supportive (1ff). Cheadle *et al.* (2002: 492) submit, in my view, correctly that –

[t]here is an obvious link between the right of access to health-care services, sufficiency in food and water and access to social security. Social security provides access to health, food and water which are essential for life.'

The notion of public health includes access to water and sanitation, food, clothing, housing [and related needs] (Cheadle *et al.* 2002: 494). Nadasen (2000: 2ff) also offers a broad definition of 'health' or 'health-care services'. However, the right to health-care services does not guarantee the right to be healthy (Nadasen 2000: 495). All three categories of rights (civil, political and cultural rights, social and economic rights and the rights to development and environment that is not harmful to health) in the South African Bill of Rights are interdependent and interrelated (Government of the Republic of South Africa v Grootboom and Others 2000 (11) BCLR 1169 (CC)).

Olowu (2009: 1) states that by their very nature socio-economic and cultural rights are designed to satisfy the conditions of poverty and deprivation. The UNDP human developments reports consistently reflect bad poverty and deprivation levels in African countries (UNDP 2007-2008). Consequently, diseases ravage the population and life expectancy in Sub-Saharan Africa has declined to 49, 6 years (UNDP 2007-2008).

Until the 1990s development enterprise and human rights existed apart from each other (Uvin 2007: 597). The development enterprise lived as if human rights do not exist and, if it did, had nothing to do with it. In other words, the development theorists and practitioners did not conceptualise a confluence between human rights and development. Fortunately, the 1990s saw a change in approach. The change was occasioned by three factors-

- (a) The end of the Cold War between the West and the East led to the globalization of the world village. The openness, democratization and restructuring of the world order integrated the countries of the world (developed and developing world) into a global village. Globalization forced the world to renovate, optimise and improvise in order to create an effective and efficient world system that binds the 1<sup>st</sup> World and 3<sup>rd</sup> World countries together.
- (b) The failure of structural adjustment programs prompted a push for good governance and democracy. The World Bank marketed structural adjustment programs as economic gospel. International Aids, grants and loans accompanied these programs. However, the lack of government accountability failed structural adjustment programs (Uvin 2007: 597). The principles of good governance, accountability and democracy were substituted for those of structural adjustment programs.
- (c) Development thinkers sought to redefine development as being about more than economic growth. The new paradigm sought to put the people on the center of development.

Uvin traces the recognition of the notion of the right to development back to the UN resolution of 1986 (Uvin 2007: 598) that stated as follows-

The right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in, and contribute to, and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realised.

The resolution recognises the interconnectedness of the three generations of human rights. This paradigm sharpens the comprehension of the unity and diversity of nature. The principle of complementarity is the thread that knits the human rights system together into an integrated whole.

Uvin states, further, that in 1993 the World Conference on Human Rights in Vienna unanimously re-adopted the right to development as part of the broader Vienna Declaration and Programme of Action. The right to development now enjoys global legal consensus. However, its status is less than a treaty. It is non-obligatory and non-binding. Furthermore, it carries no resource-transfer obligations. The world countries may incorporate it into their legal system through legislation.

The relationship between the different logics of human rights and development is, however, often conflicted (Uvin 2007: 599). However, human rights and development cannot be treated as airtight compartments. Development is of the people for the people by the people. This paradigm of looking at development from the prism of humanism posits human rights and development together. Development is a costly exercise. Uvin (2007: 600) states, furthermore, that the implementation of human rights through development projects and programs is not sufficient for the welfare of people. People also need social guarantee. The way the state, citizens and corporations interact is essential. The post-modernist paradigm of development takes into account indicators of human rights, freedom, accountability, transparency, openness and good governance, among other factors. Democracy and development are linked.

Obviously, the rights-based approach to development is a development concept that seeks to fulfill human rights by dint of development programs. It redefines development as human right and the process of realizing development as the one that respects, promotes protects and fulfills human rights (Uvin 2007: 602-3). It seeks, furthermore, to integrate the objectives and performance indicators for promoting, protecting and fulfilling human rights into development programs. Although all human rights are interrelated and interdependent, this study puts more emphasis on socio-economic

rights. It is understood, though, that civil and political rights are not less important and pertinent to the object of the study. In any view, political dynamics play a leading role in the advancement of human development in less developed countries in Africa. Matters of environment and development have in the recent past been put on the world agenda. The rights-based approach to development integrates the three generations of rights into an interpenetrative and complementary system.

Olowu (2009:9) argues that it is necessary to place economic, social and cultural rights on the African human rights agenda and make them central subjects in defining integrative rights-based strategies for human development. The human rights instruments have put the right to have access to health services on human rights agenda. For instance, the Constitution enshrines the right to have access to health services in its section 27.

While the duty-bearer has a duty to treat a patient, a patient has a corresponding right to health care access. The duty and corresponding right arise from the Constitution, common law, legislation or contract. According to McQuoid-Mason (2001: 5), a patient enters into a contract with a doctor (in a private sector) or a hospital in a public sector. A patient must consent to treatment. A doctor has no right to treat patients without their consent except in cases of emergency. There are substitute consent by people such as parents, guardians, spouses, relatives, medical superintendent and Minister of health. A doctor does not guarantee a cure but must treat a patient in the normal manner according to generally accepted medical procedures. If a doctor disregards a patient's express instructions or fails to treat a patient for no good reason or in the manner agreed upon or expressly guaranteed, the doctor will be guilty of a breach of contract. The state health institutions have a duty to treat patient presented at their facilities (McQuoid-Mason 2001: 6). A patient has a duty to avail him or herself for treatment.

Lack of access includes the refusal to provide health care and the provision of health care that falls short of the required standard of care. It comes in multiple forms, for instance, lack of transport, lack of reasonable accommodation of people living with

disability, turning the patients away during, before or after official working hours, lengthy waiting periods, lack of medication and drugs, medical negligence, failure to refer to the place of the required service, poor referral policy, lack of human resource and institutional capacity, and lack of medical instruments and equipment.

Professional or medical negligence alludes to the failure to adhere to the required standard of care and skill. Professional negligence denies a patient's right to a reasonable care. It is *per se* a denial of access to the required standard of health care and skill. Negligent malpractice by health care workers such as doctors and nurses is a form of negligence applicable to professional people (Claassen & Verschoor 1992: 31). Claassen and Verschoor explore a number of malpractices as follows-

**(a) Diagnosis**

Diagnosis identifies the medical condition from which a patient suffers and brings the information associated with the medical condition and recommended treatment plan within the personal knowledge of the patient or authorised persons. After the access to the facility and practitioner, diagnosis becomes a gateway into treatment. There are two salient problems relating to diagnosis, namely incorrect diagnosis and the failure on the part of the practitioner to communicate diagnosis to a patient. Wrong diagnosis consists in either the failure to identify the medical condition from which a patient suffers or the diagnosis of an illness from which a patient does not suffer.

**(b) Failure to communicate diagnosis to patient**

A patient has a right to the diagnostic report. The practitioner must inform the patient of his or her medical condition and what needs to be done to remedy the situation. The information empowers a patient to make informed decisions about his or her medical condition and grant informed consent to treatment.

**(c) Treatment**

After diagnosing the patient's medical condition a practitioner is enjoined to treat the patient with reasonable care and skill as a reasonable practitioner would. While the

practitioner has a duty to treat his or her patient, the latter must consent to treatment. If a patient refuses to consent to treatment, the practitioner cannot treat the patient against the latter's will.

#### (d) **Operations**

The practitioner must operate the right patient at the right time. Liability can also result from-

- (1) The failure to operate in time.
- (2) The failure to perform a necessary operation.
- (3) The performance of unnecessary operation.
- (4) Operating a wrong organ.

### **2.9. Case law:**

There are a number of court decisions that deal with socio-economic rights. The following are classical examples -

#### **2.9.1. Government of the Republic of South Africa v Grootboom and Others 2000 (11) BCLR 1169 (CC)**

The Grootboom case involves the right to adequate housing (a socio-economic right). The primary object of the court action was to enforce the rights of the homeless people to have access to adequate housing. The Constitutional Court confirmed the right. Most importantly, the court also held that the rights in the Bill of Rights are mutually supportive and interdependent. According to article 5 of the Vienna Declaration and Programme of Action –

All human rights are universal, indivisible and interdependent and interrelated ...

Rights are, therefore, polycentric. The enjoyment of a right by one must be extended to the enjoyment of the right by all who are similarly situated. Moreover, the failure to



realize one right is the failure to realize all, for the simple reason that rights are universal, indivisible and interdependent.

The holding in Grootboom indirectly calls for an integrated rights-based approach to development. For instance, the rights to income, education, housing, food security and environment (that is not harmful to one's health) may not be separated from the right to have access to health care.

### **2.9.2. Soobramoney v Minister of Health, KwaZulu-Natal 1997 (12) BCLR 1696 (CC)**

Sachs J, in Soobramoney case, stated that “healthy life depends upon social interdependence: the equality of air, water, and sanitation which the state maintains for public good; the quality of one's caring relationships, which are highly correlated to health, as well as the quality of health care and support furnished officially by medical institutions and provided informally by family, friends and the community ...”

### **2.10. Conclusion**

Human rights instruments provide that everyone has a right to have access to health care. They clearly spell out the indivisible and mutually supportive rights that people have. Health care access is not only the treatment of a patient by a health professional but there are four dimensions of health care access: geographic accessibility, availability, financial accessibility and acceptability. However, there are demand-side and supply-side barriers that usually impede universal health care coverage. Health care access barriers affect the right of health care users to have access to health services. Health care access barriers account for the gap between the right to have access to health care, health care utilisation and realised health care need. Classical examples of health care access barriers are the conditions of roads and transport, travelling time and distance, scarce skills, lack of medication and equipment and cultural and religious belief systems. The stakeholders must develop and implement supply-side and demand-side interventions to address barriers to access to health care.

## **CHAPTER 3: RESEARCH DESIGN**

### **3.0. Introduction: choice and rationale of the design**

This chapter explores, among others, the research design, research methodology, study area, target population, population sample size, data collection methods and ethical considerations.

### **3.1. Defining research design**

Research design is a plan or blueprint according to which a researcher intends to conduct research (Mouton 2001: 55). Welman, Kruger and Mitchell (2005: 52) define research design as the plan according to which a researcher obtains research participants (subjects) and collect information from them. The research design must, therefore, specify, among others, the following -

- (a) The number of groups that should be used.
- (b) Whether these groups are to be drawn randomly from the populations involved and whether they should be assigned randomly to groups.
- (c) What exactly should be done with them in the case of experimental research?

According to Mare (2010): 70, a research design is a plan or strategy which incorporates, among others, the selection of respondents, the data gathering techniques and the data analysis methods. Terre Blanche and Durrheim (1999: 33) point out that a research design must take into account four dimensions -

- The purpose of the research;
- The theoretical paradigm informing the research;
- The context or situation within which the research is carried out; and
- The research techniques to be employed to collect data.

According to Leedy & Ormrod (2001:4) research methodology is the systematic process of collecting and analysing information (data) in order to increase the understanding of

the phenomenon about which the researcher is concerned. According to Bless and Higson-Smith (1995:63), research methodology is 'a specification of the most adequate operations to be performed in order to test a specific hypothesis under given conditions'. De Vos *et al* (2005:132) concludes that definitions of research design are rather ambiguous. It is submitted, however, that these definitions proffer guidelines on how to develop research plans. In the instant case, the researcher began by perusing and studying the contents of sampled medical records.

### **3.2. Research methodology**

The study combines quantitative and qualitative research approaches (De Vos *et al* 2005: 357-366). According to Creswell (1994: 2), a qualitative research method is "an enquiry process of understanding a social human problem, based on building a complex, holistic picture, formed with words, reporting views of information, and conducted in a natural setting". On the other hand, in his distinction between qualitative and quantitative research designs, Neuman (2000: 121-155) shows that quantitative research includes experiments, content analysis and surveys. De Vos *et al* (2005: 133-142) categorises quantitative research designs into –

- Notational system
- Pre-experimental, hypothesis-developing/exploratory designs
- Quantitative-descriptive (survey) designs
- Quasi-experimental/associative designs
- True experimental/cause-effect/explanatory designs

### **3.3. Study area**

The study area is Ratshaatsha Community Health Centre. Ratshaatsha Health Centre is situated at Eldorado Village in the Blouberg Municipality. It is strategically situated to provide services to the communities of Maleboho-North, Ga-Kibi, Ga-Makgatho and Ga-Mamadi (Taaibosch). Some of the surrounding villages have clinics that provide primary health care (PHC) services. The nearest 'referral' hospital is Hellene Franz which is on

average 40 km away from the above-listed communities. It is situated approximately 200 km from Polokwane City and 70 km from Beit Bridge border between Zimbabwe and South Africa. For obvious reasons, the population sample comprises participants from the villages within the proximity of the health centre, i.e. within 10 km radius. Some of the villages within this radius are Eldorado, Pax, Makgari, Eso Rinca, Slaaphoek, Goudmyn and Wegdraai.

### **3.4. Target population**

According to Welman, Kruger and Mitchell (2005: 52), '[t]he population is the study object and consists of individuals, groups, organisations, human products and events, or the conditions to which they are exposed'. They state, furthermore, that the population encompasses the total collection of all units of analysis about which the researcher wishes to make specific conclusions. A population is a full set of cases from which a sample is taken (Welman, Kruger & Mitchell 2005:53). Closely akin to this definition is the one by Seaberg (1988: 240) that defines a population as the total set from which the individuals or units of the study are chosen, while Bless and Higson (2000:85) defines population as the set of elements that the research focuses upon and to which the obtained results should be generalised. According to Powers *et al* (1985:235) a population is a set of entities in which all the measurements of interest to the practitioner or researcher are represented.

The population consists of the consumers of the health care services [patients] at the Ratshaatsha Community Health Center. The population is drawn from the communities of Maleboho-North, Ga-Kibi, Ga-Makgatho and Ga-Mamadi (Taaibosch). The population is over 60,000.

#### **3.4.1. Population sample size**

A sample is a small section or set of individuals selected from a population (Gravetter & Forzano 2003:465). It is a subset of measurements drawn from a population in which the researcher is interested (De Vos *et al* 2005:194). According to Seaberg (1998:240), a sample is a small portion of the total set of objects, events or persons who together

comprise the subject of the study. The researcher uses the sample to explain some facet of the population (Powers *et al* 1985:235).

#### **3.4.2. Data collection methods**

A researcher has a duty to collect information about the object of study from a variety of sources. There are various methods of collecting data, particularly regarding qualitative research, namely participant observation, interviewing and document study and secondary analysis (De Vos 2005 *et al* (274-326)). The research problem and population determine the type of research method and data collection method. The study used a combination of the following data collection methods: questionnaire for quantitative data collection and focused group discussion as well as participant observation in respect of qualitative data collection. The language of the interview guide and questionnaire was English. The research was conducted from the 16<sup>th</sup>-20<sup>th</sup> June 2011 and May-June 2012. The purpose and questions were explained to the participants in Northern Sotho and the discussions were themselves held in Northern Sotho. The participants were allowed to ask questions for clarity throughout the proceedings.

As explained earlier, the population size is approximately 30,000. The initial intention was to constitute a sample of 70 community members comprising two focus groups of 20 members each and 30 individual interviews. These numbers were informed by a careful consideration of financial, logistical and practical circumstances. For purposes of quantitative data collection, respondents were selected randomly at public places such as shops, health facilities and streets within the study area. Care was exercised to pick up on people from different villages. The respondents disclosed their church membership in the questionnaire. Forty (40) individuals were requested to complete and return the questionnaire. All of them agreed to participate in the survey. Five (5) did not return the questionnaire for various but undisclosed reasons.

The researcher formed a focus group discussion (FGD) of thirty (30) participants for purposes of qualitative data collection. He selected the participants purposively. He

conducted focus group discussions. He designed an interview guide in order to regulate the group discussions. He took time to explain the purpose and content of the questionnaire with each respondent. He interviewed the respondents and jotted down notes. Questions for clarity were asked and answered as much as necessary. Where necessary, follow up questions were asked to eliminate the possibilities of drawing wrong inferences and miscomprehension. Notes of this additional data were taken for purposes of contemporaneous analysis and interpretation. Males were more willing to participate than females.

### **3.5. Ethical considerations**

The researcher gave the respondents a pre-interview explanation of the purpose of the research interviews so that they can make informed consent. He assured them that they would be protected from harm and that their right to privacy would be respected. He created an environment that made the participants to play their roles in the focus group discussions without duress or fear. He guaranteed anonymity and confidentiality of the particulars of the participants. The participants were free to end their participation in the interviews at any time.

### **3.6. Conclusion**

The researcher developed a research design that combined quantitative and qualitative approaches. He selected a sample of 40 individuals for purposes of quantitative data collection and one focus group composed of thirty (30) participants for purposes of qualitative data collection. The questionnaire was used to collect quantitative data from individual respondents, while an interview guide was used to direct and regulate focus group discussions and collect qualitative data.

## CHAPTER 4: DATA ANALYSIS AND INTERPRETATION

### 4.0 Introduction

Chapter 4 analyses and interprets the data. The study uses, among others, the content analysis method (Welman et al. 2004:9). There are two categories of data: quantitative and qualitative data. The study analyses both quantitative and qualitative data.

### 4.1 Analysis of quantitative data

Thirty respondents were successfully interviewed. In order to determine the role of alternative health care service providers, the questionnaire contained some questions relating to religion or faith as well as its use for healing purposes. The following were the findings of the study from the quantitative component of the study.

#### 4.1.1 Gender of respondents

Out of thirty respondents, eighteen were male (60 %) and twelve were female (40 %). The largest group of the faith-based participants is ZCC membership, while the smallest group of the faith-based participants is the membership of the splinter but multiple apostolic churches. St Engenas ZCC and African religion are the intermediate groups.

**Table 1: Gender distribution of respondents**

Gender	ZCC	St Engenas ZCC	Apostolic church	African religion	Others	Total	%
	No.	No.	No.	No.	No.	No.	
Male	6	3	1	3	5	18	60%
Female	4	1	2	2	3	12	40%
<b>Total</b>	10	4	3	5	8	30	100%

(NB: The fractions are discarded and the total of 99% is rounded to 100%).

### 4.1.2 Age of respondents

Out of the thirty respondents, seven respondents (23%) fall within the age category of 20-45, ten respondents (33%) fall within the age category 46-60 and thirteen respondents (43%) fall within the age category 61 and above.

**Table 2: Age of respondents**

Age	ZCC	St Engenas ZCC	Apostolic	African religion	Others	Total	%
20 – 45	3	1	1	0	2	7	23%
46 – 60	2	3	1	2	2	10	33%
61 +	5	0	1	3	4	13	43%
<b>Total</b>	10	4	3	5	8	30	100%

(NB: The fractions are discarded and the total of 99% is rounded to 100%).

### 4.1.3 Source of income

According to table 3 below, 12 respondents (40%) are dependent on government social security, namely old-age pension, disability grants, foster care grants and child support grants. Nine respondents (30%) have miscellaneous sources of income such as subsistence farming, formal and informal business. Six respondents (20%) are state employees. Three respondents (10%) do not earn any income of any form.

**Table 3: Source of income**

What is the main source of Income?	Salary/wage	Pension/grants	Other	No Income	Total
%	20%	40%	30%)	10%	100%



Eighteen respondents (60%) earn between 0 and 1200 rand per month. Most of the people in this category are dependent on government pensions or grants, subsistence farming, informal business and other impermanent jobs. Others are not gainfully employed and earn no income. Only 1 respondent (3%) earns between R1201 and R1500 rand per month, while 3 respondents (10%) earn between R1501 and R2000 rand. Eight respondents (27%) earn more than R2000.

**Table 4: Household income**

What was the total household Income last month?	R'00 0-1200	1201-1500	1501-2000	2001 or more	Total
%	60%	33%	10%	27%	100%

#### 4.1.4 Geographic accessibility (distance)

Ratshaatsha Community Health Center (RCHC) provides services to a population that is largely within 30km radius. According to the respondents, ten respondents (33%) reside within 10km radius, twelve respondents (40%) reside within 20km radius and eight respondents (27%) reside within 30km radius.

**Table 5: Geographic accessibility (distance)**

What is the distance between Ratshaatsha CHC and your place of abode?	0-10km	10,1-20km	20,1-30km	Total
%	33%	40%	27%	100%

#### 4.1.4 Geographic accessibility (means of transport)

There are five categories of means of transport, namely foot (pedestrians), taxis, buses, own or family vehicles and other means. Eleven respondents (37%) indicated that they use taxis to visit the RCHC. Five respondents (7%) indicated that they use bus transport to visit the RCHC. Two respondents (7%) indicated that they use own or family-owned cars to visit the RCHC. Six respondents (20%) indicated that they use other means of transport such as bicycles and donkey carts to visit the RCHC. Six respondents (20%) said they walk to the RCHC.

**Table 6: Geographic accessibility (means of transport)**

How did you travel to the facility?	Foot	Taxi	Bus	Own car/family car	Other	Total %
	20%	37%	17%	7%	20%	100%

#### 4.1.5 Waiting time

Seventeen respondents (57%) indicated that when they visited the RCHC they were attended to within 60 minutes of their arrival at the out-patient department. Eight respondents (27%) indicated they waited for one to two hours (61 – 120 minutes) before they were served. Four respondents (13%) indicated that they waited for two to three hours (121 – 180 minutes) before they were served. One respondent (3%) indicated that he waited for over three hours (181 minutes and more) before he was served.

**Table 7: Waiting time**

How long did you wait before you were attended to by a health worker?	0-60min.	61-120min.	121-180min.	181 or more	Total %
%	57%	27%	13%	3%	100%

**4.1.6 Availability of medication**

The term medication is used here to refer to, among others, medicines, drugs, medical equipment, skills and other requisites for adequate treatment of patients. The medication requisites differ from one patient's needs to another. Eleven respondents (37%) said medication required for their personal conditions was always available. Seventeen respondents (57%) said their medication was sometimes available. Two respondents (7%) said their medication was seldom available.

**Table 8: Availability of medication**

Was medication available for your condition?	Always	Sometimes	Seldom	Total
%	37%	57%	7%	100%

(NB: The total of 101% is rounded to 100%).

**4.1.7 Service hours**

Two respondents (7%) said that they arrived at 07h00 and the RCHC attended to them at 07h00 (i.e. immediately). Sixteen respondents (53%) said, although they arrived at 07h00 or earlier, the RCHC started to provide service at 07h30. Ten respondents ((33%)) said, although they arrived at 07h00 or earlier, the RCHC started to provide service at 08h00. One respondent (3%) said, although he arrived at 07h00 or earlier, the RCHC started to provide service at 08h30. One respondent (3%) said, although he

arrived at 07h00 or earlier, the RCHC started to provide service at 09h00. As things stand 07h30 and 08h00 appear to be the favoured service times. It is worth stating that the opening times are not always starting times. In other words, it may happen that the doors of the facility are opened 24 hours but the officials begin to provide services later than the starting time of a particular shift. The participants emphasised that usually the officials would take their blood pressure and other preliminaries and let them wait for a health care provider for an inordinate time while the staff chat among themselves, eat or drink tea..

**Table 9: Service hours**

At what time did the facility open on the last day of your visit?	07h00	07h30	08h00	08h30	09h00	Total
%	7%	53%	33%	3%	3%	100%

#### 4.1.8 Appointments

Twenty seven respondents (90%) said when they visited the RCHC, without appointment, they were helped. Three respondents (10%) said when they visited the RCHC, without appointment, they were not helped but were given appointment for another day.

**Table 10: Appointments**

If you present yourself at the facility without appointment are you helped?	Helped/Not helped	Given appointment for another day	Total
%	90%	10%	100%

#### 4.1.9 Rating of health services

The health services must meet the requisite norms and standard. There are best practices. However, the best barometer is the satisfaction of the patients' needs. Although not decisive, the perceptions of patients are of consequence in the health services provisioning. Out of thirty (30) respondents, six respondents (20%) said the health services at RCHC were good and fourteen respondents (47%) said the services were average and ten the respondents (33%) said the services were poor.

**Table 11: Rating of health services**

How do you rate health services at the facility?	Good	Average	Poor	Total
%	20%	47%	33%	100%

#### 4.1.10 Financial accessibility (affordability)

No respondent pays personally for health services provided to him or her at the RCHC. Most of these people are dependent on government social grants. They are required to produce social grants certificates/receipts to prove that they are dependent on government social pension and, therefore, qualify for free health services. Others are unemployed and economically inactive. Most of those who fall within the unemployed category rely heavily on alternative health services.

**Table 12: Financial accessibility (affordability)**

Do you pay personally for the Health services?	Yes	No	Total
%	0	100%	100%

#### 4.1.11 Choice of service

Nine (9) respondents (30%) said even if they had a choice between the RCHC and competing health care providers they would continue to use the health services at the RCHC. On the contrary, twenty one respondents (70%) said if they had such a choice they would not continue to use the services at the RCHC. In other words, if private health service providers were available and provided affordable and better health services in the study area, they would not continue to use the health services at the facility. Surprisingly, the salary and wage earners and business people are among those who said they would continue to use the services offered by the RCHC. The only explanation is that these groups had always had a choice to use the services of RCHC or private health services providers. They can afford it. Most of them are government employees and members of the medical aid schemes. Moreover, medical aid schemes such as GEMS have a free option (SAFARI) for lowly-paid public servants such as cleaners, labourers and lower categories of administration clerks (levels 1 to 3). The other categories choose among three other options.

**Table 13: Choice of service**

If you had a choice would you continue to use the health services at this facility?	Yes	No	Total
%	30%	70%	100%

#### 4.1.12 Use of Alternative health services

Twenty-nine respondents (97%) said they use alternative health services more often. One respondent (3%) said he often uses the services of alternative health services providers. No respondent said he or she seldom uses the services of alternative health services providers. In other words, although they use Western medicine, they do not do so exclusively. Religion plays quite critical a role in their lives.

**Table 14: Use of Alternative health services**

How regularly do you use alternative Health services?	More Often	Often	Seldom	Total
%	97%	3%	0	100%

**4.1.13 Preference of an alternative health services provider**

Surprisingly, the answers to this question in Table 15 differ from those in Table 1. Thirteen respondents (43%) said they use ZCC faith-healing services, while six respondents (20%) said they use the services of St Engenas ZCC, four respondents (13%) use the services of Apostolic Church. Five respondents (17%) use the services of traditional African religion. Six respondents (6%) use the services of other faiths.

**Table 15: Preference of an alternative health services provider**

If you do, which of the following do you use?	ZCC	St.Engenas ZCC	Apostolic church	African religion	Other	Total
%	43%	20%	13%	17%	7%	100%

**4.1.14 Health care access**

While all respondents (100%) often receive services at the RCHC, none of them said that he or she always have access to health services at RCHC.

**Table 16: Health care access**

Do you have access to health services at RCHC?	Always	Not always	Total
%	0	100%	100%

**4.1.14 Causes of lack of access to health care**

Four respondents (13%) complained that distance makes it difficult to access health care at RCHC, five respondents (17%) cited transport, four respondents (13%) cited affordability, five respondents (17%) cited staff attitude, six respondents (20%) cited lack of drugs and six respondents (20%) said they prefer alternative health services. However, there is a cross-section of the causes of lack of health care access.

**Table 17: The cause of lack of access to health care (violation of the right to health care access)**

If not always, why?	Distance	Lack of transport	Affordability	Staff attitude	Lack of medical equipment, medicines and drugs	Prefer alternative Health services	Total %
%	13%	17%	13%	17%	20%	20%	100%

**4.2 Analysis of qualitative data**

This section presents data from personal observations and focus group discussions (FGD). The researcher visited the bus depot, taxi rank, community clinics, the RCHC, church services points to observe the goings-on. He jotted down his observations. He often asked questions in order to clarify his observations.



The role of the researcher in the focus group discussions was limited to observation, facilitation and guidance. He explained the guidelines and questions in the interview guide in the language of the participants: Northern Sotho. The term 'participants' in the instant case alludes to the members of or respondents who participate in, focus group discussion formed by the researcher for purposes of collecting qualitative data from a sample. Participants freely asked questions for clarity. He clarified. Participants discussed issues and answered questions. He asked follow-up questions where necessary.

#### **4.2.1 Geographic accessibility**

Geographic accessibility alludes to the travelling distance and time from the health care facility to the point where the health care user is picked up and ferried to the health care facility. According to the participants, in the case of emergency, an ambulance goes out, as and when necessary, to pick up and transport a patient to the health care facility for treatment. The Emergency Medical Service (EMS) staff provides a patient with in-transit medical service. In any case, an ambulance travels to and fro the health care facility. Distance (space) and time are critical factors in the provision of health care services. The other factors that affect the timely provision and utilisation of health care services are roads, transport and communication system. This rubric focuses on travelling distance and time, roads and transport and communication system. These components of geographic accessibility are discussed *seriatim* in the following paragraphs-

#### **4.2.2 Travelling distance and time**

Ratshaatsha Community Health Centre (RCHC) is situated at Eldorado village (Bochum-North). Hellene Franz Hospital is about 50 km away from the RCHC. There are at least four clinics within the 25 km radius, namely Gideon Community Clinic, Makgafela Community Clinic, Kibi Community Clinic and De Vrede Community Clinic. According to the participants, the community members are either referred to the RCHC for further or higher level of observation by nearby community clinics or a private doctor or present themselves at the RCHC without a referral letter from a community clinic or

private doctor. The EMS ambulances convey seriously ill/injured patients and obstetric emergencies to hospitals.

According to the participants, the distance from or to the RCHC varies from village to village. It is measured from the RCHC to the patient-pick-up point and from the patient-pick-up point to the RCHC. Travelling time is affected by, among others, the following factors: distance, the condition of the road and the roadworthiness of the transport. The general belief, for which the researcher has not collected empirical evidence, is that state drivers drive recklessly, negligently or inconsiderately and that government fleet is generally un-roadworthy. The researcher observed that the public roads in the study area run through built environments. Unless the emergency traffic rules permit the speed limit is generally 60km/h.

The researcher observed that those who cannot defray transport costs visit the RCHC on foot. The participants confirmed that the travelling time in respect of pedestrians is lengthy in spite of the fact that the majority of them reside within a 10 km radius.

#### **4.2.3 Roads and transport**

The researcher observed that that the transportation system comprises a variety of makes and models of road transport. It is divided, furthermore, into public and private transport. The study area is underdeveloped. There is a tarred road that off-ramps to the West from Polokwane-to-Alldays Rd and turns North-West at Kgobokanang General Dealer as the road proceeds towards Endermark village. Unfortunately, this tarred road ends half-way at a turn-off towards Kgomotshehlo en route to Eldorado. Almost 10 km distance of the road to Ratshaatsha Community Health Centre is not tarred and is in poor condition.

#### **4.2.4 Public transport**

According to the participants, public transport consists of both public sector transport and private sector transport. Public sector transport is financed by government (Public Treasury), while private sector transport is owned and funded by the private sector.

#### **4.2.5 Government-owned transport**

According to participants, there are two categories of government transport to which the health care users may have access and use to and fro the Ratshaatsha Health Centre and the feeder community clinics: the Great-North Transport and public patient transport.

#### **4.2.6 Great-North Transport**

According to the bus drivers, the Great-North Transport is licensed to transport public passengers on the public roads that include the routes that extend from the Ratshaatsha Community Health Centre, feeder clinics, Hellene Franz Hospital and Polokwane-Mankweng Hospital Complex. One fleet of three buses takes the route from Eldorado Trade Store South West through Goudmyn, Slaaphoek, Wegdraai, Gideon, Top and Ziest, to name but a few villages *en route* to Polokwane. The other fleet of three buses takes the route to the South-East through Fountain Du Chamb (Ga-Mashamaite), among other villages *en route* to Polokwane.

The researcher confirmed that Eldorado makeshift bus depot is in the proximity of the RCHC (i.e. within 2 km distance). The buses depart from the Depot before 06h00 in the opposite directions but away from the Community Health Centre. The Eldorado-bound buses begin to arrive at Eldorado late in the afternoon. Taking into account the RCHC business hours (07h30-16h30), the bus travelling times are not absolutely patient-friendly.

#### **4.2.7 Public patient (emergency) transport**

According to the 2011/12 Annual Report of the Department of Health, the Department of Health has a division called Emergency Medical Services (EMS) within its Health Branch. A director, a qualified EMS professional, heads the division. The EMS provides emergency medical services. It has generally properly equipped ambulances staffed by

EMS specialists. It provides emergency medical services and ferry emergency patients to a health institution which provides the requisite standard of medical services.

#### **4.2.8 Taxi industry**

The researcher observed that the main taxi rank is situated at Kromhoek (Ga-Makgatho). There is a small, under-resourced and under-utilised taxi rank at Eldorado Village – a stone's throw away from the Ratshaatsha Community Health Centre. However, there are no call-taxis or city-taxis. Taxi service is consistently available between 6 am and 09 am en route to Polokwane and between 14h00-18h00 from Polokwane to Kromhoek and 18h00 to 20h00 from Kromhoek en route to different villages surrounding Ratshaatsha Community Health Centre.

#### **4.2.9 Personal transport**

According participants, only a minority in the communities has cars, tractors, carts, bicycle or motor cycles. Some teachers, administrators, clerks, small-scale farmers, and migrant workers count among such a minority. They use these transport for multiple purposes. When necessary, they use their transport to and fro a health care facility. They bear the necessary expenses such as fuel, maintenance and related expenses.

#### **4.2.10 Hired transport**

According to the participants, the have-nots may bear the delivery expenses of the hired transport that ferries them to and fro the health care facility. The irregular bus and taxi services leave a hiatus that is filled by the hired transport. These are not the commercial car hire schemes such as those provided by Budget and Avis Car Hire companies. These are as and when arrangements between the haves and have-not fellow residents in different catchment communities. If someone falls ill, say, at night when taxi and bus services are rarely available, a transport-owning person may be hired to deliver the sick to and fro the health facility at a fee. The charges are often prohibitive.

#### **4.2.11 Transport costs**

Costs attach every means of transport. There are opportunity costs attached to visiting the RCHC on foot. For instance, if a care-provider brings a patient to the RCHC on foot, he or she forgoes a day's income or takes a time off from his or her daily program at home or workplace. The following paragraphs deal with the question of travelling costs *seriatim* –

##### **4.2.11.1 Great-North Transport**

According to bus drivers and participants, patient pays the bus fare equal to a fare payable by an ordinary bus passenger for the same distance on the same route. Great-North Transport does not provide off-route delivery service. While there is a reduced bus ticket fare for scholars, there is no special dispensation for patients. However, the bus fares are prescribed in such a fashion that passengers share the travel expenses in accordance with a predetermined system. Government subsidises the bus industry.

##### **4.2.11.2 Taxi Service**

According to taxi drivers and participants, a patient pays the taxi fare equal to a fare payable by an ordinary taxi passenger for the same distance on the same route. The taxis from Ga-Kibi (in the North), Gideon-Wegdraai-Slaaphoek-Goudmyn village route (in the West) and De Vrede-Burgrecht-Pax-Makgari-Ga-Mashamaite (in the East/South-East) and Eso Rinca (in the South) drop and pick up the sick and those who accompany them at the Ratshaatsha Community Health Centre at a fee. However, unlike the hired or own transport, the taxi fares are prescribed in a fashion that ensures that passengers share the travel expenses. Taxis provide off-route delivery service at extra charges.

##### **4.2.11.3 Personal (own) transport**

According to the participants, a patient is responsible and liable for the overall expenses in respect of his or her privately owned transport. Even if he or she were using a donkey he or she incurs expenses in relation to the cart and a span of oxen, donkey, mules or horses. He or she dedicate labour and time and herd and feed the draughts animals

with fodder. All these are paid for in money or kind. Nowadays, animal-drawn carts are no longer in favour among the catchment communities. Few people use them.

#### **4.2.11.4 Hired transport**

According to the participants, hired transport is expensive to call. The owners often over-charge. It is a sort-of a once-in-while hire of transport service. Service providers hold a view that ferrying a sick person to and fro a health care facility is a more inconvenience to the transport-owner than giving a lift to a hitch-hiker.

#### **4.2.12 Communication system**

There are various kinds of means of communication. Post and telecommunication systems play essential roles in this regard. Public and private sector organisations such as Post Office, Postnet, Telkom, MTN, VODACOM and CELL C provide much-needed communication services.

##### **4.2.12.1 Telkom**

According to the participants, the TELKOM telephone service is nigh-absent in the catchment communities. For a long time post and telecommunication services were only available at Lebogo Traditional Authority offices. From time immemorial, the sole proprietorships and schools within the study areas were providing collateral postal services: managing the postal bag. Where the service exists, it is dear and customer-unfriendly. With the exception of the portable and mobile cellular phones, the TELKOM phones are immobile and fixed telecommunication gadgets.

##### **4.2.12.2 Cellular communication system**

According to the participants, the cellular phones are mobile and user-friendly. Even if the user did not insert air-time, he or she could still receive messages and calls at a relatively reasonable and affordable fee. A patient may send a “please call me”

message to the next-of-kin, neighbor, colleague or friend in order to obtain help at the time of need and emergency.

#### **4.2.13 Causes of violations**

The poor conditions of the roads and transport lead the violations of the right of the health care user to health care access. They affect time and space negatively. The official communication system between the users and health care facility is nigh-absent. This affects the ambulance call-up and response times.

#### **4.2.14 Rationale for the health access barriers**

The health care barriers are generally the ramifications of the age-old neglect and underdevelopment of the study area. The apartheid government turned a blind eye. The Lebowa Government (the then homeland state) did not develop the area under the Bahananwa Traditional Authority (under the aegis of Kgoshi Maleboho) because the senior traditional leader (Maleboho) refused to collaborate with the apartheid government and its lackeys. From 1994 to date, the democratic government has implemented some isolated development projects. There is no evidence of integrated development approach.

#### **4.2.15 Availability of health services**

According to Peter (2008: 12), availability is measured in terms of the opportunity to access health care as and when needed. He defines availability as 'having the right type of care available to those who need it, such as hours of operation and waiting times that meet demands of those who would use care, as well as having the appropriate type of service providers and materials' (2008: 5). Picture 1 shows people waiting for health services.



**Picture 1: A patient arriving for service**

#### **4.2.16 Health care facilities**

There is one hospital, named Hellena Franz, within the Blouberg Municipality and two Community Health Centres, namely Blouberg Community Health Centre (formerly Blouberg Hospital) and Ratshaatsha Community Health Centre. Each community health centre has numerous referral clinics. The community health centres refer patients to Hellena Franz Hospital and Polokwane-Mankweng Hospital Complex (which comprises Pietersburg Hospital and Mankweng Hospital). Ratshaatsha Community Health Centre has at least four community clinics within its 25 km radius (i.e. Gideon Community Clinic, Makgafela Community Clinic, Kibi Community Clinic and De Vrede Community Clinic). The picture 2 below shows the front face of Ratshaatsha Community Health Centre.





**Picture 2: Ratshaatsha Community Health Centre**

#### **4.2.17 Mobile, home-based care and outreach services**

There is a mobile PHC service that complements the services which the community health centre and community clinics provide to the surrounding communities. Nurses and volunteers provide home-based care for the bed-ridden and those who cannot easily visit the health care facility owing to their medical conditions.

#### **4.2.18 Emergency transport**

EMS provides ambulance services to the communities. The EMS provides, at least, patient transport and emergency health care services.

#### **4.2.19 Human resources**

While the community clinics have at least a professional nurse, assistant nurses and general assistants, the community health centre must have the services of medical officers. The staff does not have sufficient offices and consulting rooms. The picture 3

shows the Operational Manager at work updating the notice board in her office. She has converted a consulting room into a management office because of lack of office space.



**Picture 3: The office of the Operational Manager**

#### **4.2.20 Medical instruments and equipment**

There are some medical instruments and equipment. However, others are not in good working condition.

#### **4.2.21 Medicines and surgical sundries**

There is a room for improvement of demand and supply of medicines and drugs. The stock levels leave much to be desired.

#### **4.2.22 Technology**

There is no evidence that the Ratshaatsha Community Health Centre and the surrounding clinics have to date taken full advantage of the available technology in order to improve and optimise the availability of the quality health care. The main component should be the implementation of the Provincial Hospital Information System (PHIS). The official records show that, after expenditure of almost R265m, the PHIS is not yet fully implemented and functional. The PHIS is designed to optimise health care delivery.

#### **4.2.23 Causes of violations**

The lack of PHIS affects the availability of patient information on line and health care delivery negatively. Picture 4 shows a facet of chaotic record management system.



**Picture 4: Patients' files**

#### **4.2.24 Health access barriers**

Lack proper planning delayed the implementation of PHIS and caused fruitless expenditure. At the commencement of the project implementation, the service provider discovered that the prerequisite hard infrastructure (networks) was not installed. Information technology consultants were procured to implement the project spent lengthy period of time awaiting the installation of the hard infrastructure. However, they invoiced wasted costs.

#### **4.2.25 Financial accessibility**

The fiscus carries the expenditure necessary for the provision of the health care services at the RCHC.

#### **4.2.26 Treasury (public financing)**

The National Treasury is dependent, mainly, on taxes. The National Treasury collects taxes and other revenue and allocates its shares to national, provincial and local spheres of government for public service delivery purposes in order to satisfy a public need. The budget is divided into a number of items. The study makes a finding on a few of them-

#### **4.2.27 Employee compensation**

According to the officials, the salary bill constitutes a huge percentage of the Public Service budget. The Provincial Department of Health hires and pays the salaries of the staff compliment of the community health centre and adjacent clinics.

#### **4.2.28 Goods and services**

According to the officials, the Department is liable for the goods and services expenditure at the community health centre and clinics.

#### **4.2.29 User fees**

The user fees are part of the government revenue. However, the RCHC does not charge fees to health care users.

#### **4.2.30 Consultation fees**

Patients are liable for consultation fees. However, the community health centres do not collect revenue.

#### **4.2.31 Medicines and surgical sundries**

The provincial health department has a Pharmaceutical Depot situated in Seshego which is responsible for the procurement, warehousing and distribution of medicines and drugs. The Department had since the 1990s outsourced the management of the depot as well as the procurement, warehousing and distribution of medicines and drugs at a huge fee. The bid was adjudicated and awarded on three-yearly basis. The department paid a management fee of over R2m per month. The health institutions source medicines and drugs from the depot. However, the Department has resumed the management of the depot with effect from 01 April 2012.

#### **4.2.32 Medical equipment use**

The Department procures medical instruments and equipment by means of a Supply Chain Management System in accordance with procurement legislation. Some of the medical equipment is not in good working order. Picture 5 shows some medical equipment underneath snooker.



**Picture 5: EMS operating room**

#### **4.2.33 Bed use**

A patient pays for the health care facility bed use. However, this rarely happens at the community health centres.

#### **4.2.34 EMS transport costs**

The general policy is that EMS transport costs are chargeable against users on *pro rata* basis (depending on the means test (income)). The user communities in the study area are generally indigent and dependent on government social security grants. An indigent rarely pays the user fees.

#### **4.2.35 Causes of violations**

The community is generally poor and live from hand to mouth. As said before, the main source of income is government social security. These social grants can barely buy food

for the beneficiaries. Health services and clothes are luxuries. In the main, poverty is the cause of the failure of the users to defray the costs of health care. Poverty is inversely related to the costs of health care. One way or another, it affects the quality of health care and health care access. Lack of or poor financial accessibility is a barrier to health care access and contributes towards the violation of the right to health care access of the patients in the study area.

Health services must be socially and culturally acceptable to individual users and communities. Patients' perception of quality, price and other dimensions of access is an essential part of access to health care. Staff attitudes, cultural acceptability and quality of health care are important parts of health care access (SAHRC 2009: 45-46).

#### **4.2.36.1 Service norms and standards**

The government has developed Batho Pele Principles which provides the service standard to which the public service should conform.

#### **4.2.36.2 Cleanliness**

The health care facility is generally clean. The toilets are clean. The foreground and background are dirt-free. The landscape is pruned and clean.

#### **4.2.36.3 Maintenance**

The facility is poorly maintained. Some pipes are leaking. The roofing is in poor condition.

#### **4.2.36.4 Capacity**

The burden of diseases is high and demand of concomitant health services is equally high. The RCHC must provide comprehensive service as a norm. However, the health care facility has limited capacity to serve all the health care needs of all health care users. Picture 6 shows the overflowing child-rearing crowd that sit on the floor while waiting for service.



**Picture 6: Patients waiting for service**

#### **4.2.36.5 Medicines and surgical sundries**

There is no pharmacist or pharmacy assistant to manage Dispensary at the RCHC. In consequence, the pharmaceutical services leave much to be desired. Orders are not placed as regularly as required. The norm is that the RCHC should place orders fortnightly. The failure to conform to the norm affects inventory stock levels. Picture 7 shows medicines put on the trolley and wheelchair.





**Picture 7: Medicines on the trolley and wheelchair**

#### **4.2.37 Supply Chain Management**

Supply chain management plays a critical role in the health care delivery system.

##### **4.2.37.1 Procurement**

The Department procures medicines and manages the warehouse. It outsources the distribution of medicines and surgical sundries.

##### **4.2.37.2 Demand**

The law of demand and supply is underscoring principle of the authentic procurement system. In the instant case, the Depot procures from the industry. The health institutions procure from the Depot. They demand according to their needs. The RCHC often fails to place orders regularly (i.e. fortnightly) because of shortage of staff.

##### **4.2.37.3 Acquisition**

The Depot does not always acquire and distribute medicines and surgical sundries regularly and timely. This delay affects the stock levels at health facilities. According to the officials, some suppliers fail to deliver due to lack of capacity, while others fail to accumulate raw material within a lead time of three months after tender award.

Furthermore, according to the officials, the National Department of Health department delays in awarding the tender for the acquisition of pharmaceuticals.

#### **4.2.37.4 Distribution**

One of the responsibilities of the service provider is to distribute medicines and surgical sundries to the health institutions commensurate with the item stock level requirements of each institution. The service provider does not always optimally fulfil this responsibility. While some item stock levels meet the minimum standard, others do not. Poor conditions of roads and transport contribute to poor distribution of medicines and surgical sundries.

#### **4.2.37.5 Monitoring and evaluation**

The Department monitors and evaluates the procurement, warehousing and distribution of medicines and surgical sundries.

### **4.3 Alternative health services**

For the purposes of this study, the alternative health care services refers to the services which African-initiated churches provide excluding the services of traditional health practitioners as defined by the Traditional Health Practitioners Act. (This section will focus on ZCC only).

#### **4.3.1 Zion Christian Church and St. Engenas Zion Christian Church**

For present purposes, unless the context indicates otherwise, the term “ZCC” alludes, with the necessary changes, to both sections of the Zion Christian Church of Engenas Barnabas Makgoka Lekganyane.

#### **4.3.2 Geographic accessibility**

This dimension alludes to the travel distance and time that exist between the nearest church centre and the place of abode of a church service user. It is the policy of ZCC that the patient should be attended to at the official premises of the local church. If a priest attends to a patient at any place rather than at an official church facility, the

church may not be vicariously liable for the actions of the priest. The priest will be personally liable for his actions.

#### **4.3.3 Distance and travelling time**

There are ZCC services within 25 km radius of the Ratshaatsha Community Health Centre. The church branches are available at least at Gideon, Wegdraai, Eldorado, Pax and Burgrecht villages. On the average, the travelling distance and time to and fro the church centres are shorter than to and fro the health care facilities. The centres conduct daily faith-healing and prayer services. At some intermittent villages there are outreach church services (*makhunamo*, so-called) during the week. Reverend Samuel Setumo Mongau conducts *diagelo* at Goudmyn (Makaepea). Although unauthorized, this informal centre is rendering faith-healing and prayer services of quality. Patients suffering from ailments such as osteo-carcinoma (*sefolane*) regularly pay a visit to this healing school.

#### **4.3.4 Great-North Transport**

Church members and patients often use Great-North Transport to and fro a church facility. However, the buses use the applicable routes at pre-determined times to and from Polokwane. A person who needs church services at night may not access the Great-North Transport as the last bus reaches Eldorado at or about 22h00. On the other hand, could be going in the opposite direction of the church facility. In any case, but for Wednesday, ZCC does not conduct faith-healing and prophetic ministries at night from Monday to Thursday. Wednesday is set apart for a male-only *mokhukhu* choral group.

#### **4.3.5 Public Patient (emergency) transport**

According to the participants, ZCC does not provide public patient transport that ferries patients to and from the church service sites. Church-goers and patients organise their own transport or use the available public transport such as buses and taxis.

#### **4.3.6 Taxi industry**

Taxis go in all directions between 06:00 and 22:00. They even provide delivery services at extra charges. Some church members use them to and fro the church.

#### **4.3.7 Private transport**

Those who own cars often use them to and from the church facility.

#### **4.3.8 Transport costs**

The transport costs are in accordance with the means of transport.

##### **4.3.8.1 Great-North Transport**

Bus fares to and from the church facilities are less prohibitive. However, there is no special dispensation for those who are on their way to and from the church ceremony. They pay the prescribed bus fares commensurate with the applicable distance.

##### **4.3.8.2 Patient transport**

Patients do not incur patient transport fares because the church has no ambulances for whose service the patients should pay. Patients use buses, taxis and other means of transport for travelling between their places of abode and church service centers. Others walk to and fro the church service center.

##### **4.3.8.3 Private sector transport**

Taxis and private cars are examples of private sector transport.

###### **4.3.8.3.1 Taxi industry**

The taxi fare is higher than the bus fare.

###### **4.3.8.3.2 Personal transport**

The haves use their own transport to and fro the church ceremonies. Unfortunately, they are responsible and liable for the overall transport expenditure incurred in pursuit of their religious needs.

#### **4.3.8.3.3 Hired transport**

The church families infrequently hire transport to ferry their sick to and fro the church premises to attend the faith-healing and prophetic ministries of the ZCC. The hired transport costs are higher than the bus and taxi fares. This is so because bus and taxi travelling costs are generally shared among the passengers.

#### **4.3.8.4 Communication system**

Communication system is a very important asset for effective health care delivery. There are various modes of communication among rural communities surrounding the RCHC. However, the cost of telecommunication technology and service is prohibitive.

##### **4.3.8.4.1 Telkom**

The church centres do not have fixed TELKOM telephone lines.

##### **4.3.8.4.2 Cellular communication system**

According to the participants, there are no church-financed cellular phone services. However, the majority of church members have privately owned cellular phones which they often use to contact the ZCC priests at the times of emergency.

##### **4.3.8.4.3 Church services user fees**

According to the participants, the church services are provided at no direct cost to the patient. The patients purchase their prescriptions such as tea, Vaseline and other requirements from any service provider or source. Patients defray the costs for their transport, food, lodging and so forth.

#### **4.4 Recommendations by respondents**

This category serves to highlight some of the possible recommendations proposed by the respondents in the focus group discussions. The researcher's recommendations will be outlined in details in Chapter 5. The proposed recommendations by respondents for consideration by management are, succinctly, as follows:

- Governments must co-ordinate and integrate development to ensure that the functions (inputs) of public sector and private sector are complementary and mutually supportive.
- Government in all spheres must sponsor integrated development projects.
- Government must ensure that the local economic development (LED) strategies take into account the people's views on health care services provision.
- Roads and transport and water and sanitation infrastructural development, among others, must be integrated with health infrastructural development.
- Hospital Revitalisation Program must take into account primary health care (PHC) infrastructural development.
- There should be PHC services available within a walking distance of a village community.
- RCHC and community clinics must be proportionally and adequately fully staffed with medical and allied professionals.
- Government must audit human resource skills and implement skills development programs.
- Government must assess institutional delivery capacity of health facilities and take the requisite remedial actions.
- Health authorities should co-operate with alternative health service providers in providing health care to the public.
- Government should commission research into traditional health medicine and healing procedures and protocols of other health care providers.
- Government must set minimum norms and standards for the delivery of alternative health care services.
- The Department must develop and implement comprehensive medical equipment plans at the RCHC and all community clinics.
- The RCHC and community clinics must be provided with roadworthy ambulance vehicles.
- There must be functional hospital boards and health services committees at the RCHC and community clinics respectively. The hospital boards and health

services committees must be composed of, at least, health care experts and local community representatives.

- Government must strengthen supervision and management of health care delivery.
- Government must upgrade the RCHC to, at least, a level one hospital.

#### **4.5 Conclusion**

The target population is generally religious. Some members of the population adhere to different brands of Christianity, while others subscribe to traditional African religion. The health care system comprises public sector and private sector health care services. There are barriers to access to health care such as staff attitude, waiting period, distance, prohibitive health care costs, lack of medication and drugs, inadequate or undersupply of medical equipment, poor conditions of roads and transport and so forth. Government intervened in a variety of ways. However, there is pervasive failure to implement integrated development programs and monitoring and evaluation systems.

## CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

### 5.0 Introduction

This chapter presents conclusions and recommendations. Access to health care is the object of a fundamental constitutional right in South Africa. The right to health care and the right to health care access are the human rights that belong to human beings fundamentally by virtue of being human beings. Apartheid South Africa racialised health care and polarised health care users. Democratic South Africa sourced the antecedents of the right to health care and the right to health care access from the rich history entrenched in numerous human rights instruments: international, regional and national human rights system. In terms of the General Comment No 14 of CESCR, the right to health care includes the following –

- (a) The state must refrain from denying or limiting access to health care services to any individual.
- (b) Health care services should be available to all on a non-discrimination basis;
- (c) The obligation to protect include, *inter alia*, adopting legislation and other measures to ensure equal access to health care facilities provided by third parties; to ensure that privatization does not constitute a threat to the availability, acceptability and quality of services provided; and to control the marketing of medicines by third parties;
- (d) The State must disseminate appropriate information: foster research and support people to make informed choices.
- (e) The State must facilitate and implement legislative and other measures in recognition of the right to health care and must adopt a national health policy with detailed plans on how to realise the right; and
- (f) The State must provide the right for people in disaster situations or in dire need when an individual or group is unable, for reasons beyond their control, to realise that right themselves with the means at their disposal.



The research questions are alive to these factors and find expression within the purview of the indivisible and mutually supportive fundamental human rights.

**5.1 Research question 1:** Are there gaps between human rights in principle and human rights in practice?

Clearly, the international and national human rights instruments catalogue a number of human rights. These human rights may be divided into first-generation rights, second-generation rights and third generation rights. Chapter 2 has ably demonstrated that human rights are indivisible and mutually supportive. It demonstrated, furthermore, that the court has proven to be an activist court that does not hesitate to enforce socio-economic rights in appropriate circumstances. The right to have access to health care is one such a socio-economic right.

The Executive Summary of the South African Human Rights Commission Report (2009:6) put it as follows –

Access to health care services, especially for the poor, is severely constrained by expensive, inadequate or non-existent transport, by serious shortages with regard to emergency transport [ambulances], and by long waiting times at clinics and other health care service providers.

Tables 5 to 17 show that there are gaps between human rights in principle and human rights in practice. The largest group of health care users does not enjoy the right to have access to health care. It is incontrovertible that the law does not unfairly discriminate against people because of personal physical, spiritual and intellectual attributes. All human rights instruments protect all human beings equally. However, the applicable human rights instruments are not fully implemented. Several factors account for this gap between the right to have access to health care and the realisation of the health care needs of the health care users. Classical examples are –

- Quality of health services.

- Travelling distance and time.
- Roads and transport.
- Cost.
- Staff attitude.
- Scarce skills.
- Lack of medicines and drugs.
- Lack of medical equipment.
- Waiting periods.
- Opening time (starting and closing times).

### **5.1.1 Recommendations**

- The Department should develop a mechanism that enforces compliance with international best practices as well as norms and standards. Implementation plans must be developed and rigorously actualised.
- The Monitoring and Evaluation Unit must intensify its activities, site visits and reporting.
- Government must integrate health care indicators into IDPS.
- Health care delivery must be provided in an integrated intergovernmental manner.

**5.2 Research question 2:** Are there any violations of the rights of individuals to have access to health care services?

According to Peters *et al* (2008: 161-171), health care access refers to 'the timely use of service according to need'. The RCHC must provide patients with the right health care at the right time. Time is of the essence in health care administration. Cost, quality and time affect effectiveness and efficiency of health services provisioning.

As stated earlier, the right to health care is equal access, based on the principle of non-discrimination, to health care facilities, goods and services (General comments No 14 of the Committee on Economic, Social and Cultural Rights (CESCR.)). The General

Comment states, furthermore, that health care facilities, goods and services must be available in sufficient quantity; must be physically and economically accessible to everyone; must be culturally and ethically acceptable; and must be scientifically and medically appropriate and of good quality (General Comment No 14 of CESCR para 1; SAHRC Public Inquiry: Access to Health Care Services 2009: 10). The question is whether the RCHC provides health care services consistent with General Comments No 14, the Constitution and legislative and other applicable measures that provide rights to health care services.

According to respondents, the lack of geographic accessibility, availability, financial accessibility and acceptability affect their right to access health services at RCHC.

- Distance: The standard is that there must be at least a health facility within a 25 km radius. According to Table 5, the target population resides generally within 30 km radius.
- Poverty: The target population is relatively poverty-stricken. Eighteen respondents (60%) earn between 0 – R1 200, 00 per month (Table 4). Three respondents (30%) are not economically active and, therefore, earn no income (Table 3). The majority of the population is poor. Poverty is a barrier to health care access.
- Waiting period: According to Table 7, seventeen respondents (57%) indicated that they were attended to within 60 minutes of their arrival at the out-patient department. Eight respondents (27%) indicated they waited for one to two hours (61 – 120 minutes), 4 respondents indicated that they waited for two to three hours (121 – 180 minutes) and 1 respondent (3%) indicated that he waited for over three hours (181 minutes and more).
- Staff attitude contributes to the length of the waiting period (Table 17). Out of thirty (30) respondents, five (5) respondents (17%) said they did not have access to health care due to staff attitude.
- Lack of skills, medicines, drugs and medical equipment: According to Table 17, the lack of equipment and medication contribute to the denial of health care

access. In fact, six (6) respondents (20%) out of thirty (30) said they did not have access to health services because of lack of medicines and drugs.

The RCHC does not meet the standards set out in the General Comments No 14.

### 5.2.1 Recommendations

- Government must adopt human rights-approach to health care delivery.
- The health care delivery must be people-centered and people-driven.
- There must be a community clinic within an 8km radius of a community.
- Staff must undergo change management and people skills training.
- Procurement and distribution of medication should be improved in accordance with the international best practices.
- Government should ensure that poverty alleviation projects are implemented in the study area.

### 5.3 Research question 3: Why do some people in the study area still make use of alternative health care services?

Almost all the respondents said they are religious. They either belong to organised faith (church) or traditional African religion. The undeclared reason is that they use the alternative health services because they are provided by their own churches or faiths. However, the majority of the respondents use both systems of health services, namely government public health services and alternative health services. The minority rely heavily on alternative health services. The minority of the respondents said they the cost of transport, user fees and other incidental expenses are prohibitive.

According to Table 14, twenty-nine respondents (97%) said they use alternative health services more often. One respondent (3%) said he often uses the services of alternative health services. According to Table 15, thirteen of the respondents (43%) who often use alternative health services said they use the services of ZCC. Six respondents (20%) said they use the services of St Engenas ZCC. Four respondents (13%) said they use

the services of the Apostolic Church. Five respondents (17%) said they practise traditional African religion and use the religious services for health purposes. Two respondents (7%) said they use the services of other alternative health services providers.

### 5.3.1 Recommendations

- Government should recognise the alternative health care providers as a fact of life.
- Government should co-ordinate primary health care services in collaboration with churches and traditional healers.
- Priests and healers should be trained in patient management, in particular management of communicable diseases.
- There must be cross-referral of patients.

**5.4 Research question 4:** What policy interventions are necessary to make health care services accessible?

In terms of the General Comment No 14 of CESCR, the right to health care includes the following –

- (a) The state must refrain from denying or limiting access to health care services to any individual.
- (b) Health care services should be available to all on a non-discrimination basis;
- (c) The obligation to protect include, *inter alia*, adopting legislation and other measures to ensure equal access to health care facilities provided by third parties; to ensure that privatization does not constitute a threat to the availability, acceptability and quality of services provided; and to control the marketing of medicines by third parties;
- (d) The State must disseminate appropriate information: foster research and support people to make informed choices.

- (e) The State must facilitate and implement legislative and other measures in recognition of the right to health care and must adopt a national health policy with detailed plans on how to realise the right; and
- (f) The State must provide the right for people in disaster situations or in dire need when an individual or group is unable, for reasons beyond their control, to realise that right themselves with the means at their disposal.

The state has enacted many legislative and other measures to undergird access to health care by all. For instance, the following measures have been enacted –

**(a) Statutes**

- The Constitution of the Republic of South Africa, 1996.
- National Health Act, 61 of 2003.
- Promotion of Equality and Prevention of Unfair Discrimination Act, 4 of 2000.
- Promotion of Administrative Justice Act, 3 of 2000.
- Promotion of Access to Information Act, 2 of 2000.
- Traditional Health Practitioner Act, 2004 (35 of 2004).
- Regulation 158/6832/1 February 1980.

**(b) National plans, policies and programs**

- Department of Health *Restructuring the National Health System for Universal Primary Health Care – Official Policy Document issued by the Department of Health (DOHPOLDOC)1996: 5.*
- Reconstruction and Development Program (1994).
- National Health Plan for South Africa (1994).
- White Paper for the Transformation of the Health System of South Africa (1997).

**5.4.1 Recommendations**

- Government should implement existing health legislative and related measures.

- Government should improve community participation in future health care policy development and implementation.
- Government should co-ordinate the development of health care management guidelines for health care providers.

### **5.5 Conclusion**

The state has taken legislative and other measures to protect, promote and fulfill the right of the people to health care services. Basically, integrated development approach to health provisioning is the most appropriate approach to improve access to health care at Ratshaatsha Community Health Care and everywhere else. The three spheres of government must strengthen and consolidate vertical and horizontal intergovernmental fora for purposes of optimising co-ordination and improvement of the quality of public services. The integrated development plans and local economic development must take into account the related objectives and roles of each sphere of government. The principle of community participation must be given regard as one of the fundamentals for sustainable community development.

## REFERENCES

### Books

- Bless, C & Higson-Smith, C (1995) *Fundamentals of Social Research Methods: an African perspective* Juta: Cape Town.
- Claassen, NJB and Verschoor, T (1992) *Medical negligence in South Africa* Digma: Pretoria.
- Cheadle, M H, Davis, DM & Haysom, NRL (2002) *South African Constitutional Law: The Bill of Rights*, Butterworths, Durban.
- Creswell, JW (1988) *Qualitative inquiry and research design: choosing among five traditions*, Sage: Thousands Oaks.
- Currie, I and De Waal, J (2005) *The Bill of Rights Handbook*, Juta: Cape Town.
- Dada, MA & McQuoid-Mason, DJ (2001) *Introduction to Medico-legal Practice*, Butterworths: Durban.
- Dauids, I, Theron, F & Maphunye, KJ (2005) *Participatory Development in South Africa – A development Management Perspective*, Van Schaik: Pretoria.
- De Vos, AS, Strydom, H, Fouche, CB, & Delport, CSL (2005) *Research at Grassroots – for Social Science and Human Service Professions*, Van Schaik: Pretoria.
- Gravetter, FJ & Forzano, LB (2003) *Research methods for behavioral sciences* Wadsworth/Thomson Learning: Belmont.
- Leedy, PD & Ormrod, JE (2001) *Practical research: planning and design*, Merrill Prentice Hall: New Jersey.
- Maree, K, (2010) *First Steps in Research*. Pretoria: Van Schaik Publishers.
- Marshall, C & Rossman, CB (1999) *Designing qualitative research*, Sage: London.
- Matsepe, SS (2004) *The Appropriation of African Traditional Healing by the Zionist Churches: A Challenge to the Mission Churches in Gaborone “Botswana”* (MTh. UNISA).
- Mbiti, SJ (1969) *African Religions and Philosophy*, Heinemann Education Publishers.
- Mouton J (2001) *How to succeed in your master's and doctoral studies: a South African guide and resource book* Van Schaik: Pretoria.



- Mubangisi, J.C (2004) *The Protection of Human Rights in South Africa – A Legal and Practical Guide*, Juta, Cape Town.
- Nadasen, S (2000) *Public Health Law in South Africa*, Butterworths, Durban.
- Neuman, WL (2000) *Social research methods: qualitative and quantitative approaches*, Allyn & Bacon, Boston.
- Olowu D (2009) *An integrative rights-based approach to human development in Africa*, Pretoria University Law Press: Pretoria.
- Powers, GT, Meenagan, and TM & Toomey, BG (1985) *Practice-focused research: integrating human service practice and research*, Prentice Hall: New Jersey.
- Seaberg, JR (1988) *Utilizing sampling procedures*. In Grinnell, RM (ED), *Social work research and evaluation*, III: Peacock: Itasca.
- Terreblanche, M. & Durrheim, K (1999) *Research in Practice*, Cape Town: University of Cape Town Press.
- Todaro, MP & Smith, SC (2009) *Economic Development*, Addison Wesley (an imprint of Pearson Education, England): London.
- Welman, Kruger and Michell (2005) *Research Methodology*, Oxford University Press: South Africa.
- Yegidis, BL & Weinbach, RW (1996) *Research methods for social workers*, Allyn & Bacon.

### **Chapter in a book**

- Fouche, CB & Delpont, CSL “In-depth review of literature ” in De Vos, Strydom, Fouche and Delpont (2005) *Research at grass roots – for the social sciences and human service professions*, Van Schaik: Pretoria.

### **Journal articles**

- Agere, S (1990) “Issues of Equity In and Access to Health Care” *Journal of Social Development in Africa* 5,1,31-38.
- Currin, G, Mathauer, L Xu K & Evans, DB (2008) “Universal coverage of health services: tailoring its implementation” *Bulletin of the World Health Organization* 86: 857-63.

- Ensor, T & Cooper, S (2004) "Overcoming barriers to health services access: Influencing the demand-side" *Health Policy and Planning* (19)(2):69-79.
- Jacobs, B, Por, IR, Bidgeli, M, Annear, PL, van Damme, W (2011) "Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries" *Health Policy and Planning* (19)(2):69-79.
- O'Donnell, O (2007) "Access to health care in developing countries: breaking down demand-side barriers" *Cadernos de Saude Publica* 23 2820-34.
- Oliver, A & Mossialos, E (2004) "Equity of access to health care: outlining foundations for action" *Journal of Epidemiology and Community Health* 58:655-658.
- Peters, DH, Garg, A, Bloom, G, Walker, DG, Brieger, WR & Rahman, MH (2008) "Poverty and access to health care in developing countries" *Annals of the New York Academy of Science* vol 1136 161-71.
- Uvin, P (2007) " From the Right to Development to the Rights-based approach ; 'how rights entered development'" *Development in Practice*, Vol 17 No 4/5 597-606.

### **Statutes**

- The Constitution of the Republic of South Africa, 1996.
- National Health Act, 61 of 2003.
- Promotion of Equality and Prevention of Unfair Discrimination Act, 4 of 2000.
- Promotion of Administrative Justice Act, 3 of 2000.
- Promotion of Access to Information Act, 2 of 2000.
- Traditional Health Practitioner Act, 35 of 2004.
- Regulation 158/6832/1 February 1980.

### **National Plans, Policies and Programs**

- Department of Health *Restructuring the National Health System for Universal Primary Health Care – Official Policy Document issued by the Department of Health (DOHPOLDOC)* (1996).
- Reconstruction and Development Program (1994).
- National Health Plan for South Africa (1994).
- SAHRC Public Inquiry: Access to Health Care Services (2009).

White Paper for the Transformation of the Health System of South Africa (1997).

### **Foreign Plans, Policies and Programs**

British Medical Association *Complementary medicine: New approach to Good Practice* (1993).

### **International human rights instruments**

International Conference on Primary Health Care Alma-Ata USSR 6-12 September 1978 - Declaration of Alma-Ata.

International Covenant on Economic, Social and Cultural Rights.

United Nation Universal Declaration of Human Rights.

UNDP Human Rights Report (2000): Human Rights and Human Development.  
<http://hdr.undp.org/reports/global/2000/en/>.

UNDP Indicators for Human Rights-based Approaches to Development in UNDP Programming: Users' Guide (2006).

Vienna Declaration and Plan of Action.

### **Continental Instruments**

African Charter of Human and Peoples' Rights.

### **Court decisions**

AZAPO v President of the RSA 1996 8 BCLR 1015 (CC).

B v Minister of Correctional Services 1997 6 BCLR 789 (C).

Government of the Republic of South Africa v Grootboom and Others 2000 (11) BCLR 1169 (CC).

Soobramoney v Minister of Health, KwaZulu-Natal 1997 (12) BCLR 1696 (CC).

**THE RIGHTS-BASED APPROACH TO DEVELOPMENT : ACCESS TO HEALTH CARE SERVICES  
AT RATSHAATSHA COMMUNITY HEALTH CENTRE IN BLOUBERG MUNICIPALITY OF LIMPOPO.**

**SECTION A: ADMINISTRATIVE INFORMATION**

1.1 Name of respondent:

1.2 Questionnaire number:

1.3 Date:




Time:

1.4 Number of visits:

**SECTION B: DEMOGRAPHIC INFORMATION**

**2.1 Date of birth**




**2.2 Sex**

- 1 = Male
- 2 = Female

1
2

**2.3 Qualification**

- 1 = No schooling
- 2 = Primary education
- 3 = Secondary education
- 4 = Diploma
- 5 = Degree
- 6 = Degree and Diploma
- 7 = Higher degree
- 8 = Other, specify .....

1
2
3
4
5
6
7
8

**2.4 Marital status**

- 1 = Married
- 2 = Living together like husband and wife
- 3 = Widow/Widower
- 4 = Divorced or separated
- 5 = Never married

1
2
3
4
5

**2.5 Population group**

- 1 = African/Black
- 2 = Coloured
- 3 = Indian/Asian
- 4 = White
- 5 = Other, specify .....

1
2
3
4
5

**SECTION C: ACCESS TO BASIC SERVICES**

**3.1 What is your source of income?**

- 1 = Salaries and/or wages
- 3 = Pensions and grants

1
2

3 = No income

3
---

**3.2 What was the total household income in the last month?**

- 1 = 0 - 1200
- 2 = 1201 - 1500
- 1501 = 2000
- 2001 or more

1
2
3
4
5

**3.3 What is the distance between Ratshatsha Community Health Centre and your home/place of residence?**

- 1 = 0 - 10km
- 2 = 10,1 - 20km
- 3 = 20,1 - 30km

1
2
2

**3.4 How did you travel to this facility?**

- Foot
- Taxi
- Bus
- Own/Family car
- Other

1
2
3
4
5

**3.5 Is there public transport system from your place of residence to their facility?**

- 1 = Yes
- 2 = No

1
2

**3.6 How long did you wait before you were attended to by health workers?**

- 1 = 0 - 60min
- 2 = 61 - 120min
- 3 = 121 - 180min
- 4 = 181 - 240min

1
2
3
4
5

**3.7 Is medication available for your conditions?**

- 1 = Always
- 2 = Sometimes
- 3 = Seldom

1
2
3

**3.8 At what time did the facility open on the last day of your visit?**

- 1 = 07h00
- 2 = 07h30
- 3 = 08h00
- 4 = 08h30
- 5 = 09h00

1
2
3
4
5

**3.9 If you present yourself at the facility without appointment are you?**

- 1 = Helped
- 2 = Given appointment for another day

1
2

**3.1 How do you rate the health care services at the facility?**

- 1 = Good
- 2 = Average
- 3 = Poor

1
2
3