People's Dignity is at stake: The Ambulance Availability Crisis in Lusikisiki, Ingquza Hill Local Municipality

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DECLARATION

I declare that this Masters research report is my own unaided work. It is submitted for the degree of Master of Art at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination in any other university.

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Sinovuyo Boltina (2089468)

30 June 2024

DEDICATION

To my paternal grandparents, this work is dedicated to you. Thank you for raising me and instilling all the values you have instilled in me. Makhulu noTamkhulu, ndikule ndawo nje kungemisebenzi yenu. Ndiyabulela nge nto yonke. [Grandmother, Grandfather, through your work, I am where I am.]

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To my maternal grandmother, Khuluza, enkosi nge nto yonke nokundithandazela yonke imihla. [Thank you for everything and for praying for me every day.] You have checked up on me every day throughout this entire journey. We had always imagined getting to this point from when I was in High School, and at times, I felt it was hard, but you never doubted me for one second. Enkosi ndiyakuthanda kakhulu. Khuluza wam, ndohlala ndikubulela ngalo lonke ixesha. [Thank you. I love you so much and will continue to thank you always.] I am most grateful that you are alive to see it all.

To my wonderful parents, who have held my hand from the very beginning. You have always said that my name, Sinovuyo means to bring happiness, and that is something you say I have brought to you. However, you will never know or understand what your love and support feel to me. You have always said that I should let you carry some of my load and that I am never alone, which is true. For all the calls and times, we talked about my research and moments where I was confused about whose research this was, you truly immersed yourself in what I was passionate about and talked about as this as though it was yours, as you have always done all my life. Thank You. May you never think that all your love, support, hard work and efforts to see me reach my dreams go unseen. I will never forget all that you have taught me as it led me to this topic, and to always strive and advocate for humanity and to do work that matters and is right no matter the circumstance.

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ABSTRACT

Access to healthcare is and remains a challenge globally. In South Africa, the limited ambulance availability crisis is an example of this. The people affected the most rely on public healthcare in remote and rural areas, such as the small town of Lusikisiki in the Eastern Cape Province. This study sought to investigate the research question, "How does the limited ambulance availability impact access to public healthcare for the people of Lusikisiki in the Ingquza Hill Local Municipality?". I adopted a qualitative research approach and interviewed twenty participants identified through purposive and snowball sampling techniques. Limited ambulance availability inhibits the people of Lusikisiki from accessing healthcare. This crisis exists and impacts clusters of communities already facing socioeconomic, political, and geographical issues. These factors are at play and impact people's day-to-day lives. Recommendations entail implementing more strategies and policies, looking at a more holistic approach, and examining this crisis from a social and health context perspective to overcome healthcare access barriers; thereby ensuring access and the health and well-being of everyone.

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Chapter 1- Introduction

1.1 Introduction

Access to healthcare services continues to be a challenge worldwide, especially for those who rely on public healthcare systems. South Africa, for example, the public healthcare system operates with less than half of the ambulances that it needs (Kahn, 2022). People living in townships and remote rural areas often the suffer the brunt of this ambulance availability crisis. Within the South African context, those who suffer the brunt of this are those who rely heavily on public healthcare services, mostly those who live in townships and remote rural areas.

Existing research typically focuses on the dysfunctionality of the public healthcare system due to the lack of infrastructure and equipment, in part because of as well as poor management and the necessary staff to ensure quality healthcare services. Furthermore, the resource-rich private sector caters for only 15% of the South African population, whilst the public sector is "limping" along, lacking the most basic resources (Felix, 2023). More research is needed to document the experiences of people attempting to access healthcare facilities and the challenges surrounding their healthcare journeys, which in themselves sometimes do not happen because of the limited ambulance availability.

This study identified and profiled many voices of those who have been suffering in silence in Lusikisiki. This qualitative study focussed on the personal narratives and experiences of a sample of twenty, that included community leaders, community members, union representatives, healthcare professionals and ambulance drivers. Data was collected through in-depth interviews and thematic analysis was used to analyse the findings. Participants voices have previously gone unheard because the ambulance crisis is the norm. Therefore, people have been forced to come to terms with the fact that they have been failed by the state repeatedly, despite their right to healthcare services. People expressed that their health is deemed unimportant because of their circumstances which include poverty and the remoteness in which they live.

Additionally, when analysing the health-related dimensions of the crisis, what could not be ignored was how fundamentally imperative the broader social and economic aspects of the crisis are.

This issue was prevalent throughout the study, as not only are there limited ambulances, but the town of Lusikisiki comprises people who face many social-economic challenges. The most significant of these is that people have limited financial resources and therefore rely heavily on the government for free services and assistance in getting to health facilities. Crime is also another significant factor. Thus, when investigating this crisis and its impact, it was clear that the social determinants of health do indeed impact one's health outcome, as argued by the World Health Organisation [WHO] (2010).

The socio-economic challenges facing the people of Lusikisiki cannot be separated from the existing breakdown of the public healthcare sector. This study of their experiences demonstrated that access to healthcare continues to be a challenge and a threat to their livelihood, dignity and very survival.

1.2 Context and background to the research

Ambulances play a crucial role within healthcare systems around the world. This role entails servicing communities and people facing "unplanned urgent and life-threatening health conditions" (Snooks et al., 2019,p.2). The inability to fulfil this role has become a crisis for many healthcare systems across the globe, but the reasons for these crises are different. In the global North, this crisis is not due to the lack of ambulances but rather due to the lack of paramedics, paramedic training, and hospital beds. Together, these factors have significantly slowed down patient handovers, such that ambulances become stuck in long queues at hospitals rather than being on the roads servicing communities (Sharma,2023).

Since 2023, the United Kingdom (UK) has been experiencing a severe challenge in regard to ambulance availability. Sharma (2023) refers to the Savanta market research poll that surveyed 2,093 people across the UK. In this poll, 34% of adults who called for an ambulance had to make their own way to the hospital due to the long waiting time (Sharma, 2023). About 17% drove to hospitals, 11% took a taxi, and 6% used public transport (Sharma, 2023). Just more than half (55%) waited and did not take any alternative transport; this group waited despite a long waiting period. The work of Percey (2024) demonstrates this is still an issue in 2024.

For example, ambulance services such as the East of England Ambulance Trust (EEAST) have had to lease 15 ambulances to help. Unions such as UNISON further spoke to this, saying that ambulances were often off the road or stuck outside hospitals (Precey, 2024). Thus, many people in need of ambulances wait for long periods only for the ambulance to arrive late or not at all, forcing many people in East England to try to make alternative transport arrangements.

In Berlin, Germany, the city faces the "exceptional circumstances" of having 94 ambulances available, and every single one is always in use and at times having to cover long distances that can take up to 42 minutes making it difficult for an ambulance to be available due to the distance and the limited availability (Jacobson & Salzmann, 2022). This crisis in Germany, has been known for a long time, as there has been an increase of approximately 40% in Emergency Medical Services (EMS) deployments between 2013 and 2021(Jacobson & Salzmann, 2022). From 2013 to 2021, there have been 305,000 to 425,000 EMS deployments per year (Jacobson & Salzmann, 2022). Yet the actual ambulance shortage has still not been addressed, resulting in the crisis.

Additionally, in the global North, the ambulance crisis is due to the shortage of beds in hospitals, making ambulances queue for prolonged periods outside hospitals rather than being on the road. Whereas, in the global South, the crisis of ambulances is predominately due to the shortage of ambulances to service communities. There is only one ambulance per 125,000 people available in India. This stands in contrast to the United States, which has one ambulance per 1,000 people (Balachandran, 2023). The severity of this crisis can be seen in the example of the city of Ludhiana in India, which only has 41 basic life support ambulances to service a population of approximately 1,95 million people (Popli, 2023).

Within sub-Saharan Africa, this crisis continues to be prevalent. Zimbabwe is such an example. According to an audit done by the Bulawayo City Council, only six ambulances out of 15 were running (Nkala,2023). Ideally, there should be 30 ambulances (Nkala, 2023) as the six ambulances currently service a population of 650,000 people.

Kenya's ambulance shortage has led to dire consequences, such that people have waited for six hours for an ambulance that does not arrive, and families have lost their loved ones. (Mkongo, 2023). The population in Kenya is close to 4.3 million. Ideally, one ambulance should serve 7,000 people, yet one serves 100,000 people according to the standard in Kenya (Mkongo, 2023).

Nairobi has approximately 100 ambulances that are majority-owned by private hospitals and investors (Mkongo, 2023). This means only those who can afford these private ambulances have access to them. Mkongo (2023) further describes the situation as challenging as these ambulances usually cost between Sh5,000 and Sh10,000. It may seem small, but most Kenyans, particularly those who rely on free public services, which is most people in Kenya, live below 1 US dollar a day (Mkongo, 2023).

Free or public ambulances are a challenge to get ahold of. Mkongo (2023) explains this by saying, "Most of the [telephone] numbers listed for public hospitals went unanswered while some were non-functional. Those lucky to get ambulances are usually required to pay up-front by hospitals and service providers".

South Africa operates with less than half the ambulances it needs. The government's target is to have, on average, one ambulance per 10,000 people, but it is currently operating with only 49% of the 6,824 ambulances needed (Kahn, 2022). This crisis is highlighted at the provincial level; North West has only 70 out of 370 ambulances needed, Western Cape has 120 out of 570 ambulances needed, Eastern Cape has 448 of 670 ambulances needed, Kwa-Zulu Natal has 432 out of 1,174 needed, and Gauteng has 1,600 ambulances out of the 2,592 needed (Kahn, 2022). Unfortunately, these figures do not indicate that ambulances are fully operational, as some may undergo maintenance and are therefore unable to service communities.

In short, South Africa is facing a crisis of limited ambulances available nationally. This study, therefore, sought to explore the impact limited ambulance availability has on the people living in the small town of Lusikisiki, Ingquza Hill Local Municipality. This area has not been well researched. This was a problem because there were gaps in research knowledge as the voices and experiences of the people living in Lusikisiki have gone unheard, and therefore, the necessary solutions and interventions that would suit this area are lacking and have not been implemented. Instead, Lusikisiki has been assumed to be like all other rural areas. This ignores that specific rural areas have different needs and experiences depending on context. This point leads to the significance of the research study reported on here.

1.2.1 Study Significance and Rationale

South Africa has been a democratic state for 30 years. This is symbolic as it represents a shift from darkness to a new dawn, away from the oppressive, exclusive, and discriminatory apartheid regime to a free society. This speaks particularly to the realities of black people who, during the apartheid regime, faced inhumanness embodied within the healthcare delivery service, which mainly was inaccessible, of poor quality, and was experienced as undignified by the black population (Rapanyane, 2022,p.61).

Approximately R115 per person was spent on healthcare for black African people by the apartheid government in 1985, (which increased to R137 in 1986) compared to the R451 that was spent per white person in 1985 (which increased to R597 in 1986) (Baldwin-Ragaven et al., 1999, p. 17). Post-apartheid, the realities of black people did not change much: "South Africans have been subjected to severe, daunting and harsh treatment that is unsigned for" (Rapanyane, 2022, p. 61). Here, Rapanyane speaks to the poor treatment of patients at hospitals and the lack of ambulance availability, raising the question of whether "Black life is indeed less important?" as these issues impact particularly those who are the most marginalized and poor, i.e., the black population within townships and the rural areas as a legacy of past oppressive policies.

Additionally, the crisis of access to healthcare is particularly acute within the Eastern Cape, where limited ambulance availability forms just one part of the problem. It is illuminated by the painful words of a mother, who, when interviewed in 2014, said, "Now, I am grieving the death of a child I carried for nine months but could not hold in my arms" after waiting for an ambulance that did not come (Mvlisi, 2014). These words illustrate the impact of the lack and delays in ambulance services of an ambulance. According to Kamnqa (2023), approximately 671 ambulances are needed for the Eastern Cape province, yet only 200 of the current 447 are rostered. Within the Chris Hani District, 72 ambulances are needed, yet only 38 of the available 62 are rostered. This means that most ambulances are being repaired and are unavailable (Kamnqa, 2023).

This problem has, for many years, been embedded in the healthcare systems of the Eastern Cape, particularly in small rural towns such as Lusikisiki (Kamnqa,2023). The South African Human Rights Commission (2015) highlighted the lack of ambulance services in the Eastern Cape (Eliseeva, 2020). This report flagged the shortage of ambulances and how communities were tired of empty promises.

Key issues raised included the poor road infrastructure, criminal actions during which in which ambulances were robbed, and the resultant costs because of the lack of ambulances (Eliseeva, 2020).

The lack of ambulances strips people of their dignity when they are most vulnerable and need healthcare services. This study examined the severity and impact of this crisis on the people of Lusikisiki while exploring the socio-economic factors enmeshed in this crisis for people living in rural areas who travel long distances to access healthcare.

Ambulances play a significant role in the healthcare system, ensuring people can access healthcare services and healthcare facilities (Mkhize, 2021). This study explored the impact of limited ambulance availability, seeking to understand the breakdown of the ambulance system from the people's perspective and how this impacts their day-to-day lives. It sought to spark conversations and solutions from the ground up, bringing academic and sociological value to the forefront and enabling positive change.

1.3 Main Research Question

How does the limited ambulance availability[1] impact access to public healthcare for the people of Lusikisiki in Ingquza Hill Local Municipality?

1.3.1 Sub-questions

- What role do ambulances play in the healthcare system in the rural area of Lusikisiki, Ingquza Hill Local Municipality?
- What do participants understand by 'limited ambulance availability', and what has resulted in this?
- How do participants navigate/circumnavigate the existing system?
- How does the limited ambulance availability affect access to public healthcare (specifically to hospitals within the municipality and referrals to district and provincial hospitals)?
- Generally, how does this limitation impact on people's overall well-being and health?

[1] "Ambulance availability"- refers to the ambulance quality to be used or obtained.

1.4 Research Objectives

This study sought to provide an understanding of the ambulance availability crisis by explicitly exploring the experiences of people who live through it in Lusikisiki to gauge the impact of the limited ambulance availability. It therefore focused on the needs and reasons people use ambulances, the overall role ambulances play in Lusikisiki, the processes and systems in place to access ambulances that people follow (or do not), and the impact this has on their resultant journey (or lack thereof) to access healthcare. These avenues of exploration were prioritized throughout the study to ensure that the voices and experiences of the people of Lusikisiki were indeed amplified.

i) Moreover, the study explored when people used ambulances and their reasons for the use or need of ambulances in the various clusters of communities in Lusikisiki. This then also entailed establishing a consensus/common understanding of the state and availability of ambulances in Lusikisiki and whether and what challenges make it difficult for the community to access healthcare. Not only was it important to look at the ambulance availability issue but also to be open to a holistic approach that considered the context of the study and provided room to investigate other issues that may emerge, such as the social determinants of health, that could indicate the many factors that affect health-related issues.

ii) The study and the aspirations of the researcher have also been to amplify the work of those on the ground who speak for, advocate, and promote projects and programmes to change the community's circumstances. The findings of this study provide insight from the people of Lusikisiki themselves, including ordinary community members and people who work in the health sector and have leadership roles in the community. This was considered important for providing an overview of the range of experiences of the many clusters of communities in Lusikisiki.

iii) Lastly, the research project profiles bottom-up recommendations to deal with this crisis in a way that services and addresses the challenges faced specifically by the communities in Lusikisiki.

1.5 The Organization of the Remaining Chapters

In chapter two, the conceptual framework locates the study not only as a health issue but as a sociological issue that is analyzed will be discussed through key concepts and existing literature to identify current gaps in the field and to argue for the study's relevance. Key concepts include (1) health and the ideas of well-being, (2) the social determinants of health, and (3) political economy. The themes in this chapter outline and discuss these issues within the public health system; of central importance are the South African healthcare system and its inequalities, as well as the role of ambulances and community based-volunteer emergency services in South Africa.

The third chapter provides an overview of the research methodology adopted and rendered appropriate for this study. It entails a discussion of the methods used, the sampling technique chosen, data collection and the analysis approach.

Chapter four looks and describes the stories of some of the participants and the context of the study. Chapter five includes a discussion on the findings and analysis of the study and is broken down into five themes, namely, the reasons why people need and use ambulances in Lusikisiki, the processes of trying to get a hold of an ambulance in Lusikisiki, the challenges experienced in the process and the steps people are forced to take, the implications of limited ambulance availability, and lastly the recommendations made. The final chapter draws the study to a close by concluding the study.

Chapter 2-Literature Review

2.1 Introduction

The literature review locates the study within the existing field of scholarship. The literature review argues how the crisis[2] of ambulance availability in the Eastern Cape amplifies local issues and shows how the entire healthcare system has been disrupted and fails to function properly. This is done through a discussion of the following literature themes: (1) South Africa's healthcare system and health inequalities, (2) The role of ambulances in the healthcare system, and (3) The role of ambulances in rural areas, the ambulance availability crisis in the Eastern Cape, and (4) Community Based-volunteer emergency services in South Africa. Following this, the conceptual framework brings together the broader theoretical debates within which the research questions and the study are embedded. The conceptual framework covers the following dimensions: (1) the conceptualization of health, (2) the social determinants of health, and (3) the political economy of health. These all demonstrate the value and need of this study. Morris-Paxton et al. (2020, p2) write, "*The WHO has identified a need for national and regional research to ensure that relevant information is available for relevant and timely responses to needs."* This quote highlights the value and aim of this study, which attempts to bring to light the hidden, hard, and unspoken realities within places in South Africa where people have the right to access health services regardless of their location.

2.1.1 Literature Review – by theme

2.1.1.1 South Africa's healthcare system and health inequalities

In South Africa, public services are theoretically available to ease the burden on the poor. However, the ambulance crisis ends up costing the poor more through, for example, additional charges for alternative transportation to facilities. This is not something that has occurred serendipitously but is a result of the history of South Africa. When the National Party came into power in 1948, the political climate became increasingly hostile, racist, discriminatory, and more oppressive than before.

[2] Hereafter the word " crisis" will be used when referring to the ambulance availability challenge.

This resulted in a shift from the previously proposed “social medicine” approach (of 1942) in which health and healthcare were understood to be socially embedded and community-driven to a system of vastly unequal healthcare services which de-prioritized and largely ignored the needs of rural, black communities (Sanders & Reynolds, 2019,p.5).

The work of McLaren et al. (2013) speaks to this. Although we may be firmly in post-apartheid, the apartheid regime and its legacies are still prominent, and one of the ways this can be seen is through access to health care. The post-apartheid government has put in place health policies that included ensuring more healthcare facilities, particularly in remote areas that were previously ignored or not prioritized because these areas were made up of predominately black people. As such, one of the legacies of apartheid is that distance acts as a barrier to healthcare access.

McLaren et al. (2013) stated that 90% of South Africans live within seven kilometers of the nearest public clinic. However, 15% of Black people live more than five kilometers from the nearest facility; in contrast, only 7% of coloured people and 4% of white people do (McLaren et al.,2013). The implication is that those who live in remote and rural areas are underserved and left to face the costs and burden of transportation to access healthcare. Healthcare policies do not consider or deal with these demographic factors. As such, even with the provision of free services and clinics, the issue of distance remains unsolved. This is a core issue for the limited ambulance availability crisis.

Moreover, the current two-tier South African healthcare system was established under apartheid. The public healthcare system was primarily reserved for the poor black majority in townships and rural areas, with inadequate funding and infrastructure. In contrast, the private sector was reserved for the white minority, with high quality standards. This two-tier healthcare system has resulted in a large underfunded public and a high-quality private sector.

A large proportion of funding and specialists went and still go into the private sector (Buswell, 2023). Thus, further broadening the gap between public and private healthcare. Post-1994, reforms were put in place to deal with this. The National Health Plan developed by the African National Congress was established to address this inequality. One of the ways it did so was by introducing free medical treatment for pregnant women and children under the age of six years (Omotoso & Koch, 2018, p. 13). Other changes occurred through the constitutional level of ensuring rights and laws for equality and access to healthcare.

This is depicted under Act 108 of 1996 or the Bill of Rights which seeks to address and acknowledge the ills and injustices of the past, including access to health.

Section 27 of the Constitution (1996) speaks to this by stating:

> 1. Everyone has the right to have access to:
>
> (a) healthcare services, including reproductive healthcare;
>
> (b) sufficient food and water; and
>
> (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.

However, despite efforts to fix the ills of the past, health inequalities within the South African healthcare system persist. The apartheid regime is the past; however, its legacies remain (Ataguba & Alaba, 2012). These are evident through socioeconomic factors such as inadequate access to education, basic infrastructure, transportation, quality healthcare, little access to productive resources, and dependence on social grants (Ataguba & Alaba, 2012, p. 758). These socioeconomic factors have an impact on most South Africans, who also happen to be black people. Healthcare services for the black majority are underfunded, particularly in rural areas. The persistence of such socioeconomic conditions results in the persistence of barriers to healthcare. This point is crucial, and it is at the core of this study. This illuminates the poor healthcare system and the significant health disparities within which the limited ambulance availability crisis is embedded.

An example of this is illustrated in the work of Willie and Maqbool (2023) who demonstrate this through the discussion on financing health in South Africa between 2000 and 2019. Money to support the two-tiered healthcare system in South Africa (the public sector and private sector) comes from general tax (which is allocated to public healthcare or sector) and "direct out-of-pocket charges or medical programs contributions" (which is allocated or used for private sector) (Willie & Maqbool,2023, p.0111).

In Figure 1 below, Willie and Maqbool (2023) further demonstrate that 42% of expenditures for health in South Africa was paid by Voluntary Health Insurance (VHI) with 36% coming directly from individuals and businesses and the remainder being subsidized by the government to VHI. The aforementioned was for the years 2000 to 2019 (Willie & Maqbool,2023, p.0111). During 2019, 59% of the general government's expenditure went towards South Africa's health bills. Private health expenditure accounts for 40.1% of South Africa's total health expenditure.

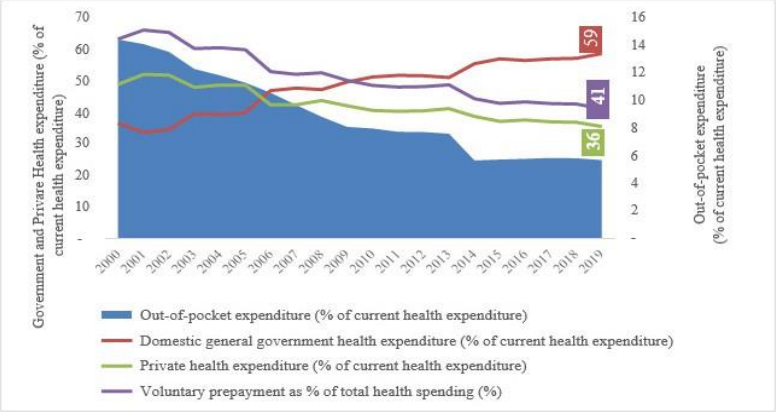

Figure 2: Healthcare financing in South Africa 2000-2019 [29].

Figure 1: Healthcare financing in South Africa 2000-2019 (Willie & Maqbool,2023, p.0112)

Moreover in 2023, R260 billion was allocated towards healthcare, with 23% (R60 billion) allocated towards the National Department of Health and 85% transferred to the different provinces to fund national health systems as grants (Rensburg, 2023). The grants are namely, The Tertiary Services Grants (used to fund central hospitals for services rendered to provinces), The Health Facility Revitalization Grant (used for maintenance and building of healthcare facilities), The National Health Insurance direct grant (used to fund contracting mental health practitioners and oncology services), Human Resources Training Grant (used to train healthcare workers and cover salaries of medical interns and community service health workers) and lastly the District Health Grant (used formerly as the HIV/AIDS, TB and STI grant) (Rensburg, 2023).

Despite this, public healthcare is still not up to shape with some healthcare systems, such as that of the Eastern Cape, where there are insufficient beds and ambulances in the province.

The work of Willie and Maqbool (2023) speaks to this through Table 1, demonstrating bed shortages in the Eastern Cape in 2015. During 2015, South Africa was estimated to have between

1.7 to 2.3 beds per 1000 people, which is argued to conform to international norms. However, across districts, the distribution of these hospital beds appears to be lower, particularly in "poverty-stricken areas" (Willie & Maqbool, 2023, p.0013).

	Hospitals	Number of beds	beds per 1000 people
Sarah Baartman			-
Chris Hani	14	993	1.2
Amathole	14	1362	1.5
Nelson Mandela			-
Buffalo City Metro			-
OR Tambo	9	1254	0.9
Afred Nzo	6	688	0.8
Joe Gqabi	11	454	1.2

Table 1: Number of district hospitals and beds in the Eastern Cape Province (2015) (Willie & Maqbool, 2023, p.0014).

Public healthcare is still described as facing shortages and challenges, which depict a reality where the system is unable to or cannot cater to the needs of people who rely on it. Arguments have been expressed that the government needs to put more money into ensuring good quality health like that experienced by those who rely on medical schemes or the private sector. However, the government cannot even currently pay healthcare practitioners.

This crisis is argued and discussed as being a result of budget restraints which have left more than 800 doctors unemployed (BizNews, 2024). Though the services may be free in rural areas or the public sector, the disparities with what is available in the private sector can be seen. An example of this is the 3,714 free public clinics that are plagued with broken equipment and lack of medication and beds (BizNews, 2024). The ratio of practitioners to the population in public healthcare systems is 0.3 per 10,000 whereas in the private sector, it is 1.75 per 10,000 (BizNews, 2024).

The issue of funding public healthcare, particularly in the Eastern Cape, is illustrated through Community Healthcare Workers (CHWs) who are there to ensure healthcare reaches those deemed 'unreachable'. CHWs have been underpaid for more than 30 years (Witbooi, 2023).CHWs are paid less than R5,000 a month without any benefits such as transportation. However, their role is to go

door to door to bring people medication (Witbooi, 2023). Witbooi (2023) states that the Eastern Cape faces neglect and corruption that has caused the public healthcare system to collapse, leaving many, particularly those in rural areas, to fend for themselves.

The pressure the healthcare system was under at the peak of the COVID-19 pandemic also illustrates and further exposes the terrible state of public healthcare. At the time of this specific health crisis, there were only 18 hospital beds per 10,000 people in South Africa and 32 medical practitioners in the public sector per 100,000 people to assist those without medical aid (Evans, 2020). Public hospitals have been and continue to be the subject of exposés on their poor conditions until the government intervenes. Public Hospitals in Gauteng are described as being in "shambles" preventing those who are sick and vulnerable from enjoying dignified healthcare services (Maromo, 2022).

Moreover, it is reported that the Gauteng Department of Health owes more than 42,000 suppliers approximately R3.1 billion. After the fire that ravaged Charlotte Maxeke Johannesburg Hospital in April 2021, 220 staff resigned and left the hospital with 677 vacant posts, and a shortage of doctors, nurses, and administration services. The implication of this, is that fewer and fewer people will be able to receive healthcare efficiently thus their medical needs will not be met on time and the hospitals cannot meet the needs of people (Maromo, 2022).

Gauteng's health scandals are constantly exposed. Maromo (2022) has interviewed various parties about the state of public healthcare in the province. One individual stated, "It is mind-boggling that close to R2 billion was wasted of the extra money made available to save lives in the COVID-19 epidemic. The delay in reopening the Charlotte Maxeke Johannesburg Hospital is devastating for hundreds of cancer and heart patients whose deaths will exceed the 144 deaths of the Esidimeni patients" (Maromo,2022).

Nonetheless, Gauteng is not the only province to face a healthcare system crisis. The Eastern Cape Department of Health was threatened it would no longer receive medical oxygen from Afrox as this service provider was owed R6 million (Zuzile & Sizani, 2023). This is sadly not a new crisis in the province, as many clinics and hospitals have been operating with a shortage of medical oxygen supply (Zuzile & Sizani, 2023). According to the WHO, oxygen is essential to treat respiratory illnesses such as COVID-19 and pneumonia and is needed in surgery and trauma

(Zuzile & Sizani, 2023). It is also needed regularly for newborn babies, pregnant women and the elderly (Zuzile & Sizani, 2023).

Hospitals in Mthatha and Gqebera in the Eastern Cape, face barriers, such as anaesthesia shortages, delays, and a periodic lack of medication availability, which prevent the proper operation of hospitals in these areas.

Similar to the Gauteng Department of Health, the Eastern Cape has also failed to pay landline services for its emergency services and as a result, the contract with Telkom has been suspended. (Ellis, 2024). This has left the province's emergency services in disarray as it has been difficult to contact of ambulances using the standard 10177 number. This occurred before the Easter Weekend holiday; when many hospitals were forced to fend for themselves as the call center was not functional.

Many trauma cases typically occur during long weekends. For example, in Nelson Mandela Bay, there were 326 assault cases, 35 gunshots, 73 car accidents, 25 burn cases, 250 falls, 5 cases of domestic violence and 91 stab cases that occurred over the month in public hospitals such as Livingston Hospital in Gqebera (Ellis,2024). Ellis (2024) interviewed Wesley Bester from Bester Emergency Services, who stated, "*We then tried to get hold of the metro ambulances … but I can tell you we had a few desperate people who put their money together to get a private ambulance because they needed one"* (Ellis, 2024).

These experiences all occurred in a province that already faces challenges because of the shortage of ambulances. There are 650 ambulances needed, yet only 439 ambulances exist; and of these, 190 have broken down (Ellis, 2024). According to Russel Rensburg from the Rural Health Advocacy Project, the Eastern Cape has been rendered unable to afford itself (Ellis, 2024). Hospitals in rural areas in the Eastern Cape are poorly researched, yet they lag behind hospitals in cities such as Gqebera. The aforementioned state of public healthcare, with the examples of Gauteng and the Eastern Cape, speaks to the reality of the public sector, which is falling apart. This contrasts starkly with private healthcare used by a minority of the South African population.

In 2022 15.8% of individuals (which is 9.7 million people) had medical aid (Statista, 2023). The remaining 84.2% rely on the public healthcare sector for free healthcare services (Statista, 2023). This illustrates the socio-economic standing of most South Africans who rely on free healthcare

services and public ambulances. Therefore, when barriers and limitations occur, the overall impact of this crisis is essential to research because of its scope.

The lack of ambulances potentially serves as a healthcare barrier – which contributes to the factors constraining access as seen through the "racial, socio-economic and rural-urban differentials in the health outcomes and between the public-private health sectors" (Harris et al., 2011, p. 103).

The government plans, through the National Health Insurance (NHI), to cover services delivered through a "people-centred integrated healthcare platform" that will ensure a more responsive health system (Department of Health, 2017, p. 14). The NHI has been in the works since 2003, yet it has only just been signed into law. The lack of implementation leaves the public healthcare system without attention. It is also unclear how the emergency or ambulance services crisis will be dealt with, with the ultimate implementation of the NHI. What is mentioned in the NHI bill under section 39(a) is that the NHI Fund will purchase services from the public and private ambulance providers through a single number to call, irrespective of where you are in the country (National Health Bill, 2019, p. 21). It is not yet clear how the issue of ambulance availability will be addressed, particularly for remote or small towns such as Lusikisiki (given the existing barriers faced by people in such areas).

The study looked at the barriers facing the people of Lusikisiki and their experiences of the ambulance availability crisis. The study's findings may help these issues to be better understood.

2.1.1.2 The role of ambulances in the healthcare system

It is imperative to study the role of ambulances within the healthcare system as this speaks to a framework that informs healthcare systems globally, including South Africa. This is particularly the case as ambulances have a significant role to play within all healthcare systems.

According to the Department of Health (2021), ambulances are defined as,

> *an appropriately equipped vehicle which is either airborne or land-based and designed or adapted to provide emergency care and the transportation of patients which is licensed to an Emergency Medical Service registered, staffed, and equipped in terms of the Emergency Medical Services (*Department of Health, 2021,p.6).

Gaston (2007) stipulates how important ambulances are to healthcare systems as they provide pre-hospital care and patient transfer. This serves as a form of what the author refers to as "easy access to health services", where patients are provided with assistance even after hours, through what is supposed to be an organized and disciplined system (Gaston, 2007). Ambulances play a significant role in transporting patients to healthcare facilities on behalf of the healthcare system.

Ideally, ambulances are supposed to (1) be an excellent service that works together with the healthcare system to increase efficiency and to assist patients in getting to healthcare facilities whilst also providing medical care where possible, (2) do the fieldwork, where qualified paramedics are skilled to provide pre-hospital care, and lastly (3) serve communities that require flexible roles to be played by paramedics which may not always be emergency cases but serve as a form of patient transport for patients who may not otherwise be able to go to hospitals or clinics (Singh, 2022).

Whilst Gaston (2007) and Singh (2022) highlight the importance of ambulances globally and in India (respectively), their writing speaks to the South African context. Typically, the literature available within the South African context looks at the number of ambulances and the shortfall and sets targets for what is needed (as discussed in Chapter One). South Africa is operating at less than half the required capacity. Therefore, the government has not met its target of one ambulance per 10,000 people. Furthermore, at a provincial level, the Eastern Cape operates 67% of ambulances, with Northwest having 19% of its ambulances operating, Gauteng has 61% ambulances of the ambulances it needs, Kwa-Zulu Natal has 37%, and the Western Cape has 21% (Kahn, 2022). Despite these records, there are fewer rostered or on the road (Kamnqa, 2023).

Knowledge gaps exist in small rural areas such as Lusikisiki. This study therefore sought to bridge these gaps by increasing the knowledge of the extent of this crisis and how people cope or not in small rural areas. This study provides an opportunity to address this, and the next section below further discusses why this is important in the context of rural or remote areas.

2.1.1.3 The role of ambulances in rural areas and the availability crisis in the Eastern Cape

Ambulances play a significant role in rural areas for various reasons. The most significant reason is that healthcare facilities are far from communities known as "iilali"[3] People seeking healthcare services must travel very long distances. In addition, healthcare facilities in rural areas are not always well-equipped or well-managed.

Research shows the health disparities between those living in urban and rural areas. To reiterate, most people living in rural areas depend on free public healthcare. However, the rural populace also faces challenges trying to access this healthcare such as transport costs, and long travelling due to living in remote areas (Morris-Paxton et al., 2020).Morris-Paxton et al.(2020) state that,

> *There is no railway line, and public and private transport services are rare, expensive and dependent on road and weather conditions, which are not conducive for the use of motorbikes or even bicycles. Only a few people drive as most cannot afford a private four-wheel vehicle, hence walking and donkey carts are the most common means of going from one place to another*. (Morris-Paxton et al.,2020, p.2)

Ideally, ambulances should address this need by providing transportation and pre-hospital care to the community. However, poor roads, long distances, and a collapsing healthcare system with hospitals facing equipment and staff shortages mean that patients are moved from district hospitals to regional hospitals for care that should be provided at the district level. Eliseeva's (2020) work speaks to this by illuminating how dysfunctional and on the verge of collapse the Eastern Cape health system, particularly hospital care, is.

Morris-Paxton et al. (2020, p2-3), using the district of Mbashe as an example, discuss challenges to rural health provision in the Eastern Cape. They highlight that the Eastern Cape is made up of districts that face low national and regional standards of employment, clean water, and access to healthcare (Morris-Paxton et al., 2020). The Mbashe district is also facing changes in local demographics, where the elderly are looking after children while experiencing health-related problems, such as ageing and poverty-related malnutrition (Morris-Paxton et al., 2020, p. 2-3).

[3] The term "lali" or "iilali"-refers to communities or villages found within rural areas, particularly those in the Eastern Cape.

Moreover, the province is facing the aforementioned ambulance availability crisis. The extent of this is highlighted by Kamnqa (2023) who reported on the shortage of healthcare workers and ambulances in the province's Emergency Medical Services. The Eastern Cape had 3,269 posts occupied early in the year 2022. However, in October 2022, 1,202 of those posts were already vacant (Kamnqa, 2023). Research on the Chris Hani District, in the province, reveals it is supposed to have and needs 72 ambulances. Yet, there are only 62 ambulances, with only 38 rostered, meaning the other ambulances are likely out most of the time for maintenance or are not in a good state to be on the road (Kamnqa, 2023).

There is also a staff shortage that impacts ambulance availability; the extent and description of which is not available. However, this study uncovered and unpacked key issues of ambulance unavailability as this pertains to Lusikisiki while also looking at the impact and implications for the people of Lusikisiki.

The existing literature is very useful as it sketches the ambulance availability crisis within the Eastern Cape. This study sought to look specifically at the local level to unpack the severity of this crisis from the ground up by exploring in depth the experiences of the people of Lusikisiki.

2.1.1.4 Community Based-volunteer emergency services in South Africa

The issue of limited ambulance availability has been shown to be a national crisis. The existing research has shown that many communities, particularly in the Western Cape, have taken matters into their own hands. What is clear from this is how, even with these solutions and efforts in play, rural areas (like Lusikisiki in the Eastern Cape) struggle for available alternatives for their communities.

The oldest (private) ambulance service in Cape Town, the Hout Bay Volunteer Emergency Medical Service (HBVEMS), was started in 1994 by a group of residents who were concerned about the response times within Hout Bay (Cunningham et al., 2022,p.237). HBVEMS was also established to manage and work around the crisis of not having 24-hour hospitals or emergency centres in Hout Bay. This resulted in people being transported to the nearest state hospitals, including the Victoria (District) Hospital, 12 kilometers away; the Retreat Community Health Center, which is 17 kilometres away; or even further to see specialists at the Groote Schuur Hospital, 18 kilometres away (Cunningham et al., 2022,p.237).

This volunteer organization provides remuneration for hours worked and covers the expenses for paramedic training and registration fees. It relies on the “goodwill” of community members and sponsorship from other organizations, donations from local businesses and received funding from the provincial EMS (Cunningham et al., 2022,p.237).

Another example of a community taking matters into its own hands is that of Camps Bay, where in 1998, two local paramedics saw that the Camps Bay area's EMS response was deficient and worked to find a remedy (Community Medics, n.d.). The Camps Bay Community Medics (CBCM) achieved an average response time of 8 minutes.

Demand grew for their services, and they extended their services to the Cape Town City Bowl in 2013 and launched its third division to include Table View in 2015 (Community Medics, n.d.). Table view was identified as an emergency or priority project as the area faced significant health-related challenges, including accelerated growth, large portions of vulnerable groups (such as the elderly and lower socioeconomic class) whose risks are “compounded by significant lack of government emergency medical services” (Community Medics, n.d.). CBCM was registered as a trust in 2007 and renamed the Community Medics Trust in 2013 (Community Medics, n.d.). It relies on sponsorships, volunteers and supporters, like HBVEMS.

Other volunteer groups around the country include the Community Emergency Response Team and the ComMed. The Community Emergency Response Team caters to the communities of Centurion and the Vaal (CERT-SA, n.d.). It is a non-profit organization that offers (1) medical services such as an ambulance, (2) special operational support which entails private and public emergency services, community policing forums, fire department and security companies, (3) trauma support provided by trained trauma counsellors and (4) training and education including first aid training, scene safety training, basic fire fighting among other education workshops and programs (CERT-SA, n.d.). ComMed, another group of volunteer medics, operates in Florida, Roodepoort, Randburg, Bosmont and Strubens Valley, also in Gauteng It is also a non-profit organization that seeks to provide “ lifesaving services” (ComMed, n.d.). It is self-funded with assistance from private emergency services and donations (ComMed, n.d.).

However, no research was located where volunteer EMS groups work in townships or rural areas as these volunteer services are found in middle-class or suburban areas. This speaks volumes to why this is the case, as they rely on certain networks within the communities that are most likely

to have the money, donations, and assistance from businesses within the private sector. The possibility of such organizations being established in townships and rural areas has yet to come to fruition as the communities cannot take the matter into their own hands as they live in areas where most people rely on social grants and are unemployed. Whilst this exacerbates the effect of the ambulance availability crisis in these areas, this study will explore what, if any, alternative strategies the community has employed.

2.2. Conceptual Framework

The key concepts of (1) health and the ideas of well-being, (2) the social determinants of health, and (3) political economy are significant to the study as this research sought to explore the impact of limited ambulance availability on the people of Lusikisiki, Ingquza Hill Local Municipality, as well as the broader factors surrounding this crisis. As discussed above, this study was concerned with the provision of healthcare via ambulances within a local context and the experiences and coping strategies of individuals within that specific rural area, as shaped by their living context. Lusikisiki is a small and rural town that faces many challenges. To fully answer the research question and understand people's experiences and how they cope with this health crisis, it is necessary to explore the concept of "health" from the biomedical and socioeconomic perspectives.

2.2.1 Health and the ideas of wellbeing

The concept of health is important to this study as this crisis of ambulance availability is health related. Ambulances play a significant role in providing pre-hospital care and transportation to hospitals where patients are to be assisted with medical care or assistance for any emergency health cases such as strokes and any other medical condition that needs to be dealt with and prevented from becoming worse or life-threatening (Rebello, 2023). The researcher also appreciates that words such as "health", "disease", and "illness" are words often used interchangeably and that comes with ambiguity (Blaxter, 1990). Thus, in unpacking this health-related crisis, it is important to acknowledge that the concept of health can be translated in many ways because it is a social construct.

There is no consensus on the meaning of health other than the medical field's hegemony over the provision of healthcare. This study sought to engage the concept of health from both medical and sociological standpoints. The medical understanding of health was particularly important to this study as the core of the research was identifying and understanding the different medical

challenges that the crisis has on the physical, mental, and emotional well-being of individuals in Lusikisiki. This was identified and highlighted in the work of Morris-Paxton et al.(2020) in their research on primary healthcare services in rural Eastern Cape.

Existing research has looked at how health is understood in South Africa. The work of Mojola et al. (2022) speaks to the meaning of health in rural Mpumalanga. Their research provides an example of health established through self-rated health assessments. Mojala et al. (2022) used a gendered life course approach, and health was understood and filtered through whether gendered social expectations and tasks were met or not. Similarly, Gessert et al. (2015), sought to engage and activate patients in their healthcare to develop: "[a] better understanding of the health beliefs in rural populations" (Gessert et al.,2015,p.2). What emerged from their study was how individuals define "health" is based on their personal health-related beliefs, knowledge and values (Gessert et al.,2015,p.2). These researchers assert that more than 25 years of research suggest that rural populations have distinct views of health that are different from non-rural populations. Gessert et al. (2015) substantiate this by referring to the seminal study done by Weinert and Long in 1987 that reported how "health" as a concept is associated with the "ability to work" which at times delays healthcare-seeking, even when people are faced with grave illness (Gessert et al.,2015,p.2). According to Davis et al. (1991), the health beliefs of rural elders are described by elders themselves as based on autonomy and self-reliance. When these two features are absent, elders feel they become a burden on others; only then could it be said that the elders are sick and faced with ill health (Gessert et al.,2015,p.2).

This study suggests the importance of considering the socioeconomic and social determinants of health in communities' conception of health and illness. It also shows that when considering 'health' in rural areas, one needs to take into cognizance and locate this beyond an individual's mental, physical, and emotional well-being. Such includes healthcare practitioners' ideas but is not limited to these. It seeks to give voice to and acknowledge how health is located within lay beliefs and social relations that influence and help people understand and respond to health-related issues (Aggleton, 1990). Thus, this study aimed to bridge and fill the gaps in the existing knowledge by specifically uncovering the context-specific health understandings and conditions that may exist in Lusikisiki in/for which ambulances are needed. Therefore, it served as an

opportunity for relevant information speaking to the needs of the people of Lusikisiki and for relevant care to be provided.

It explored the different approaches, understandings, and conditions of health to assist my research and illustrate why it is important to know what engulfs the people of Lusikisiki, the need for ambulances in the area, and how the shortage or limited ambulances impact their health. Therefore, understanding what health and well-being means to the community is necessary.

2.2.2 Social Determinants of Health

In addition to understanding what health means to the cluster of communities and people of Lusikisiki, it is also necessary to understand how social determinants affect their health. According to the WHO (2010), the social determinants of health are all non-medical factors that are seen to influence health outcomes. These entail all conditions in which people are born, work, or grow and ultimately live and often serve as forces that shape the conditions of their daily lives (see Figure 2 below) (WHO, 2010).

This demonstrates that health and health outcomes do not exist in a vacuum but result from broader systems that include political and economic systems and policies, social norms and values, and social policies and agendas (WHO,2010). Social determinants influence health in/equities in positive and negative ways, and entail namely (1) income and social protection, (2) unemployment and job security, (3) education, (4) working conditions, (5) housing, basic amenities, and the environment, (6) food security, (7) early childhood development, (8) structural conflict, (9) social inclusion and non-discrimination and lastly, (10) access to affordable health services of decent quality (WHO, 2010).

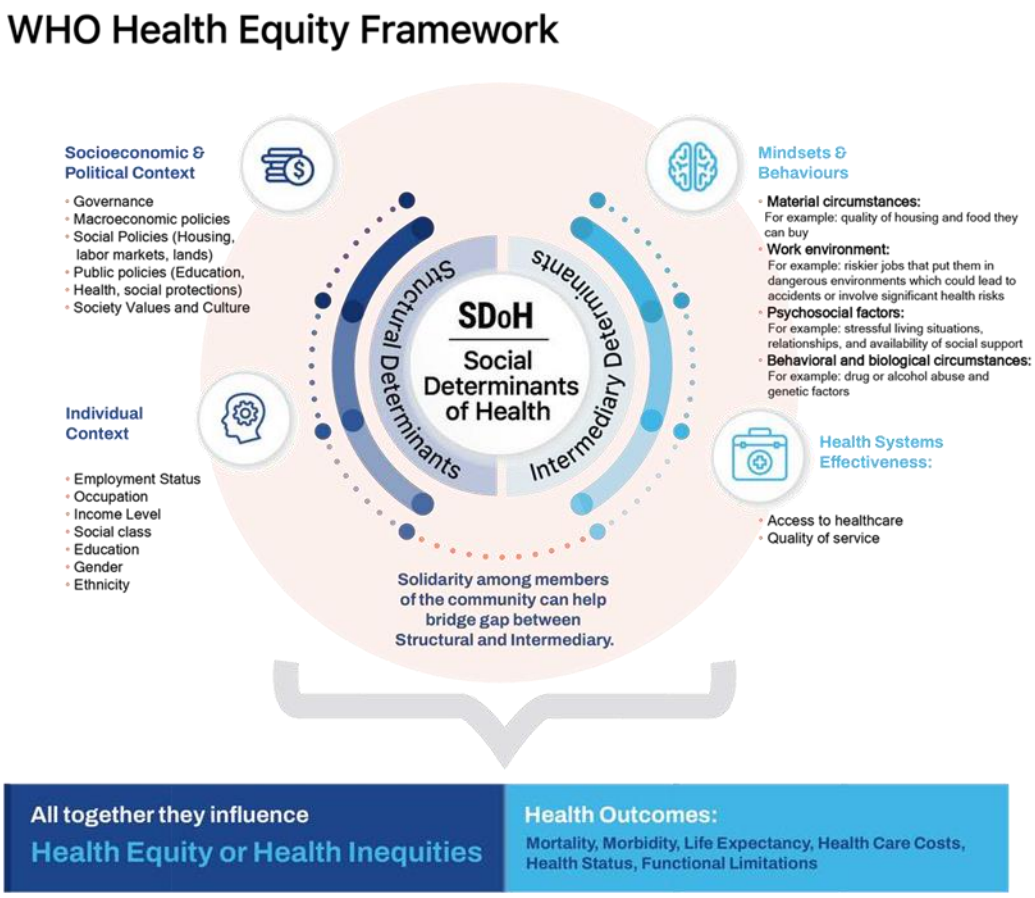

Figure 2: WHO Health Equity Framework (Gautier, 2022, p. 2).

Research and existing knowledge highlights how medical conditions and medical services are important and are also enmeshed within the social determinants of health. The work of Scott et al., (2017) uses various examples to illustrate the importance of holistic interventions to address both the immediate and distal factors (see Figure 3). In their work, what stood out was how the social determinants of health are the root or ultimate cause of premature mortality in South Africa (See Table 2 below).

These determinants were listed as "poor housing, inadequate water and sanitation, a sub-optimal food environment, high levels of alcohol and substance abuse, low levels of social cohesion, and an inadequate health-system response across the three clusters' (Scott et al., 2017, p.79). The value of this information is that it assists understanding that health inequalities of a specific country, town, or city are interconnected challenges and thus need to be addressed as such.

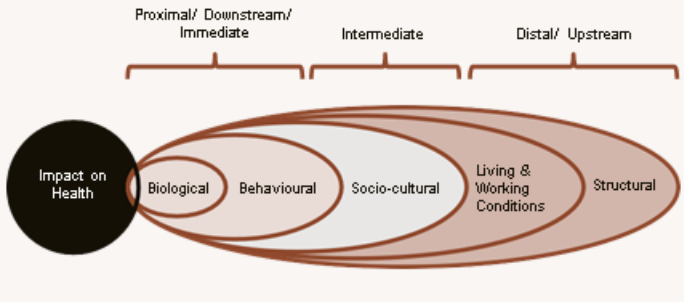

Figure 3: Framework of determinants of health (Scott et al., 2017, p. 79).

Proximal – downstream – immediate	
Co-morbidities	Low birth weight, under-nutrition and HIV infection lead to impaired immunity Maternal malnutrition, HIV-positive status, depression Smoking tobacco and other substances and/or drinking alcohol during pregnancy Infectious disease
Behavioural	Lack of exclusive breastfeeding and poor complementary feeding. Poor handwashing before preparation of food and after defaecation Insufficient recognition of severity of illness and care-seeking Late access to ANC (and resultant late diagnosis of preventable or manageable conditions) and poor access to nutritional support and PMTCT
Socio – cultural – intermediate	Lack of appropriate health education for caregivers – particularly in low socio-economic environments Women's decision-making power and access to resources is limited.
Distal – upstream – social determinants	
Living and working conditions	Household food insecurity Inadequate drinking water and/or sanitation facilities Overcrowding and poorly ventilated structures Poor quality of early childhood care and education Lack of community safety and security resulting in physical, sexual, and emotional violence and neglect Barriers to accessing effective, quality health services (including ante- and postnatal care, immunization, growth monitoring and IMCI) and other essential child protection services Poor maternal educationLow levels of income
Structural	Inadequate collaborative institutional and governance arrangements between health and other sectors to support the implementation of the country's progressive child development and protection statutory frameworks Neo-liberal policies resulting in the reduction of social provisioning Inequity in political power and resource distribution

Table 2: Major determinants of child-ill health in South Africa, 2017, (Scott et al., 2017, p. 80).

However, the existing research has gaps as it does not explore the experiences of people presented as challenges or unpack how people must navigate the lack of social determinants of health, particularly in remote rural areas.

This can be exemplified by looking at the distal-upstream social determinant of income, those who are likely to come from low-income households might be in this predicament due to poor quality childhood care and education. Thus, they experience household insecurity, live in overcrowded and poorly ventilated structures, are prone to violence and alcohol abuse, and possibly face barriers to accessing healthcare services due to not having the proper knowledge or resources (Scott et al., 2017).

The small town of Lusikisiki is not exempt from these challenges. The discussion below illuminates this further by shining light on how Lusikisiki is an example of a rural village facing structural vulnerability (see Figure 4) whose life, conditions, and health outcomes are at risk of being negative due to socioeconomic, political, cultural or normative hierarchies that cannot necessarily be changed by individual agency (Bourgois et al., 2017,p.300). Indicators that speak to this are demonstrated through (1) Risk environment (not discussed or illustrated here but raised in the findings in Chapter Five), (2) financial security, and (3) education.

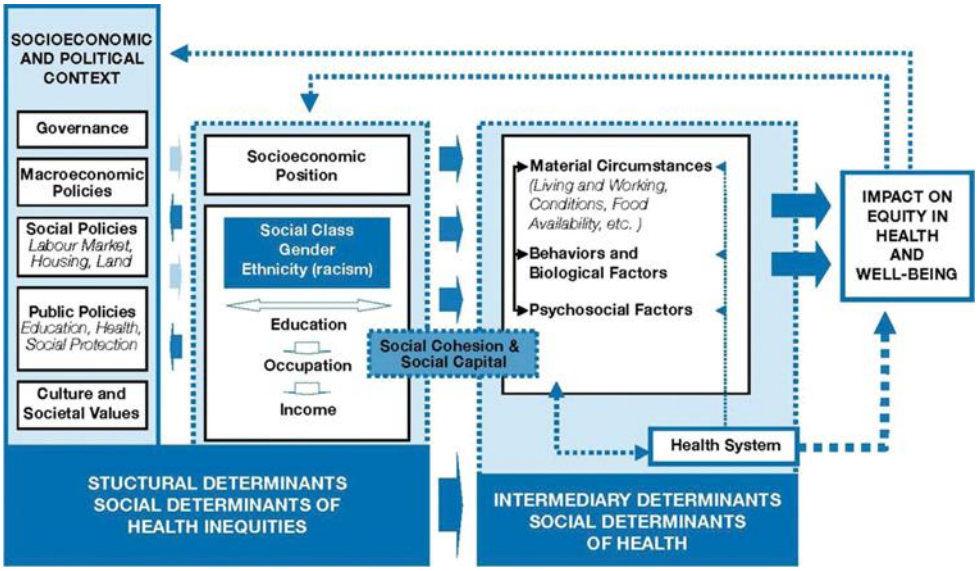

Figure 4: Social Determinants of Health (WHO, 2010).

Furthermore, statistics from the Ingquza Hill Local Municipality Integrated Development Plan (IDP) of 2019 indicate that the unemployment rate in Lusikisiki increased from 30.9% to 42.2% between 2006 and 2016, while the education and literacy rate remained low, with 32,000 people having no formal education and 18,000 not having passed matric. Thus, only 2.4% of the

population have matric, and only 1.4% have post-matric qualifications (Ingquza-Hill-Final-IDP, 2019,p.41).

Although these are statistics from 2016, they illuminate how this municipality is characterized by low rates of employment and education exacerbating the rates of low or no income. According to the municipality's IDP (2019), with a population of 320,000 people, less than 1.4% of the households earn more than R76,000 per annum, or R6,333 per month. Thus, even those working can hardly afford to pay for their daily living, let alone afford to pay for alternative transportation such as a van or a taxi to hospitals or clinics. Therefore, this illuminates the challenges facing the people living in this small town. Households with the highest monthly earnings were R9,601.00 per month, while 17% of households had no income. Approximately 63% of households are headed by women (Ingquza-Hill-Final-IDP, 2019, pp. 39).

Moreover, these statistics also tell how socioeconomic, political, and cultural hierarchies already position small towns such as Lusikisiki at risk of structural vulnerability. These statistics also indicate how there is a ripple effect that starts at the top with a government (looking at the socioeconomic political context level). It has not been able to do away with inequalities where small towns such as Lusikisiki are faced with unemployment issues due to many being unable to finish school and go to university. Therefore, placing them at a disadvantage to get employment where they can get paid decently (that is above R6,333.00 per month). People in Lusikisiki are predominately in the lower class and forced to rely on the government's policies focused on ensuring free public healthcare through various grants discussed previously.

However, given this knowledge and the link that has been made with structural vulnerability, there are gaps in the literature that exist, such as the lack of information on recent statistics as well as the impact these challenges may have on the people in Lusikisiki, and which social determinants specifically impact their health and their need to access healthcare through the use of ambulances. This research sees value in the concept of social determinants of health which raises the social embeddedness of healthcare and the limited ambulance availability and the intertwined nature of this issue and its impact.

2.2.3 Political Economy of Health

The realities illuminated by the social determinants of health indicate how South Africa is a stratified society, with most people falling within lower socioeconomic groups and a minority falling within the upper socioeconomic group.

Marxism highlights how, under capitalist economic systems, societies' foundation relies on inequality and class divisions. Within a capitalistic society, the accumulation of profit and capital (and ultimately wealth) is through the accumulation of goods and services (Brand et al., 2021), which relies on the surplus exploitation of value from workers. (Barry & Yuill, 2011).

Additionally, for Barry and Yuill (2011), the source of economic inequality [that stems from ownership and non-ownership of the means of production] is important when looking at inequalities in health. Barry and Yuill (2011) argue that those who own the means of production are likely to have access as they can purchase good quality healthcare, whilst those who do not have access to the means of production have the least access to quality healthcare. Therefore, they rely primarily on free public healthcare. These are people who live in rural areas that place them at risk and as a result experience structural vulnerability (as discussed above and later in Chapter Five which means they need free access to healthcare the most because of their financial, education, and environmental situation, and yet they receive and access this healthcare the least.

South Africa continues to be among the most unequal countries in the world. Its inequalities stem from European imperialism and settler colonialism, which was expansive and reliant on natural resources and cheap labour. Furthermore, it politically and violently enforced population distinctions (McKeever, 2023). These population distinctions brought life to economic inequality based on racial categorization (McKeever, 2023). McKeever (2023) argues that the hope many held of eradicating inequality in South Africa post-apartheid is gone.

South Africa may have repealed all the discriminatory laws put in place before 1994 that resulted in inequalities in ownership, education, income, or occupation. However, change has only occurred slowly as some of these, if not all, inequalities are still prevalent. McKeever (2023) further explains and illustrates this through the Gini coefficient, a statistical measure of income distribution, measured between 0 and 1. One represents perfect inequality, which translates to one individual

in the country owning the wealth of the whole country, whilst, zero represents perfect equality (Valodia, 2023). South Africa has a Gini coefficient of 0.63 (McKeever, 2023).

The implications are seen through the highly unequal and two-tier healthcare system made up of the private and public sectors. The private sector caters for those with medical aid schemes and/ or who can afford to pay out of pocket, while the public sector is mainly free for those without the means to pay. South Africa is also engulfed with poverty, where 47% of South Africans rely and depend on the social relief grant of R350.00 per month (Patel, 2023). Statistics reveal that in 2022, 42% of households in the Eastern Cape rely on social grants as their primary source of income, compared to 37.3% who rely on salaries (Bhengu, 2022). The Eastern Cape is, therefore, considered the poorest province in South Africa, with approximately 880,000 people living in poverty in rural areas (Alexander, 2023).

Furthermore, these statistics are important in the light of how they impact health outcomes generally and in the context of this study that speaks explicitly about how such inequalities impact accessibility to healthcare services. The work of Gordon et al. (2020, p. 6) highlights this through a study that looks at socioeconomic inequalities and the multiple dimensions of access to healthcare. In the case of South Africa, the socioeconomically disadvantaged are negatively impacted when it comes to their health outcomes. One way this is highlighted is by examining help-seeking. Gordon et al. (2020) argue that those with a low socioeconomic status delay treatment as they cannot afford to get healthcare. Therefore, this impacts their health negatively as they end up not getting the healthcare services and treatment they need. This is demonstrated in Figure 5 which looks at why people delayed seeking healthcare services, with one reason being that they cannot afford it (Gordon et al.,2020, p.8).

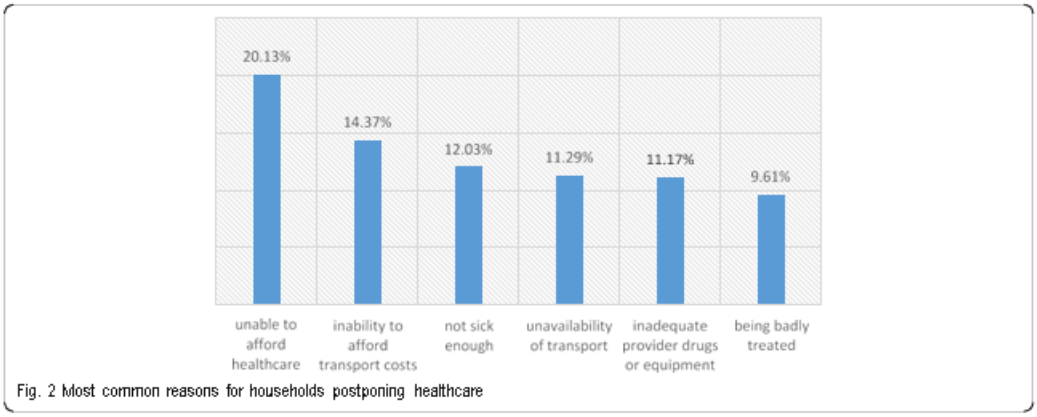

Figure 5: Most common reasons for households postponing healthcare (Gordon et al., 2020, p.9)

The aforementioned statistics speak to the COVID-19 context. However, before the pandemic, 17.8 million people in South Africa relied on social grants. This number increased to 18.2 million in the 2020/21 year, as a result of the pandemic lockdown (Patel, 2023, p. 2). These high numbers are due to poverty and unemployment, which have also increased because of COVID-19. However, even before COVID, South Africa faced high rates of poverty and unemployment. Before the pandemic, 55% lived below the upper-bound poverty line of R992 a month in 2017 (Patel, 2023, p. 2). When looking at the three grants, namely, the child support grant, old age pension, and the disability grant, approximately 13 million, 3.7 million, and 1 million people relied on each grant, respectively (Patel, 2023, p. 2). These figures have remained dismal, as poverty remained high at 67.7% in 2023 when using the upper-middle income poverty line (World Bank, 2023, p. 1).

Political economy, as a perspective, further emphasizes health as more than the physical and emotional well-being of an individual but emphasizes that it has to do with one's access to material wealth (Lupton, 2012). Those who have little access to or control over basic material and non-material goods are less likely to be able to live a healthy life with high levels of satisfaction. This information is relevant for the context of the research as Lusikisiki is a rural area made up of mostly poor, unemployed people who rely heavily on the public sector for healthcare services. It is relevant as it demonstrates how healthcare services and overall healthcare utilization are based mainly on the ability to pay rather than actual needs.

It is hard to ignore as healthcare is a reflection of one's income, and the lack of access to healthcare reflects income inequality (Francis & Webster, 2019). This is built on in Chapter Five specifically within the context of Lusikisiki.

2.3 Conclusion

This chapter centred around the key themes of the South African healthcare system and its inequalities, the role of ambulances in a healthcare system, the role of ambulances particularly in rural areas, the ambulance availability crisis in the Eastern Cape, and the alternative presented by community volunteer emergency services. These sections illustrated the severity of the crisis but also highlighted how rural areas are not generally well-researched even though they are impacted more by health inequalities facing the public healthcare system in South Africa. The conceptual framework consolidated the key ideas within the chapter by reiterating that the study concerns a health-related crisis that does not exist in isolation but is embedded in socioeconomic and political contextual factors, and specifically how these apply in the rural area of Lusikisiki in the Eastern Cape. Therefore, the concepts of health, well-being, the social determinants of health, and the political economy of health anchored the study, consolidated the literature, and framed the study.

Chapter 3: Research Methodology

3. Introduction

This chapter addresses the research process. It outlines the study's design, the methodological approach and the data analysis tools. As the study focused primarily on participants' experiences, it adopted the qualitative research approach to collect and analyse participants narrated lived experiences. The study used semi-structured, in-depth interviews with twenty (20) participants. The participants were selected from among different groups in the community of Lusikisiki, namely (1) community leaders, (2) community members, (3) ambulance drivers, (4) healthcare workers and (5) union representatives. The ethical considerations and processes are also outlined in the chapter to demonstrate how the study met professional requirements and ensured confidentiality through the data collection in the reporting process. Lastly, the chapter addresses the study's credibility, validity and trustworthiness.

3.1 Study Site and Demographics

The research took place in a small rural town called Lusikisiki in the Ingquza Hill (previously Qaukeni) Local Municipality, located in the OR Tambo District in the Eastern Cape (see Figure 6 below). As previously outlined in Chapter Two, there is little publicly available data specific to Lusikisiki. However, there is some data from about the municipality of Ingquza Hill.

The municipality's total population in 2016 stood at 303,379 (Ingquza-Hill-Final-IDP, 2019, pp.28). In 2022, this had grown to 354,573 (Statistics South Africa, 2022).The unemployment rate increased from 30.9% in 2006 to 42.2%. In 2016, 24,600 employed people lived in the municipality, which amounts to 13.31% of the total population in the OR Tambo District demonstrating that fewer people from the Municipality are employed as there are 329,973 unemployed of the total population of 354,573 population in 2016 (Ingquza-Hill-Final-IDP,2019, pp. 41). In 2022, the working population (15-64 years) stood at 56,3% (Statistics South Africa, 2022).

These statistics speak to the context of Lusikisiki, which is further discussed in Chapter Four. Many communities in Lusikisiki are under-resourced and face many socio-economic challenges. They are engulfed in poverty and have no or little financial security.

Furthermore, within the municipality, there are three hospitals., two of which are district hospitals: Holy Cross Hospital in Flagstaff and Bambisana Hospital in Lusikisiki (Ingquza-Hill-Final-IDP,2019, pp. 43). The other is the regional hospital, St Elizabeth Hospital, in Lusikisiki.

Lusikisiki was chosen for this research as little to no previous work specifically looked at the experiences of nor the impact of the ambulance availability crisis in rural towns such as Lusikisiki. Such towns do not have updated demographic information nor reliable, accessible information about their health, including the limited ambulance crisis. Thus, the experiences of many in such towns go unheard, and their issues and challenges continue to be unresolved.

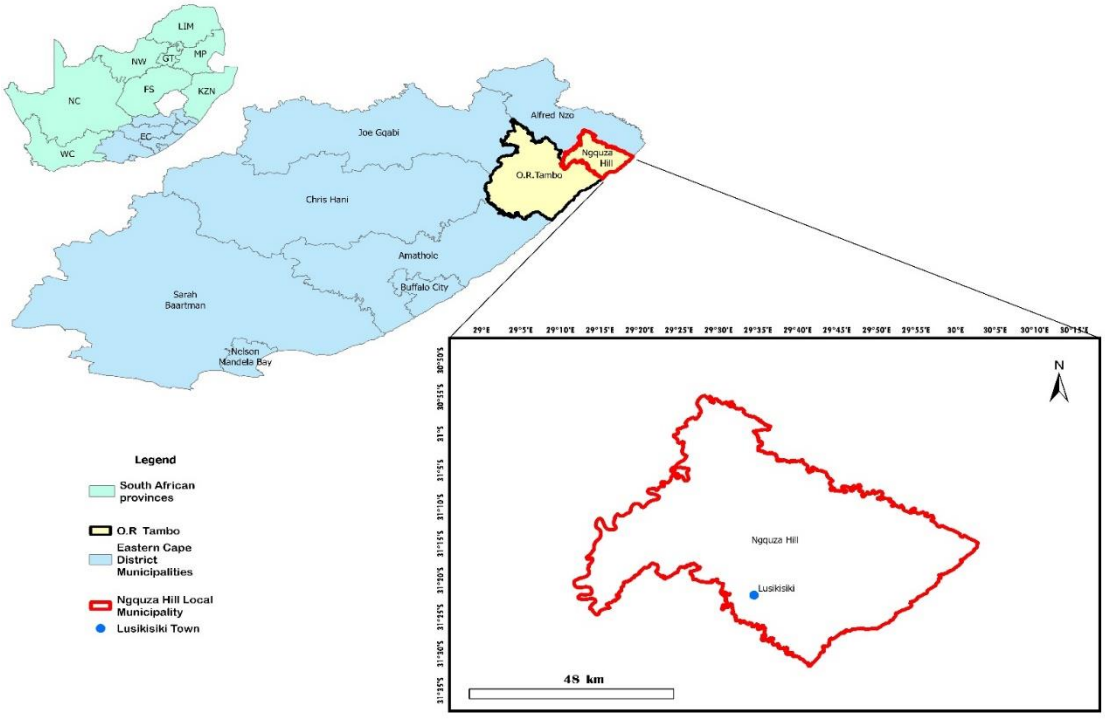

Figure 6: Map of the study area, the country province municipality boundary, with the Eastern Cape districts and Ingquza Hill local municipality (Belgiu, 2023)

3.2 Qualitative Design

3.2.1 Methodological Approach

The study used a qualitative approach and study design as best suited to a project on this topic, to explore and provide insights into real-world problems by focusing on participants' experiences, perceptions, and behaviours (Tenny et al., 2023). This project sought to gain an in-depth understanding and knowledge about the ambulance availability crisis by interviewing the people of Lusikisiki about their experiences. The recollection and documentation of in-depth experiences is possible through and central to qualitative research (Roberts et al., 2003). It enables participants to provide longer answers and the researcher to observe their expressions, strengthening the understanding and meaning of participants' experiences.

This approach allowed the researcher to take on a more non-linear approach that explained processes and patterns of human behaviours, which are difficult to quantify. It is possible through in-depth interviews and conversations, which allow participants to express their thoughts, feelings, and engage the how's and why's (Tenny et al., 2023). This can be seen in how most of the participants would express that trying to have an ambulance dispatched is difficult by using the word "kunzima" (it is hard).

At times I would have to probe and find out why they say so despite it being evident in their body language and tone where there would be a sigh here and there, but as the researcher, I would have to probe deeper to find out why they say so. In this way, I was able to get participants to unpack their challenges, which would eventually lead into the conversation of how they manage, the process they undertook and other alternatives or plans, they have in place to manage and navigate these difficult processes.

Additionally, it is important to highlight that as the researcher, I went into the field understanding that different people would be interviewed, so I expected many realities, perspectives, and experiences to surface. I understood I would need to appreciate each context and its complexity when presented. This was the case as participants spoke to me from different positions and capacities, some as ordinary people, others as healthcare workers and some as community leaders. Badenhorst (2008) speaks of how quality insights can be facilitated. She suggests that qualitative

researchers *"immers[e] oneself in [the] research context" rather than having a distance between the researcher and research* (Badenhorst, 2008, p. 93).

One of the ways to achieve this is to be in spaces where these challenges are taking place, which entails travelling to where participants are, such as meeting in communities at community halls and homes. Not only was it good for me to see some of the issues and challenges spoken about in the interview, but it also allowed me to establish some sense of trust where the participants could see and be comfortable with sharing and trusting me with their stories.

In this way, qualitative research can capture and ensure that the context and narratives are not lost. For example, having to go to community halls and homes was also insightful as you could see or get a sense of the challenges participants described, such as issues of roads and distance. Having travelled the roads, myself and seeing the state of homes drew a picture of the socioeconomic status of participants. The story of Makhulu* later described in Chapter Four speaks to this point. This is important to the research as it shed light on and brought attention to people's experiences rather than just looking for statistics and figures without capturing participants' voices, feelings, thoughts, and day-to-day experiences. It is because of these reasons that a qualitative research study design was chosen and used.

3.3 Research Methods

3.3.1 Sampling

At the core of this study are the people of Lusikisiki and their experiences of the limited ambulance crisis. It was, thus, important to ensure that the people interviewed were from Lusikisiki and had knowledge or experience of living in the town and, especially, of this crisis. Purposive sampling entails selecting participants specifically based on their lived context and knowledge of the issue (Taherdoost, 2016, p. 23). Thus, purposive sampling was a good fit for this study. I deliberately chose the criteria of people who live or have lived in Lusikisiki and have knowledge and experience of the ambulance crisis personally (first-hand) or via the workplace, political and societal/ civil role.

The strengths and weaknesses of this type of sampling were taken into consideration. The strengths included convenience, low cost, not being time-consuming and specifically generating key participants. The weakness was that it does not allow for statistical generalization. However, this

was not an issue for the study as I was led by who and which groups would ensure as much representation as possible.

To ensure diversity in the sample and of perspective, I sought to ensure that different groups within the community who were relevant, were interviewed. The composition of the final sample is represented in the table 3 below. There were 20 female and male participants, above 18 years old.

Table 3 participants:

Interviewed Participant categories:	**Number interviewed:**	**What perspective was added to the research:**
Councillors and Chiefs	4	Shared experiences of community members that have been brought to them as councillors/ chiefs; measures put in place to manage the crisis from a community level
Community members	6	Gave perspective on how the ambulance availability crisis impacts them, what ambulances are used for, issues around distance, alternative transportation used, and recommended ground-up solutions at play or to be implemented.
Nurse/ambulance union representatives	2	Shared the experiences of nurses through sharing reports on the ambulance availability crisis and efforts to bring this crisis to the health department, information on the length of the crisis.
Ambulance drivers	2	Shared drivers' experiences in the ambulance crisis, distances covered, and types of cases they drive patients for.
Nurses	3	Gave perspective on the processes of getting a hold of ambulances and some insight into the experiences of healthcare professionals and patients.

Doctors	3	Gave perspective as doctors on the ambulance availability crisis, processes of getting a hold of ambulance drivers, and the impact on patients.

3.3.2 Gaining access to the research site

For this research, I relied on community members to assist me in advertising the study to members of their community, including that participation was purely voluntary and that there were no rewards for participating, or vice versa. I anticipated the possibility of either having too many or too few participants. However, it worked well as community leaders acted as point people and had people reach out to them, with the final sample slightly under the hoped-for number. What was important was that I, as the researcher, explained the research its purpose properly and clearly to the community leaders who provided enthusiastic responses on how people would be eager to speak about this. Some of them had people in mind to whom they would advertise the study, and who be interested and willing to participate voluntarily.

When approaching the community leaders, I provided them with my information, such as my cell phone number and email, so that people interested in the study could contact me (see Participant Information Sheet in the Appendices). Sometimes, the community leaders or participants who had volunteered or referred me to others would help me connect or contact those who showed interest and willingness, and we would then organise the logistical details of the subsequent interviews. The interviews took place during the week and sometimes during the weekends. The participants' availability led me, and I was fortunately not faced with time clashes.

After the interviews, participants also referred me to others who were keen to participate. This occurred a couple of times, particularly with community members. The experience taught me about people's knowledge and willingness to participate in research, but more so on issues that have become normalised but still affect them daily. There were no challenges or miscommunications when doing the interviews; people would often say things along the lines of, "Oh, I am familiar with that and have no problem answering your questions", and this brought me great relief, as the researcher and assisted in making the process as smooth as possible. Despite the overall focus of the research project, I, as the researcher, was met with a lot of friendliness from people I had never met before yet who trusted me with their stories.

Some participants preferred to meet at a private office space (secured if needed), while others preferred to meet in community halls, and others asked that I visit them in town or Elalini. I ensured that the entire experience prioritised my and the participant's safety throughout. This was what was sought from the beginning, and by conducting interviews face to face, I could observe facial expressions, body language, and even the environment to determine that the participant and I felt comfortable and safe. A little bit of travelling was required, but it was bearable and worth it. It helped that I was familiar with and from the small town and did not experience any challenges. I am used to the remoteness and the idea of having to travel to the different lali's. I had the privilege of being accompanied by a family member with a van which made travel to remote areas easier.

3.3.3 Data Collection

In-depth, open-ended interviews were used as a method to provide the opportunity and facilitate participants' sharing as much information as possible. It was a good choice as the interview style allowed me to ask for elaboration and clarity. The semi-structured interview schedule (see the appendices) was developed ahead of time, as were the logistical aspects of each interview, such as the date, time, and location. The interviews were conducted in isiXhosa [which I speak] as the people I interviewed spoke isiXhosa or isiMpondo. Both are Nguni languages, and the participants and I communicated and understood one another. This benefited us as the in-depth interviews felt more like a conversation, which relaxed us. I benefitted from being able to access fully the meanings people attribute to their experiences (Ritchie & Lewis, 2003) authentically.

The interviews generally proceeded as follows:

- I went through 'what the research was about' as led by the participant information sheet.
- I also discussed and emphasised the research project and the distress protocol (see appendices). I highlighted that, in the event of distress, an appointment for free counselling could be set up at St Elizabeth Hospital.
- I explained to the participants that the research was (1) purely voluntary and that there were no benefits to participating in the research; (2) they could stop the interview at any point, and (3) they were able to choose not to answer any question if they did not want to.

- I requested permission to record the session. I ensured I obtained informed verbal consent (consent forms were presented but participants were comfortable to give consent verbally) to begin the research after providing an opportunity to clarify or ask any questions.
- I asked which language the participant preferred. All participants were comfortable with the interviews being conducted in isiXhosa or isiMpondo.
- At this point, each interview was then conducted.
- I took notes and recorded the interviews (with the participants' consent and as per the permission granted).

3.3.4 Data Analysis

Data was collected through in-depth interviews, where I took notes and recorded the conversations as permitted. I used thematic analysis to analyse the qualitative data, which is neither technical nor a technical exercise. The process consisted of transcribing the interviews, audio recordings, and other non-textual material, as stated by Wong (2008). When analysing the data, I had to listen and re-listen to the interviews, which was time-consuming, but it was a good exercise as it reminded me of the discussions I had with participants and enabled me to add more context to my summarised notes.

The next step in the analysis of qualitative data is coding and categorising, through what Wong (2023) describes as *"Reducing the volume of raw information, followed by identifying significant patterns and finally drawing meaning from data and subsequently building a logical chain of evidence" (Wong,2023, p.14)*. I tabled and summarised my notes into themes. I was able to identify the sub-themes that came out, as well as participants' meanings, narratives, and experiences, and represent them in a more organised and structured way to make linkages to the research question initially asked.

Therefore, I was able to achieve the objectives of the research in this way. These looked and spoke to the themes discussed in Chapter Two and highlighted how people were negatively impacted by the ambulance availability crisis and that is also enmeshed with the issues surrounding the rural town of Lusikisiki. The issues and challenges include and illuminate how broken the public

healthcare system is, and the socioeconomic, political, and geographical issues that impact participants access to healthcare and overall health.

3.4 Ethical considerations

Participants' well-being was a top priority of this research and study. I ensured that participants were treated with the utmost respect regardless of age, gender, religion, race or lifestyle choices (Mirza et al., 2023, p. 442).

Throughout the proposal stage, the internal ethics committees raised concerns and challenges with the study. This was due to a lot of misunderstanding. There seemed to be an impression that I would randomly approach healthcare workers whilst they were working in the hospital to participate in the research. It was recommended that the research be advertised on social media. This recommendation depicts a lack of understanding of the research site and the people I sought to reach. Most people would not be on social media as not many people use this, considering that it is in a rural area with network and electricity challenges and socioeconomic/financial constraints, as discussed in Chapter Two.

While all researchers need to be clear about the intention and research process to ensure all studies abide by the ethics regulations of the university, the researcher's knowledge and understanding of their home community was under-appreciated. I understood, planned and advertised the research to community leaders and community members who would only, and did, take part voluntarily without any feeling of coercion to take part.

When recording the sessions, permission was asked, and the participants were told why this permission was sought. They were also provided the option to decline or refuse to be recorded. Consent was asked, and all the participants chose and gave verbal consent. As the researcher, it was important to further protect the participants by ensuring confidentiality in participation and anonymity in the report writing process.

Arifin (2018) emphasizes that the confidentiality and anonymity of the participants should be preserved and that the privacy and confidentiality of the interview environment should be managed as carefully as possible. The interviews were done in private to try to ensure anonymity as best as possible, with interview time well spread. Whilst some chose to meet in the community hall, spaced out interviews avoided any cross over of participants.

This was further achieved by using pseudonyms and leaving out any possible details or descriptions that could lead to someone's identity being revealed in the study's write-up. However, in some instances where participants were being referred and introduced by another participant, anonymity was in the field was not always possible.

When it came to "who" said what that remained confidential during the fieldwork and pseudonyms have ensured anonymity for participants in my writing the research report.

3.5 The credibility, validity and trustworthiness of the study

Validity entails and relates to the level of appropriateness of the tools, values, techniques, and data collection methods of research (Chetty & Thakur, 2020). To maintain and achieve this, Chetty and Thakur (2020) state, "*To maintain the validity of the research, there is a need to understand the underlying needs of the research, the overarching process guidelines, and the societal rules of ethical research"* (Chetty & Thakur 2020).

This study followed and used the qualitative research approach, data collection methods, data analysis methods, and ethics procedures discussed previously. As the researcher, I have also kept detailed records such as the audio recordings and transcripts, the consent to participate and record, and my notes to ensure that I or someone else could replicate the process.

This was important as any research produced has to demonstrate trustworthiness but also persuade the reader of its worthiness and value (Nowell et al., 2017). It is also crucial for this study, which focuses on the meanings, realities, and stories of the people of Lusikisiki. Quotes have been used from various participants and key experiences to provide credibility. Credibility is ensured once it "addresses the "fit" between respondents' views and the researcher's representation of them" (Nowell et al., 2017, p.3). This also authenticates the study's claims and conclusions. It allows me, as the researcher, and you as the reader to make and deduce links between what has been said (the views and narratives of the participants) and the deduced themes and final conclusions.

3.6 Conclusion

From the above, this chapter has discussed the research process. It has done this by outlining the study's design, the methodological approach, and data analysis tools. This study focused on the participants' interests and experiences and adopted the qualitative approach as the best fit for yielding, giving voice, and paying attention to the participant's narratives.

The data collection methods were discussed, namely, the in-depth, semi-structured interviews with a sample size of twenty (20) participants. These participants came from a variety of community interest groups in Lusikisiki; namely, (1) community leaders, (2) community members, (3) ambulance drivers, (4) healthcare workers and (5) union representatives. A reflection on the ethical considerations and challenges was also discussed.

Lastly, the chapter ended with a discussion on the study's validity, credibility, and trustworthiness, emphasising the steps taken to ensure these, throughout the study. Qualitative processes and regulations ensured that the study remained true to its aims and that its value and worth can be seen in the stories and experiences of the people of Lusikisiki, which are authentic and valid and are presented as such throughout the study, principally in the next Chapters, Four and Five.

Chapter 4-Introduction to Research Context

This study took place in the small rural town of Lusikisiki in the Eastern Cape. Specifically, Lusikisiki is in Ingquza Hill (previously Qaukeni) Local Municipality in the OR Tambo District (see Figure 7 below).

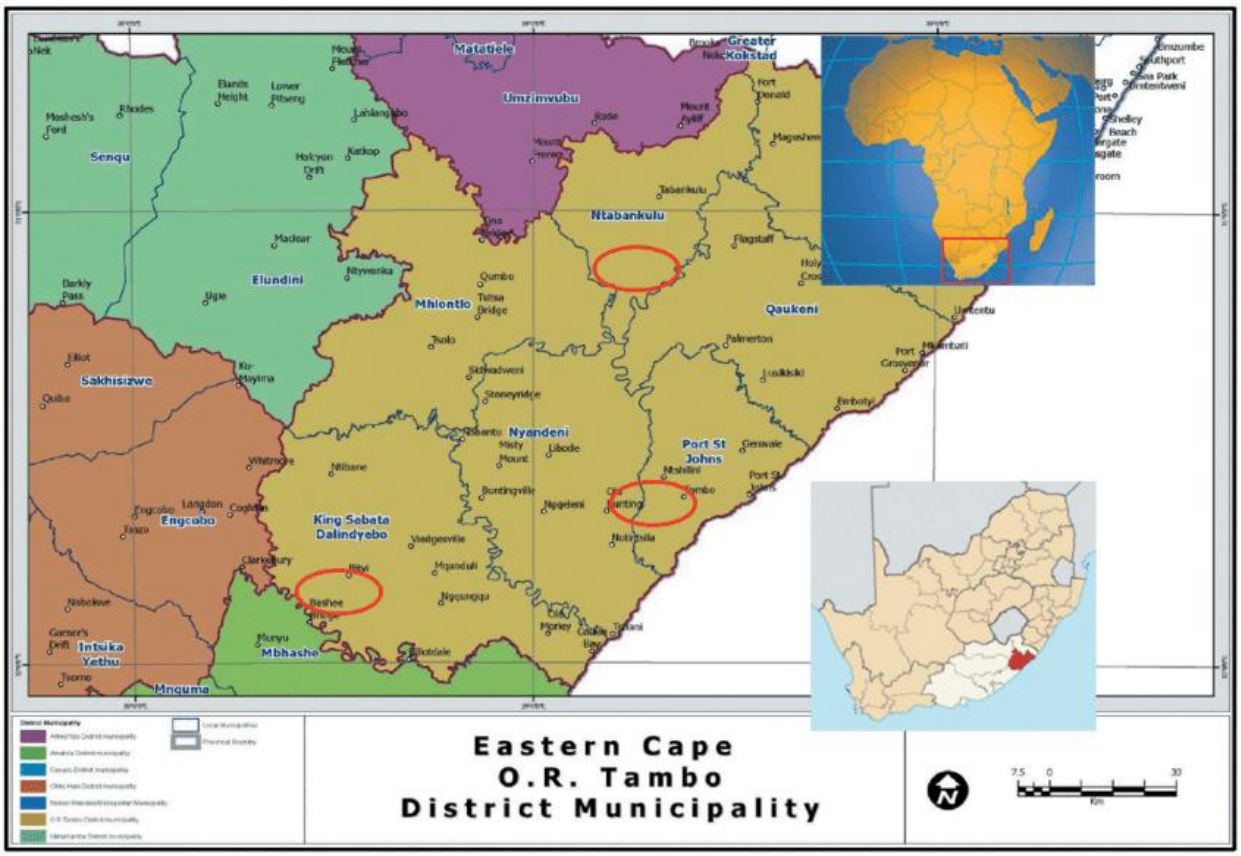

Figure 7: Map of the study area, the OR Tambo District and the Ingquza Hill Local Municipality, formally known as Qaukeni (Ngcinela, 2019, p.3)

It is a small town known for its beautiful green fertile land and beautiful landscapes, such as the Magwa Falls, which produces the famous Magwa tea. The AmaMpondo people are also renowned for many beautiful characteristics, such as friendliness, warmth, hospitality, and humility (SAHO, 2019). While these characteristics describe Lusikisiki and portray an image of a town and people with so much to offer, it would be foolhardy to ignore the other side of this rural town, which is darker and portrays an image of a town left to fend for itself.

Lusikisiki is in the Eastern Cape province. According to the Census 2022, the province has a total population of 7.2 million people (Statistics South Africa, 2023).

The OR Tambo District makes up the largest concentration and has a population of 1 501 702 people, followed by Nelson Mandela Bay, with a population of 1 190 496 people (Statistics South Africa, 2023). Within the OR Tambo District, the Ingquza Hill Local Municipality was recorded in 2016 to have a population of 303,379 (Ingquza-Hill-Final-IDP, 2019,p.28)

Additionally, Lusikisiki made it into the news for being one of the rape capitals in the country, with 104 cases of sexual offence and 92 rapes reported between October and December 2022 (Feni, 2022). The small rural town is also described as having a "potholed riddled main road cutting through its congested CBD", which illustrates failed service delivery (Feni, 2022). It then does not come as a surprise that the inhumane living conditions reflect people who have come to accept that life lacks dignity and integrity. I was met with these images when interviewing a participant, to whom I gave the pseudonym of Makhulu* (which translates to grandmother).

Makhulu* is one of many participants who have faced the conditions mentioned above and this will be demonstrated through Makhulu*, Nkosi Sthembiso* and Nkosi Kwanele* (both community leaders) and the healthcare workers Nkosazana* and Bantu* [* connotes pseudonyms]. These are some of the participants discussed in this chapter that seeks to provide an initial overview and introductory context to Lusikisiki and the participants context before moving into Chapter Five to explore the experience and impact of the limited ambulance availability at the study's core.

The story of uMakhulu speaks to the challenges and experiences people are embedded in and surrounded by but also deal with amidst and because of the ambulance availability crisis*.

This is the life of an elderly person who needs free public healthcare services such as ambulances as not only is she old but also has health issues. Makhulu is an old woman who lives in a rondavel with no bedrooms. This rondavel has no paint or proper plastering on the walls. Her double bed has no proper base and sinks in a bit, indicating that it, too, is old. On top of the bed rested Makhulu, who lay on her side with a blanket on top of her. There is no chair in the home, so when interviewing her, I sat on an upside-down water bucket.

She does not live alone but has been left by her children to look after three, sometimes four, small grandchildren who all depend on her grant money, which is around R2 090 per month (SASSA, 2023). All these grandchildren are her responsibility. Makhulu is also sick and lives with a chronic illness, diabetes, which has come with certain complications.

Makhulu also complained about having an eye problem that required her to keep going to healthcare facilities throughout the year, with her last checkup being six months earlier. At times, she has had to default on her medication, as she has been unable to collect her medication herself (either through having to walk to the healthcare facilities or having to try to get a special car)

Makhulu has lost all hope in the government and their ability to provide aid to deal with the situation of living a life of poverty, where she is unable to use free government services. This is the case as services are not being provided for, such as the limited ambulance availability crisis, which results in many not having ambulances service their communities in the Eastern Cape and especially in rural areas of the province, like Lusikisiki. The province has also been described as having healthcare workers who do not treat patients, like Makhulu, well. Her interview recounts how often she felt ill-treated by public sector staff when seeking help at healthcare facilities, which is further discussed in Chapter Five.

Mehlwana (2022) also addresses this, noting the many cases of poor attitudes from healthcare workers in clinics in the Eastern Cape. In response, the spokesperson, Yonela Dekeda of the Eastern Cape Department of Health, stated,

> "*The department will deal with any shortcomings identified during our investigation, and appropriate action will be taken. This includes taking appropriate disciplinary action where recommended" (Mehlwana, 2022).*

Despite this assurance, many people in rural areas in the Eastern Cape continue to complain that staff members' poor attitudes are still present, and access to free public healthcare continues to be a challenge because of issues such as the lack of ambulances. The story of Makhulu is just one of many examples the people in the Eastern Cape face, especially in small rural areas like Lusikisiki.

In disconsolateness, Makhulu has accepted her fate, that this is the life she will live for the rest of her life. It is a life filled with despondency and survival marked by a sense of hopelessness. Makhulu's story is not anomalous to the reality of many living in rural areas as many people have given up on the government and the prospects of ever having service delivery, such as proper roads, more health facilities, or ambulance services in their community. Yet even so, each day, despite the many challenges they face, many still seek to survive to live another day.

These are the typical experiences and realities central to this study; while they are not new or surprising, they should not exist post-apartheid. Politically, South Africa, post-apartheid, focused on enshrining human rights that were prioritized during apartheid. Yet despite there being a Constitution (2016) that states under Section 27 (1) (a) that *"Everyone has the right to have access to healthcare services, ..."*, this right applies on paper and for some remains a reality only to be longed for and not experienced (SAHRC, 2003, p. 95).

Maphumulo and Bhengu (2019) emphasize how the public has lost trust in the public healthcare system of South Africa and continues to face issues such as the shortage of human resources, prolonged waiting times, poor hygiene, poor infection control measures, shortages of resources, medicine and equipment, experience adverse events, increased litigation due to avoidable errors and poor record keeping. Each participant in this study highlighted this in some way or another. This is demonstrated in the experiences of some of the participants. Faced with this, the community's attitudes towards the public healthcare system reflect that they see this crisis as normal and are defeated and hopeless that this can be changed. Amidst this, participants like Makhulu, who are old, suffer the brunt of this, with the ambulance availability crisis further exacerbating things.

Community leaders: Nkosi Sthembiso* and Kwanele*

Makhulu's story provides a glimpse of the many challenges people living in Lusikisiki face. These are seen first-hand by those who lead these communities and carry the responsibility of taking care of their people and their needs.

The ones called to lead are chiefs, also known or called "inkosi"/ "iinkosi[4]". Sthembiso* and Kwanele* are two such participants. Nkosi Sthembiso is a chief in his community and is very involved, having dedicated his life to being there for his community members. He also expresses that the community has been left to fend for itself because it is a rural lali, far from town, with bad roads and lacks nearby and well-equipped healthcare centers.

He acknowledges that the community cannot rely on public healthcare services, and it is sometimes difficult to access these services. While he recollects many experiences, what stood out was the inhumane experience of people having to even share a small Panado (a pain killer in tablet form)

[4] "inkosi"/"iinkosi"- a chief/s or ruler/s.

due to the scarcity of medication at their nearest government clinic. Amid the ambulance availability crisis, he always seeks to help those in need. He must answer and assist with problems daily, sometimes beyond his abilities.

He tries his best to assist many community members without employment, reliant on social grants to get to the bigger hospitals in town. He drives people to hospitals or clinics using his car. It has come with challenges, such as having women give birth in the back of his van. He has made the community's needs known to the Eastern Cape Department of Health, but these pleas have fallen on deaf ears.

Nkosi Kwanele attests that neither Makhulu nor Nkosi Sthembiso's accounts are unique. During his interview, he shares the story of many living in Lusikisiki and their socioeconomic challenges. He discusses how people cannot afford airtime that will last long enough to make a call to get a hold of an ambulance; if they do, it will likely not arrive. Both Sthembiso's and Kwanele's accounts illustrate that community members no longer trust that the government will fulfil its promises of ensuring free government services, such as ambulance services.

When forced to make alternative plans during an emergency or time of personal crisis, such as an injury, someone being stabbed in the community, or even a woman giving birth, many community members seek help from their leaders, iinkosi or seek out costly and unaffordable private transportation on credit. Nkosi Sthembiso and Kwanele must regularly deal with and experience such stories and challenges in their communities.

Healthcare workers: Nkosazana* and Bantu*

However, what happens when those working for the state and healthcare facilities have many challenges ahead of them, leaving them to answer for a failed public healthcare system? Throughout the interviews, healthcare workers (HCWs) in Lusikisiki expressed that they often find themselves in a tight corner, dealing with and working in an environment with many difficult situations and cases often beyond their control. HCWs Nkosazana's* and Bantu's* stories portray an image of those working to do their very best despite the challenges faced. Nkosazana works with patients daily at a healthcare facility located within a lali; it is not well equipped and has network issues. The facility cannot always offer its services due to conditions and the lack of equipment, so patients do not always receive good health care.

Daily, she finds herself helpless and unable to help patients. She must then refer patients to better healthcare facilities, only for an ambulance not to arrive. Nkosazana claimed these conditions are known by the Department of Health. As HCWs, they do their best with what they have. However, this does not stop the questions she has to answer when patients and their families express how upset they are about the situation or when patients with varying conditions may develop complications that result in dire consequences.

Furthermore, Bantu expresses similar sentiments, highlighting that in more instances than not, patients are unaware of what is happening on the "other side". He emphasizes it is not the HCW's doing but the conditions and the lack of support from the government. Bantu speaks to this point throughout his interview and highlights that the biggest challenge is trying to do your job and being unable to do so due to the lack of equipment.

Bantu is an ambulance driver who has had to learn to always remain calm as he is constantly faced with upset and angry people who are waiting to blame him for not arriving on time or not coming at all. This paints him and other ambulance drivers as people who do not want to serve their communities when, in fact, this is the opposite, as they are trying their best to work with what they have. As there are not enough ambulances on the road, ambulance drivers are required to work longer shifts and travel longer distances. Nkosazana and Bantu's accounts provide insight into the experiences of those on the other side, seemingly left to work with insufficient resources and inadequate conditions to ensure sound public healthcare services for all.

This chapter seeks to set the context and introduce insights from the different groups within Lusikisiki and how these groups perceive the current state of healthcare accessibility in Lusikisiki, particularly the limited ambulance availability crisis. As an introduction to the main findings, Chapter Five will give voice to the different stakeholders to provide an overview of the experiences and challenges of accessing ambulances for people living in this small rural town.

Chapter 5-Findings and Analysis

5. Introduction

This chapter will present the main findings from the research in five themes. These five themes will describe, amplify, and elucidate the voices of the people of Lusikisiki by bringing their experiences to the forefront. This will be done by highlighting and discussing the range of responses according to different participant groups. The first theme explores the reasons why people need and use ambulances. Under this theme, the perspectives and a comparison of similarities and differences of various ordinary community members, including community leaders, healthcare workers, ambulance drivers, and union representatives, will be discussed.

The second theme considers the process of trying to contact an ambulance. This entails looking at the official numbers to be dialled and the dispatch process [how this is supposed to function] versus how the reality, what works and what does not, and people's knowledge of ambulances. This provides a picture of the state and the need for ambulances in Lusikisiki. The varied insights and perspectives of different community members inform this.

Thirdly, the challenges experienced by the people of Lusikisiki in accessing ambulances will be examined by participant group, which involves looking at the need to find alternative transport and the financial burden, among other discussed challenges. These encompass additional measures needed because of the difficulties experienced in accessing an ambulance. The fourth theme examines the implications or consequences experienced by the various community member groups due to limited ambulance availability, such as the impact this has on the referral system as an example amongst other implications discussed in the theme. The fifth (last) theme provides participants' recommendations, including the changes they believe should be implemented to address or impact the limited ambulance availability crisis.

5.1 Theme discussion

5.1 Reasons why people need and use ambulances in Lusikisiki

The participants interviewed provided insight into Lusikisiki. They provided insights into the needs of many community members and the reasons why they need ambulances. The issues faced are both health-related and socio-economic. Community leaders emphasized that the most common reason ambulances are needed is for emergency cases. This typically entails someone being stabbed or shot, involved in a car accident, and a woman giving birth.

5.1.1 Social issues, crime, and violence

These three answers were common and were repeated by participants, particularly the issues of childbirth [discussed in 4.1.2] and stabbing. One of the community leaders stated the following,

> *What happens in my community is that people are being stabbed and killed in broad daylight* (Thabo*)

Community members also highlighted this as a major need for ambulances. The underlying reason provided for this was alcohol and the role of taverns leading to high levels of intoxication, resulting in a significant amount of people getting stabbed. This speaks to the greater social crisis of alcoholism and violence that is quite prevalent in Lusikisiki. This is supported by Meel (2022), who provides various case studies from their research. Case No.1 is about a thirty-two-year-old male who quarrelled with three inebriated people and was then subsequently stabbed to death (Meel, 2022, pp. 1532). The perpetrators were said to be unemployed. Throughout the study, Meel (2022) demonstrates, through empirical evidence, that alcohol and crime or violence are inseparable in the former Transkei. Motor vehicle accidents were also frequently reported as a major reason for needing ambulances.

5.1.2 Health-related issues in a social context

Another major reason ambulances are needed and used is for women in labour and childbirth in emergency cases. Several examples stood out: a community member who needed to call an ambulance on behalf of a school pupil who was believed to be in labour and needed to be transported to the nearest hospital with the closest being a regional hospital. Another incident was of a woman experiencing pre-eclampsia while in labour where the foetus was thought to be in distress who needed to be taken from a district to a regional hospital (Bukeka*).

In the instance of the mentioned community members, the women who were in labour needed to go to a regional hospital as it was the closest to them. Furthermore, in cases where patients were 'stretcher patients', those who could not walk and would need an ambulance with a bed, oxygen, and necessary fluids to be transported were also mentioned for other reasons.

In addition, community members' responses were often personal and highly specific. One participant stipulated that they needed an ambulance because they were sick and needed one regularly.

When asked, "When was the last time you needed or used an ambulance and why?" They responded,

> *It was for me; ... in 2019, I think, from January [can't remember when]. I had to go to the hospital regularly due to health issues I was experiencing after I was pregnant. I also had to attend counselling. I would have to go to St Elizabeth Hospital to sleep, then the next morning, wait for an ambulance to fetch me, and then take me to Mthatha, Nelson Mandela Academic Hospital, for my appointments.* (Thando*). The journey from Lusikisiki to Mthatha takes approximately two hours.

Another participant who had a sick child with cancer also needed an ambulance regularly. They needed to use the ambulance, in some instances for emergencies and, in other instances, for check-ups in Durban at the Albert Luthuli Hospital. The distance from Lusikisiki to the hospital in Durban is approximately four and half hours. These quotes show that ambulances are often needed to transport people for checkups at clinics or hospitals.

It was also mentioned that community members use ambulances to collect medication from clinics or hospitals. For example, according to Phiwe* 'sometimes, if you have an unexpected headache and simply need a Panado but do not have one at home, you have to travel to get this Panado.' These participants demonstrate their difficulty in getting something small, like a Panado, when living in Elalini. This places many community members at a disadvantage as they find themselves forced to seek help at other healthcare facilities, outside of their community which are far away and require a lot of travelling and money for transportation. This impacts their already difficult socioeconomic condition of not having money, such that they already rely on free public healthcare which itself lacks medication and is a far distance from them, requiring travel and spending more money as there is no ambulance service available in their communities.

Similarly, an ambulance driver also spoke of community members using ambulances to fetch treatment. However, in this case, the driver felt community members should not be using ambulances for this reason. The driver felt sometimes people may lie to secure transportation. As stated,

> *It is not always just sick people who use it or need it. As some people lie and say they are sick just to be fetched to go and collect their medication. It has happened when a person called saying that their loved one had collapsed and was in pain. Only for us to get there and see that she had sores that needed to get checked at her review appointment. She wanted us to take them to and did not collapse but lied to get free transportation to the hospital or clinic* (Bantu*)

Regardless of why, ambulances take people to hospitals or clinics for non-emergency cases. This demonstrates the flexible roles of ambulances (Singh, 2022). This is often the case for patients referred to hospitals outside Lusikisiki to see specialists or for check-up appointments.

The health workers interviewed highlighted that patients are often referred to bigger hospitals due to the lack of proper equipment in local hospitals and, at times, the limited staff members in small hospitals such as Bambisana Hospital. For example:

> *It depends on the diagnosis as some patients might have to be referred to see a specialist or go to a hospital with better equipment as our hospital does not always have the right and good equipment* (Asanda*)

Transportation of patients to Mthatha or Nelson Mandela Academic Hospital usually takes approximately two and a quarter hours, while transportation to Bedford Orthopaedic Hospital takes just over two and a half hours. This means that ambulances are not available and out of circulation for other patients, for approximately four hours at a time and even longer as the journey to these hospitals from Lusikisiki at times can be longer due to delays during road repairs and reconstruction. While immobile or stretcher patients need ambulances, it was also discussed that patients who can walk might only need and could use a patient transport vehicle (PTV). A healthcare worker interviewed said,

> *It is not easy for me to say how many ambulances there are. As a nurse, we see emergency ambulances the most and sometimes a PTV for those who are outpatients.*

It is not a problem to get this [PTV] as to get an ambulance. However, they [ambulance drivers] are too lazy to come to our hospital. What they do is they take our patients and keep them the whole night at another hospital that they have to collect patients from, which is not right as they keep patients the whole night instead of taking patients from one hospital and back, then going back to another hospital. What they do is they want to take them all at once from one hospital, mixing patients.

*We spoke to management about this and how it is unfair as patients go from our hospital bed to benches at another hospital and sit in the cold the whole night. We told them our patients were admitted and if you are going to take them to go wait at another hospital rather, they should stay and be fetched in the morning from our hospital. (*Asanda*)

The point Asanda makes also speaks to the shortage and challenges of the limited ambulances, as PTV drivers may be doing this to ensure that many people are taken at once since the numbers of these vehicles could be limited. This is possible because of the shortage of ambulances and possibly where PTV drivers must ensure that they take as many people as possible at a time so that there are not a lot of trips that may cover long distances and to the point that some people must wait too long. None of the participants were sure of how many PTVs were available.

What continually stood out was the recurrence of misunderstanding between each sector where healthcare workers may view ambulance drivers/ PTV drivers as being, "lazy" not understanding that they too are faced with a lot of pressure and challenges. An ambulance driver spoke of there being four ambulances for the Ingquza Local Municipality which makes up two towns that are Flagstaff and Lusikisiki. This illustrates that there is an ambulance shortage as there is supposed to be one ambulance per 10 000 people (Kahn, 2022).

Ambulance drivers find themselves having to make decisions they should not be making to be able to deal with the pressure that comes with the shortage. As a result, if two or more patients can be taken in one ambulance [if it is the type that has more than one bed], ambulance drivers end up doing so. Doubling up also depends on the condition of the patients. An ambulance driver stated,

We can combine patients if the direction is in the same way. Let's say I went to Nkonzo elalini near Mcongo, and I received a call that said there was a patient near eNtambeni zase zalu and that I should pass there and get them. Even then it will depend on their condition or level of sickness and also whether or not it is contagious. (Bantu*)

This raised the question of whether the limited number of ambulances strains ambulance drivers. On a good day, four ambulances are available, but at times, this can be less due to maintenance issues, or the long distances travelled. This was often the case despite ambulance drivers wanting to do their work and the best work they could. At times, it was simply impossible and beyond their control.

He described this by saying,

> *What is important is for us, [is] to ensure that people get to a hospital or that we assist them where we can before they get to the hospital. This is free of charge, and none of the people pay for this. It is our duty to assist them. However, we do not have a lot of ambulances, and you will find that sometimes we have to travel outside of Lusikisiki to Mthatha, going back and forth. When we come to Lusikisiki, we find that we have a long list of outstanding calls that we need to attend to; it can be ten calls at a time. We cannot always attend to these calls even though we want to because we do not have enough ambulances* (Bantu*)

This section has discussed and shown that there is a high demand for ambulances, but they are insufficient in numbers. Currently, ambulances are used for both emergency and patient transportation over large areas and distances which exacerbates the problem more. In reviewing the issue from multiple angles no one fully understands or appreciates each other's predicament.

5.2 Processes of trying to get a hold of an ambulance in Lusikisiki

The processes of trying to get hold of ambulances in Lusikisiki were described most of the time using the isiXhosa word "indzima"", which translates into English as "too difficult." Community leaders are often sought out by community members from the beginning of the process when someone needs to go to a healthcare facility because they are injured or are an expectant mother, experiencing painful labour pains. Chief Kwanele* stated that people often come to him, so he knows this experience and its challenges firsthand when asked to describe it. He said,

> *It requires people with lots of airtime' which most people do not have* (Kwanele*)

Officially, when trying to get a hold of an ambulance, one is supposed to dial one of two numbers, which are 112 or 10177. From there, the call is supposed to go straight to the call centre with an agent on the other side who will use the details supplied to dispatch an ambulance to where it is

needed. According to an article by Meents and Boyles (2010), the Eastern Cape Department of Health published a poster with "generic standards" on ambulance response time for rural and urban areas in South Africa. This stated that "All citizens in need of emergency services will be attended to with courtesy by qualified personnel and a fully equipped ambulance within 1 hour in the rural areas and 45 minutes in urban at all times" (Meents & Boyles, 2010).

However, despite this being how the process should be, this is not the case. Kwanele* recalls his own experiences of trying to get a hold of an ambulance using his airtime as a community leader by dialling the call centre and having to wait a while or maybe after three or more tries which can be 30 minutes or more due to the voice prompts before getting through to speak to the call centre agent. Some people give up as it sometimes does not connect to the call centre, and you are unable to speak to anyone who could dispatch an ambulance. Another community leader noted that some community members opt to go to the nearest clinic if the community leader cannot help or is unavailable and they request assistance from the clinic staff.

In other cases, a community leader would try to call someone at the hospital to direct them to the relevant number, where someone could assist them. However, even then, there is no guarantee of success in getting hold of an ambulance.

It was also stated that most community members have expressed hopelessness and despondency when it comes to ambulances and that they no longer bother trying.

Instead, community leaders suggested many community members go straight to hiring a van, taking a taxi, or asking a neighbour or the chief or councillors to assist them to get to the nearest healthcare facility. This was highlighted by a community leader who noted that:

> *Sometimes you wait for so long, only for the ambulance to not arrive* (*).
>
> *Sometimes you call an ambulance, and it does not arrive, or it will arrive the next morning, if let's say you have called it late at night. You wait in hope, and you see that it's the next morning. It's hard for me to give you hours but I can say that people just hire a car in the community. People no longer have faith in ambulances* (Thabo*)

Such experiences have resulted in some community members not following the formal processes. They attested to this and said they hired a car from the get-go. The expenses of are discussed later under the challenges and implications section (see sections 5.3 and 5.4).

However, some do try to call the call centre number, 112. But this is usually attempted by community leaders in their attempt to assist community members.

One participant also said that there is a number (unfortunately, she could not remember) that sent her through to the call centre in Mount Ayliff, a town almost two hours away from Lusikisiki. This further prolonged the process of getting hold of the ambulance to Lusikisiki. The participant explained this by saying,

> *It is not easy to try to get a hold of an ambulance as it [call] does not go straight to St Elizabeth Hospital, Lusikisiki. You first have to get through to the Mount Ayliff call centre, and it took me three calls before I could get through... The ambulance arrived two hours later.* (Unathi*)

Participants experienced differing waiting times for ambulances. Some said it could take thirty minutes just to get a hold of an ambulance. Others said it could take three or more tries. Some said it took "plus or minus one hour or more" to try to call for an ambulance. Unfortunately, in most instances, participants said, "You would not get any assistance and just give up."

This also speaks to how difficult and how long it can take to get through to request an ambulance. One participant stated that,

> *In my community, you seldom see an ambulance but hear that people have hired what we call 'ispecial,' which is a car that is about R300.00 [one way]. Some people cannot afford it, so they take it on credit, owing the 'special' owner money in return. I am on a funeral cover called Siceli Nkosi that is about R110.00 per month and there I get the benefit of using their special ambulance as they have a private ambulance service. (*Yolanda*)

This community member describes how many must rely on other alternatives, such as funeral cover (a private alternative), to ensure their needs are provided for. This is similar to a community in Hout Bay in the Western Cape that created their own Hout Bay Volunteer Emergency Medical Service with faster response times that the government ambulances (Cunningham et al., 2022).

When speaking to the community members in Lusikisiki, there are (to date) no independent service provision initiatives other than individuals relying on someone with a car in the community to assist them. Such alternatives, whether a bakkie, a van, a taxi, or a car, like in the story of Yolanda, requires money that community members typically do not have.

Although this was the status quo and the experience of many, Babalwa*, who had lived close to the healthcare facility in town, stated that, in multiple cases, her experiences were smooth. She reported that she called, and the ambulance did not take long to arrive, arriving within 30 minutes. Furthermore, it took just five minutes to get to the healthcare facility. She described the experience as positive and said how friendly the staff was.

The story of Babalwa shows how proximity plays a role in her experience; she was close to the hospital, the area she lived in had relatively better tar roads, and when she called for an ambulance, it came without delay.

However, others who lived in a lali were further away from towns and healthcare facilities, on poor quality gravel roads, with difficulties in contacting the call centre, and long waiting times were common if the ambulance came at all.

Healthcare workers also spoke about how the process of requesting an ambulance is difficult as there does not seem to be a properly functioning call centre system. The effort required to refer a patient was described,

> *We first call the hospital or specialist and see if they can receive our patient. If yes, then we call for an ambulance using the 112 number. The other number is 047 532 4174.* (Khoza*)

The secondary number supplied by a healthcare worker differs (see quote above) from the other participants' official and commonly used numbers (112 and 10177). This number is used by HCWs when trying to get a hold of an ambulance, particularly when they need an ambulance to get patients to the referred hospital. If these numbers are unsuccessful, healthcare workers try contact the clinic/hospital manager to try to call someone to help. This demonstrated processes are not seamless, even for healthcare workers.

When ambulances arrive for referred patients, ambulance drivers are supposed to report back to the hospital that called them [the dispatching hospital]. This does not occur, according to healthcare workers, which is frustrating for them, and patients are sometimes taken home or left at the referral hospital without being returned to the dispatching hospital. Healthcare workers reported feeling helpless as it is difficult to get a hold of them (ambulance driver) from the beginning, and they cannot call back to follow up where the patients are.

Another healthcare worker also stressed that there is a lot of waiting time when trying to connect to the call centre to get an ambulance dispatched to the healthcare facility. Ambulances are said to come to hospitals for referral trips only from Monday to Thursday between 06:00 and 07:00 and to only go to Bedford or Mthatha. However, this is circumstantial and does not always happen the same way, all the time. A nurse highlighted that a booking needs to be made. However, this did not guarantee the transport as the booking system was said to be unreliable. On Fridays, it was reported that the ambulance does not do referrals. This was surprising, given that emergency care can be needed at any time.

A doctor stated that,

> *We have lost a lot of patients due to ambulances coming late or not coming at all. Patients have had to wait for 8 hours or more.* (Lutho*)

Furthermore, a hospital-based healthcare worker stated that the process is also difficult due to the issue of poor network reception in the area and load shedding,

> *It happens that you cannot get ambulances on the phone, and you do not know if they are busy or because of network issues, as when there is load-shedding, we struggle to get through or to hear each other properly on the phone. This happens when you have an emergency, and you cannot drive the patient in your car.* (Athandwe*)

An ambulance driver elaborated on how this made locating patients difficult. Sometimes, patients can be missed as you must go deep into rural areas without a network to locate them. You lose them on the call or due to load-shedding or even airtime issues, and then you drive and drive around the area trying to find them or a place where there is a network.

Zandile* illustrates this,

> *Sometimes, we cannot get a hold of patients due to their phones being off, network issues because of where they live or load-shedding. The load-shedding could be experienced by the community member we are trying to get to or the call centre trying to despatch the ambulance. Sometimes, it helps when the police arrive first at the scene when we are experiencing these challenges.* (Zandile*)

Such problems are worse at night.

This results in a broken ambulance process that presents many difficulties in trying to contact the patient or healthcare workers at healthcare facilities.

This section has demonstrated the breakdown in the ambulance system that services the Lusikisiki area. It shows how one's environment plays a key role in one's access to healthcare and health outcomes, as people in rural areas have difficulties contacting ambulances and, therefore, access to hospital-based care because of where they live. Rural people are forced to pay the price simply for living in a "lali". They struggle to call for help and to get help when they need it most.

5.3 Challenges experienced in the process and the steps people are forced to take

Some of the challenges highlighted by participants further demonstrated the strain they experienced due to the limited ambulance availability. This strain speaks to the issue of socioeconomic status and the financial implications of having to make alternative plans to get to healthcare facilities.

Whether health circumstances (that required transportation) were foreseen or unforeseen, participants faced challenges due to being unemployed or not having any savings/spare money for expenses beyond their daily requirements. Not having work nor an income impacted participants' living conditions. This included living in areas that are unsafe and that are far from health care services and other vital resources. For some people, the areas they live in are 30-40 minutes away from healthcare facilities; for some, it takes an hour and a half to two hours because they are far away, but also due to the bad road conditions or gravel roads.

Thus, place shapes people's experience and influences the types of lives they live and their health (including outcomes) as previously highlighted earlier and in Chapter Four, through the experience of chiefs. As highlighted in Chapter Two, when looking at the theme of South Africa's health systems and how it was designed, this does not come as a surprise as remote areas such as Lusikisiki have healthcare facilities that were more than five kilometres away from residents, leaving them with the burden of having to travel to get to healthcare facilities.

Ambulances were described as scarce or simply unavailable. Long waiting times of up to five hours, and sometimes arriving the next morning (Thabo*), if at all. This reaffirms the distances travelled. One community leader recalled,

> *I once had to drive an injured child to the clinic in the community. I dropped the child there, only to be told later that the child needed more medical attention and had waited nine hours for an ambulance to arrive.* (Sthembiso*)

The cost of hiring alternative transport is high. However, these costs depend on where you live. Some communities reported the cost to be R400.00 for a one-way trip. However, during the day, in this specific community, it was reported to cost as much as R800.00 for a return trip of 30 to 40 kilometres due to the gravel road. At night, up to R1 200.00 for the same journey could be charged.

These transport cars are sometimes referred to as "ispecial". These cars or vans would otherwise be used for business purposes, but because the owners are requested to transport a sick or injured individual to the hospital for emergency purposes, they lose out on business. Transport vehicles that would otherwise be picking up other people along the way charge the sick individual or family for the seats that remain vacant for the duration of their emergency travel.

Many people simply cannot afford these prices. They take the journey on credit or do not go to the hospital for check-ups, appointments, or medical attention. Makhulu stated that she sometimes walks to a healthcare facility or clinic. As an old woman, walking to the healthcare facility could take two hours. It is a strenuous walk, and there are safety issues that make her question whether to collect her medication or to wait until she has money for transportation. Thus, she has defaulted on her medication because she could not fetch it from the clinic.

The safety issue, particularly for women, was also raised by a participant with a car, who said,

> *Sometimes, a person comes knocking at your door at night to ask you to take them to the hospital. There is also the issue of load shedding, so sometimes it is very dark, and you have to drive in the dark on a very bad road. I sometimes fear for my safety.* (Nolwazi*)

The healthcare workers highlighted that the biggest challenge they experience within healthcare facilities is the significant delays caused by ambulances coming late to collect patients who need to travel for referrals outside of Lusikisiki to places such as Mthatha or Bedford.

This is upsetting for patients who had to arrange to get to the hospital, including paying for transportation to Bambisana Hospital to wait for an ambulance to take them to Mthatha, only to miss their appointment because the ambulance did not arrive on time.

A healthcare worker said,

> *Ambulances come late, and patients miss their appointments. Take the example of a patient with cancer. If they miss their appointment, the cancer continues to progress as they are not getting the medical attention they are supposed to get. You see?* (Nkosazana*)

Nkosazana also emphasised that the sad reality is that once patients miss their appointments, they get later dates that could be the following year. Another healthcare worker spoke to this painful reality by saying,

> *It is so sad that sometimes patients travel to Mthatha seeking help from a specialist only to get there and to be given another date without ever seeing the specialist despite all the efforts and waiting for an ambulance*. *They have to do this again* (Nkosi*)

Moreover, ambulance drivers expressed that people are often incredibly angry and do not realise that they, as ambulance drivers, also experience the challenges of the shortage of ambulances. Sometimes, getting to patients takes a long time due to the distances drivers cover. For example, from Mthatha, the roads are also bad, and the deeper you go into the lali, the more challenges you face with the network and communication. While poor communication and the lack of actual streets were an issue for drivers, they reported that they had seldom faced any safety issues.

The only safety issue a driver could recall was when someone called an ambulance to rob it. However, that was a long time ago, in 2007, and was a Patient Transport Vehicle. However, even then, community members went to retrieve it. The only other safety issue reported by drivers was that some patients get angry and want to fight the driver as though delays are their fault.

A driver stated,

> *They get angry at you for being late or delayed, and in such situations, you try to remain as calm as possible. I cannot say that the other drivers can but that is how I try to approach the situations.* (Bantu*)

When speaking to union representatives, some of the challenges raised resulted from the shortages of ambulances. This strains ambulance drivers, who are forced to work overtime without any pay increase. One of the union representatives highlighted that ambulances should be stationed in each hospital to avoid this, as these workers are being overworked due to this shortage. Drivers are often told that ambulances are limited due to them being in service for maintenance check-ups, and when these ambulances are supposed to be brought back to serve the community, they are not.

Ambulance workers stated that they were forced to work with ambulances that were not well equipped with the “essential tools” (Mehlwana, 2023). To demonstrate against their conditions of work, they embarked on an unprotected strike from April to November 2022 (Mehlwana, 2023).

The strikes took place in the Amatole and King Williams Town in the Eastern Cape. The alleged government response was to threaten to fire the 224 EMS health workers who were said to still be at work (Mehlwana, 2023). There have been efforts to speak to the provincial health department.

As a result of the outcome of the Provincial Legislature Meeting, on the 5th to 8th of September 2023, an increased commitment was given to the issue of “ frozen posts” which had led to an excessive workload (Mehlwana, 2023). Therefore, more health workers were now employed to assist nurses and improve their work conditions. However, little was said at this meeting about the ambulance shortage as a crisis facing small towns such as Lusikisiki. This suggests that this has not yet been considered urgent, which is unfortunate for the many people who cannot access ambulance services and thus cannot use the free public health sector for the necessary services.

5.4 The Implications of Limited Ambulance Availability

People in South Africa are, on paper, guaranteed the right to access healthcare services under Section 27(1)(a) of the Constitution, which states, “Everyone has the right to have access to healthcare services, including reproductive health care..." (SAHRC, 2003, p. 95). It is further stated in Section 27(1)(b) that the State is to “take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of the right.”(SAHRC, 2003, p. 95). Furthermore, Section 27(1)(c) stipulates that “no one can be denied emergency medical treatment.” (SAHRC, 2003, p. 95).

Yet despite these rights existing on paper, for many people in Lusikisiki, they seem to be a figment of their imagination and are rights they have never enjoyed. This was expressed during interviews with community members, in which many discussed their financial challenges. The little that people have from social grants is sometimes spent on alternative transportation due to the limited ambulances available. These experiences bring voice and make the position many face perceptible, where they must choose.

Makhulu* explains,

> *Ambulances are scarce, and I have to hire a car. It affects me a lot because I live by iBofolo [social grant]. Yes, we get money, my child, but it is not a lot.*
>
> *I find myself having to ask for favours so that I can catch a ride by credit, which I have to pay back because the money I have is a little and only enough to look after myself and the children you see here and food. I get sick sometimes and need to go to a hospital, but I do not have enough money. Some people say yes to the arrangement, and some do not*. (Makhulu*)

The impact of limited ambulance availability is that many community members cannot access healthcare when an ambulance cannot be reached or does not arrive. Makhulu stated that she was unable to go and collect her diabetes medication and had defaulted on it a couple of times. Other participants also drew my attention to other challenges they faced at the clinic when they went to fetch their medication.

Luyanda* stated,

> *I am HIV positive and have to fetch my treatment for HIV as well as get blood tests done regularly. I go to the clinic in Newtown, and I do not know if it is because the clinic is relatively new and fancier with new stairs, but they just ill-treat patients. The last time I went there, they lost my blood, and I had to go get tested again. This happened maybe three times before. This then means I have to go there more than I should to do other tests because I have an appointment, only to not be helped due to them losing my blood. There are unexpected costs involved due to the nurses' negligence.*
>
> *I now go to the Cebekwana clinic, which is further away, but at least they care about you more there* (Luyanda*)

Moreover, another community member spoke about the implications of safety and trauma as she recalled an experience where a young girl was raped at night. What this participant highlighted was how community members are woken up to such situations; they have no training or know how to respond to or deal with such situations. These incidents occur during the night with the perpetrator still on the run. There may be load-shedding, so it is very dark, and they are asked to help someone who is hurt and in pain.

These experiences, according to this participant, take a toll on one's [community member's] mental health. In her experience, healthcare practitioners are the first people who should be dealing with these challenging incidents, but community members have been left to respond themselves, which is traumatic and may also compromise their safety.

These issues and challenges raise socio-economic challenges, social issues such as crime and safety, load-shedding and geographical and political issues such as demarcation. Community members have highlighted that these concerns all go hand in hand and that solving one would require solving the others, as these are inseparable. It then becomes important to listen to everyone's voices and apply solutions and strategies to this provincial and national issue. This requires taking into consideration the needs of communities, such as Lusikisiki, which entails considering the social challenges they face, such as rape, alcoholism, crime, and the considerable economic issues they face.

An ambulance driver spoke about how drivers seek to be there for patients in their time of need, but how this is not always possible. Bantu* stated,

> *Some people have our personal numbers; however, because there are processes to follow, we cannot just attend to them without them going through the call centres.*

It was acknowledged that due to the limited availability of ambulances, ambulances that were dedicated to maternity cases are now being used for other cases. Ambulance drivers often face healthcare workers in healthcare facilities who want their ward patients prioritized over any other patients. This forced drivers to have to make the tough decision of choosing which patients must be transported first, as ambulances are limited in number and are often unable to take more than two patients at a time.

Healthcare practitioners also emphasized that the ambulance availability crisis means that many patients cannot get to their appointments or get treated for whatever emergency they are facing. One healthcare practitioner stated that the most significant implication is death. Women who come to give birth may experience a foetus in distress. This situation requires a procedure to be done at another hospital with better equipment than what is available in small hospitals such as Lusikisiki. However, because ambulances do not come on time or at all, some women are unable to be helped in time.

A healthcare worker elaborated,

> *It is painful, and as a nurse, of course, this affects me and bothers me. Many women carry their babies for months only to give birth to a stillborn due to having complications that require them to be sent either to St Elizabeth Hospital [which is closer] due to our small hospital or Mthatha.*
>
> *These women wait and wait for an ambulance to transport them, only to give birth to a stillborn. Some arrive at our hospital and give birth to a stillborn due to not arriving on time and waiting for an ambulance to transport them* (Asanda*)

In several cases, it was felt that had the ambulances come on time and had the women been able to carry their babies to term, the children may have lived. These were some of the tragic cases reported that have become 'the norm' due to this crisis.

5.5 Recommendations

The ambulance availability crisis is not new to the country, the Eastern Cape, or small rural towns such as Lusikisiki. Section 27 (2019) addresses and seeks to research the issue of ambulances, without speaking directly to the context of Lusikisiki, but to the Eastern Cape as a whole. The province has and continues to operate with insufficient ambulances, leaving many areas, especially rural areas, underserved. Yet, five years later it would not be wrong to expect that something should have been done about this. However, in the annual report of the Eastern Cape for 2022/2023, the MEC for Health, Nomakhosazana Meth blames poor road conditions for the limited ambulance availability.

The report states that,

> Regarding the fleet, the department maintains a fleet of 447 ambulances, with an additional ambulance donated. However, there are ongoing challenges in repairing and maintaining vehicles, leading to lengthy turnaround times. Collaborative efforts with the Department of Transport (GFMS) have been made to address this situation and expedite vehicle repairs, however, not bearing the desired results. The Eastern Cape rural roads where ambulances are experiencing difficulties on rural roads, leading to serious damage. Rural roads can sometimes be challenging to navigate due to their bad conditions, such as potholes, uneven surfaces, or limited infrastructure. This leads to departmental ambulances being repaired for prolonged periods,
>
> (Eastern Cape Department of Health, 2023, p. 115).

This indicates that the Department is unaware of or unresponsive to the full scale of the problem and the people's concerns. Hence, it continues to fail to serve its people.

Unsurprisingly, community members and leaders in Lusikisiki have been crying for better roads, but nothing has been done. So, when the government blames the problem on the poor quality of the roads instead of fixing them, this signals to the community that the end of the ambulance availability crisis is not in sight.

Moreover, community members are desperate for ambulances to be readily available to service the community efficiently so that many lives can be improved and spared. This came up frequently from all participants (from community members to healthcare practitioners, union representatives, and ambulance drivers). The bottom line is that more ambulances are needed and are needed on the road, servicing their community. Healthcare workers suggested that at least two ambulances be stationed at each healthcare facility.

This also goes hand in hand with what one community leader stated: Lusikisiki demarcation makes places far apart. This creates the demand for even more ambulances and clinics within the different clusters of communities in Lusikisiki. Some places may fall under a particular 'lali' and are far from the clinic designated for that lali. For example, if you look at a lali known as eMakhwaleni, it is big and spaced out. There is a clinic for this area; however, some people live far from the clinic and cannot access it, even though they fall within the same lali. Therefore, as a result, there is a call to have another clinic available for the part of eMakhwaleni that is far from the existing clinic.

To further illustrate this, some people might prefer going to other communities that are far away and require transportation, such as lali's like Lutshaya or Mantlaneni, as they are closer than the clinic designated for them in the Makhweleni area. The distance in kilometres might not be much on paper. However, the terrain that needs to be overcome or travelled, including mountains and poor roads, makes this even more difficult. Also, these people do not travel to visit friends or family but must endure these journeys while sick.

Leaders say they have complained about this, but unfortunately, it has fallen on deaf ears.

> *This is an old issue, and nothing has been done about it, nor has any investigation been put in place. The government does not care about its people.* (Thabo*)

A counsellor illustrated how dire the situation is,

> *No, nothing has been done or changed as people are used to not relying on them to the point that they do not even know they are supposed to rely on them.* (Lwando*).

Community leaders also called for more clinic managers to accompany the requested increase in ambulances to ensure that the relationship between these healthcare facilities and ambulances is as efficient as possible. This illustrates that more attention is needed at these clinics in general. For example, it was discussed that clinics often lack essential medication.

People are sometimes forced to share a Panado at clinics that do not have enough medication, or people must get themselves to town to larger facilities for simple treatment of a headache. Furthermore, more staff members (nurses and especially doctors) are needed at clinics, as often clinics only have two nurses and no doctors servicing them. This may be common in ward-based outreach treatment teams (WBOT), but when doctors such as General Practitioners (GP) are needed. This comes at a cost, as people must travel to access them as they are not found in within the lali clinics but in their own private practices in town.

Community members raised similar recommendations to the community leaders. Emphasis was placed on the need for more ambulances and healthcare facilities. It was also stressed that healthcare facilities must be closer to communities for access, convenience, and safety reasons. One participant demonstrated this with the following,

> *Clinics should be open for 24 hours. They should be closer to people as people are scared but are forced to walk due to the issue of transportation and are forced to ask someone to accompany them in their community. They are anxious and would rather default on their medication.* (Nolwazi*)

Community members also asked for separate transportation into communities to collect people and fetch their medication. There was also a request for a separate telephone number that goes straight to the Lusikisiki ambulance call centre (rather than first going through Mount Ayliff).

Healthcare workers and ambulance drivers shared similar sentiments. They asked, especially, for more monitoring work that needed to be done. Nontombi*, a healthcare worker, reflected that 15 years ago, when she worked at a district hospital, there would be regular meetings with the hospital by relevant managers and leaders from the Department of Health to check in with staff and listen to healthcare workers' needs and complaints. From these meetings, strategies would be

implemented and checked to ensure accountability and, most importantly, follow up on the relationships between ambulances and healthcare facilities. The healthcare worker mentioned that she was only aware of this happening at one district hospital currently, and. has not seen this happen in Lusikisiki, where she now works.

Thabile* felt that ambulances must be decentralized, with each hospital or at least each town having its own set of ambulances (currently, the towns of Lusikisiki and Flagstaff share ambulances). She further stated that communities needed to fight for their rights more, as their complaints have been ignored.

The concern of the non-functional call centre was also emphasized as a major challenge. All groups stressed that the call centre numbers should be able to go straight to the relevant town rather than being directed through the Mthatha or Mount Ayliff exchange.

Kristie Haslam, a partner at DSC Attorneys, stated that "Slow response times are also exacerbated by poorly trained emergency call centre staff and the lack of accessibility to rural areas due to poor road conditions,"(BIZCOMMUNITY, 2019). This speaks to a general shortage of skilled people available to work at these call centres and in rural parts of the province.

Ambulance drivers stated that they needed more support. For example, a driver said that supervisors and managers should make more visits to encourage drivers, as many have become despondent. In addition, more motor vehicle accident (MVA) response vehicles are needed. There is only one such vehicle that services Lusikisiki, Flagstaff, and Port St Johns. Bantu* recalled an incident where someone fell into Magwa Falls.

As there was no helicopter with proper wings or blades able to go low enough into the gorge, he, as an ambulance driver, had to risk his life, without adequate rescue training, to go down to the waterfall where one cannot safely walk. Furthermore, with only one helicopter for incidents like this in the entire OR Tambo District, people who fall, are pushed, or try to commit suicide cannot be rescued by the trained rescue team. This means ambulance drivers, like Bantu are left to do the job. These recommendations foreground the issues of ambulance availability, but from the interviews, it was clear that many issues surround and exacerbate this crisis further.

5.6 Conclusion

This research report has discussed and sought to amplify the voices of the people of Lusikisiki by exploring their experiences. This community of individuals has come to accept these conditions and become despondent as they have been forced to overcome these challenges alone. Despite a Constitution that guarantees their human rights, including access to healthcare services and a right to be treated with dignity and integrity, the day-to-day lives of the people of Lusikisiki, Ingquza Hill Local Municipality depict people who have been left to fend for themselves, who do whatever they can to survive whilst their rights are still not realized.

In this chapter, participants' voices and experiences have been amplified to tell a story of the regular challenges they face due to the limited ambulance availability. This has been done through the presentation of findings within five themes. The first finding examined the reasons why people need to use ambulances. These were health-related issues and because of the social issues facing the many communities in Lusikisiki. This illustrated that the ambulance crisis is beyond a health care system or purely a logistical issue. It also emphasized that ambulances are needed to address social inequality issues, the all-around lack of access to resources and facilities, and social problems such as rape, violence, and crime.

Secondly, the processes that need to be followed when trying to contact an ambulance were explored. This entailed looking at what is supposed to versus what actually happens. This theme highlighted that the processes and systems meant to be in place are broken. Thus, it has made it difficult and impossible to get a hold of an ambulance efficiently. Thus, there were significant delays and long routes people had to take to contact an ambulance. This resulted in many people opting not to follow these processes and sometimes opting out of contacting an ambulance or using public healthcare at all.

The third theme considered the challenges and consequences people in Lusikisiki face due to the limited ambulance availability crisis. In this discussion, the scarcity of ambulances forced people to make alternative transportation plans such as hiring cars, which requires money, asking neighbours to help, or simply not using healthcare services. It also raised people's concerns about their safety and fears of crime, which impacts their decisions to accompany each other to clinics or to assist others, especially during the night owners of cars.

Other challenges were illuminated through the experience of ambulance drivers' union representatives, who noted that ambulance drivers feel the brunt of the crisis as they are overworked and often face the community's anger about the crisis, which is beyond their control.

The fourth theme looked at the implications of this crisis. Some participants have had to default on their medication. Some have had family members, including babies, lose their lives - because they could not afford to get themselves to the hospital in the absence of a service that is supposed to be free 'emergency care' because there were too few ambulances and those available, arrived too late.

Some patients have also had to delay treatment due to missing hospital appointments in other towns. This highlights that there is also a crisis of proper equipment and the necessary staff in the hospitals in Lusikisiki. Many rely heavily on the referral system for serious cases and on ambulances to ensure this referral takes place efficiently, which is not the case.

Lastly, the fifth theme further highlighted the extent to which the public healthcare system is broken. The participants' recommendations addressed the need for more healthcare facilities that are better staffed and equipped. The community showed how inhumane it is for patients to have to share a small pill such as Panado because supplies at healthcare facilities were insufficient.

They also recommended that more ambulance vehicles are needed and that vehicles be better suited to the road conditions. It is important that solutions be found to the crisis soon. Community members have already lost faith in the state. They are angered that that the state places blame solely on the road conditions rather than addressing the complex issues. The community sees this approach as making "excuses" that do not help them, and they remain in dire need of healthcare.

This study sought to amplify the voices of the people of Lusikisiki by exploring their experiences. This community of individuals has come to accept these conditions and has become despondent as they have been forced to overcome these challenges alone. Despite a Constitution that guarantees their human rights, including access to healthcare services and a right to be treated with dignity and integrity, the communities of Lusikisiki's day-to-day lives depict people who have been left to fend for themselves, who do what they can to survive whilst their rights are not realized.

Such realities question whether an instrument like the South African Constitution is being used to restore humanity to all through enshrining human rights (for example, such as those in Section 27) or whether it merely looks good on paper and lacks the proper implementation, especially for the people of Lusikisiki. This illuminates the value and importance of this research, and it shows that urgent intervention is needed to save lives. For this not to be the case, more policies and research should look at solutions from the ground/bottom up and from the people affected the most. This would mean taking inspiration and direction from the explicit recommendations and setting this as precedence and as a foundation to build on.

Chapter 6-Conclusion

6.1 Introduction

The challenge and crisis of access to healthcare continue to be prevalent worldwide, and South Africa is not immune from this. One of the ways this is demonstrated is through the example of limited ambulance availability. This Chapter seeks to reestablish and to demonstrate that those living in rural and remote areas in South Africa suffer the brunt of this.

The main research question, aims, objectives and overall rationale and significance of the research will be reiterated to exemplify how the research sought to uncover how the limited ambulance availability impacts the people of Lusikisiki's access to public healthcare. To be able to unpack this, the study first looked at the existing literature (in Chapter Two) that not only helped conceptualise and contextualise the study but also illustrated where gaps in knowledge exist to show the significance and relevance of the study. Whilst doing this, the literature review explored themes and concepts that set the ground and a foundation to understand the context in which the ambulance availability crisis exists and later elaborated and explored these further and deeper through the experiences and stories of the participants interviewed (discussed in Chapters Four and Five).

These themes spoke to this crisis that exists in a broken and unequal South African healthcare system that was designed accordingly (before 1994, during the apartheid regime) and continued to be so post-1994 (see sections 1.2.1 and 2.1.1.1). This broken healthcare system is experienced as such, along with other challenges and factors enmeshed within it. These factors have to do with broader socioeconomic, political, and geographical issues. Together, the issues discussed in Chapter Two are linked with health and well-being as part of the conceptual framework which further illustrates and argues why this issue should not be looked at in isolation but within a social context that, when tackled, must be considered and based upon this argument (see section 2.2.1).

In this way, the main objective of the study is to expose these challenges within the context of access to healthcare and amplify the voices of the many people who experience these challenges to promote and move towards ensuring that their recommendations as highlighted in Chapter Five come to fruition.

The need and urgency is clear in the voices of participants, and they speak volumes about the poor state of their situation and the state's failure to realize health as a right and to provide healthcare post-apartheid – participants' lived reality lacked humanity and dignity and illustrates a picture of people left to fend for themselves at their most vulnerable time of need.

6.2 Summary of the findings

At the core of this chapter are the stories and experiences of many people who form and represent different parts or sectors in the different clusters of communities that make up Lusikisiki. This has been illustrated through five themes. The first theme (see section 5.1) uncovered the reason and importance of ambulances in Lusikisiki, and through this theme, social issues such as crime, violence, and alcoholism emerged, as well as emergency and non-emergency health-related issues such as the collection of medication. This reaffirms the work of Singh (2022) where ambulances play flexible roles.

The social was routed in socioeconomic status. Meel (2022) highlights that such is common but not limited to rural, remote areas that have been engulfed by the crisis of unemployment and has resulted in accompanying issues of alcoholism, crime and violence (see section 5.1.1). In this study, this was discussed by community leaders. With these social issues at play, ambulances are needed for incidents where people have been stabbed, for example, and need to be transported to hospital immediately.

More common health issues within this social context included women giving birth or being in labour, and people living with chronic illnesses who had to collect medication, the latter also linked to one's financial or socioeconomic status as they principally relied on free public transport such as ambulances. One of the reasons for this is because of the distance and costs of travel, which means that even if it is not an emergency, people need to use an ambulance or free transport. Despite these needs, ambulances are not available to meet these needs.

The second theme further shows this through the dysfunctional processes that are supposed to function, yet do not (see section 5.1.2). Many participants spoke about how difficult it is to get through a call centre to be able to call an ambulance due to calls being routed through Mount Ayliff and only then having a driver dispatched to Lusikisiki. If this happens, you are considered lucky, as many participants expressed how they have lost hope and do not even bother to call the call

centre or ambulance. They would rather find alternative transportation including asking a neighbour to transport them. The other challenge with the call centre is that it requires a lot of airtime (as one is put on hold for a long time) which community members cannot afford, which also links to the issue of socioeconomic status, which was further illuminated in the third theme.

The third and fourth themes looked at the challenges and implications of ambulance dysfunction, and this solidified the argument made and experiences shared by participants that they face so many barriers when it comes to accessing healthcare services. This was expressed particularly due to the issue of distance, location, and alternative transport costs (that are high and vary from R300 to R1200 per trip). This results in many being unable to go to healthcare facilities, some walking or trying to get transport on credit whilst already surviving on little (through social grants).

These are the realities of the people of Lusikisiki. Participants also emphasized that primary clinics that are nearby should be stocked with medication – so that people do not have the undignified experience of having to share a Panado and are not forced to travel even further to access healthcare practitioners. Mehlwana's (2023) work further demonstrates the extent of this problem as ambulances also lack the “essential tools”. This reaffirms that this crisis exists and is a problem outside of health facilities, that is, before people can even get to hospitals, they face barriers that hinder them (patients or those sick) from being assisted. This study found many such examples, including how, when reaching health facilities, people often had to face other issues that diminished one’s hope of getting better.

Lastly, the last theme looks at the recommendations made by participants. One already mentioned is the call for more clinics within communities that are equipped and well-staffed with nurses and doctors. This specific recommendation was made as a call in response to the challenge and distance community members must travel to access doctors when access should be close to home.

There is also a cry that can no longer be ignored, and that is for all-round service delivery to be provided. Roads, for example, must be fixed and more ambulances provided. Ambulances are needed on the road, but there also need to be roads to begin with – quality roads that are fixed and maintained, and that are not gravel. Call centres should be decentralised and have adequately trained staff. While this will assist in ending the dysfunction of trying to get a hold of ambulances, more ambulances are needed.

It was recommended that ambulances be decentralised, available, and parked at each healthcare facility. Through this, it is hoped and foreseen that the dignity of the elderly and the young will no longer be threatened, and the image of people travelling over rugged terrain, including mountains on foot, simply to get a Panado will be done away with. This could finally the reality of humanity to the people of Lusikisiki.

6.3 Future Research

Possible future research could investigate two issues related to the referral system: namely where patients from the district or regional hospitals in Lusikisiki are referred to hospitals outside of Lusikisiki, such as Nelson Mandela Academic Hospital in Mthatha. The first issue that would be interesting to explore would be why patients referred to specialists do not undergo all required tests and scans and are not seen by all relevant doctors in one day. Currently, patients are seen or go through specific tests only to be given another review date, often a week later. This presents another challenge of contacting an ambulance or PTV to Mthatha on that date or during that specific week. As this study has shown, this is not always possible and often causes long delays.

Additionally, this also speaks to the lack of communication between the referral hospital and the referring hospital. The referral hospital should communicate with the referring hospital to check which dates an ambulance or PTV will be available to transport the patient. This could also mean looking into the possibility of having a specific ward at the academic hospitals or referral hospitals in Lusikisiki and other district hospitals where patients are seen and tested for everything, all in one day so they do not have to come back to be seen again for the problems which otherwise would have been dealt with in their first visit. Further research on the referral system and the development of mechanisms to improve this would also improve the health experience, outcomes and efficiency of the health system for the people of Lusikisiki.

Lastly, it would also be interesting to investigate the role of the private sector, particularly small private funeral coverage that goes beyond providing cover for funerals but also offers free ambulance services. It would be interesting to see if this is the case nationally or just locally (i.e. in the Eastern Cape). This could also entail investigating their involvement with the public sector and possibly how this is becoming part of the social life of the South Africans.

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APPENDICES:

Participant Information Sheet:

The impact of ambulance availability on access to public healthcare in Lusikisiki, Ingquza Hill Local Municipality.

Dear Sir / Madam

My name is Sinovuyo Boltina. I am a Master's student in Sociology at the University of the Witwatersrand, Johannesburg. My supervisor is Dr. Kezia Lewins. I am conducting a research study about ambulance availability in Lusikisiki.

I am inviting you to take part in an in-depth interview. If you decide to take part, your participation in this research study will last about 30 minutes to an hour. The interview will take place at a mutually agreed place.

With your permission, I would like to audio record the interview. This data will be stored in a password-protected device for a year and will be deleted after that. Only the researcher will have access to the data.
During the research activity, I will need to ask for some personal information about you and your experiences regarding ambulances. The interview will be confidential. When I share the research study results, I will not include your name or anything else that could identify you so that you will remain anonymous.

If you decide to take part in the research study, it should be because you want to volunteer. You do not have to take part. You can stop being in the study at any time.

You do not have to answer any questions if you do not want to. You will not get any direct benefits if you choose to join the research study. You will not lose any services, benefits, or rights you would normally have if you decide not to join. Taking part in the research study will not cost you anything. You will not be paid for being in this research study. Your travel/data costs to attend the interview will be reimbursed.

The risks for this research study are no more than what happens in everyday life. If at any point any of the questions make you uncomfortable, I will stop the interview and continue another time. If you need some support or counselling services following the interview, these are available free of charge at St Elizabeth Hospital. The contact details for the counselling service are 039 253 5000.

This research study will be written up as a research report. The report will be available on the university library website as a publication. If you would like to receive a summary of this report, I will be happy to send it to you. If you have any questions during or afterward about this research study, feel free to contact me or my supervisor at the details listed below. If you have any concerns or complaints about the ethical procedures of this research study, you are welcome to contact my supervisor the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrecnon-medical@wits.ac.za.

Yours sincerely,

Sinovuyo Boltina (Researcher)
Sinovuyo Boltina, 2089468@students.wits.ac.za, 0840320405
Supervisor: Dr. Kezia Lewins. Kezia.lewins@wits.ac.za, Wits tel 011 717 4457

CONSENT FORM:

The impact of ambulance availability on access to health care in Lusikisiki, Ingquza Hill Local Municipality.

Sinovuyo Boltina

I, …….., agree to participate in this research project.

I agree to the following:

(Please circle the relevant options below)

The research study was explained to me. I understand what this study is about.	YES	NO
I understand that I can volunteer to take part in the study	YES	NO
I agree that the interview may be audio recorded.	YES	NO
I agree that direct quotations from my interview may be used by the researcher in their research report.	YES	NO
I agree that my participation will remain anonymous (my name or other identifying data will not be used by the researcher in their research report	YES	NO

…… (signature)
…… (name of participant)
…… (date)

…… (signature)
…… (name of researcher/person seeking consent)
…… (date)

INTERVIEW SCHEDULES

IN-DEPTH INTERVIEW QUESTIONS: Nurses and doctors

Research topic: The impact of ambulance availability on access to public health care in Lusikisiki, Ingquza Hill Local Municipality.

Questions:

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1. How would you describe the availability of ambulances in Lusikisiki, Ingquza Hill Local Municipality?

   ……
   ……
   ……

2. How many ambulances service the Local Municipality?

   ……
   ……
   ……

3. Do they all service your facility?

   ……
   ……
   ……

4. How does it get decided which ambulances respond to which calls and go to which facilities?

   ……
   ……
   ……

5. What is the process of getting a hold of ambulances?

……
……
……

6. What type of cases do you typically call ambulances for?

……
……
……

7. Are there specific ambulances for emergency cases, transfers, etc.?

……
……
……

8. How often do you need to call or use these ambulances in a day? or week?

……
……
……

9. Would you describe this process as easy or difficult? (Explain why)

……
……
……

10. How long does it take to get a hold of an ambulance?

……
……
……

11. How long will it take to get the ambulance to the patient? And to the healthcare facility?

……
……
……

12. How does this compare to the expected/acceptable wait time?

……
……
……

13. How in your experience have ambulances impacted patient referrals for emergencies?

……
……
……

14. In what ways has the current state of ambulance availability impacted patients' access to healthcare and their experiences as a result of the ambulance crisis?

……
……
……

15. According to your knowledge or understanding, why is there an ambulance crisis in Lusikisiki, Ingquza Hill Local Municipality?

……
……
……

16. According to your knowledge has something been done about this?

……
……
……

17. What do you believe
    a.) should be done about this?
    b.) can be done about this?

……

……

……

18. Is there anything you would like to add or clarify ??

……

……

……

IN-DEPTH INTERVIEW QUESTIONS: Community member

Research topic: The impact of ambulance availability on access to public health care in Lusikisiki, Ingquza Hill Local Municipality.

Questions:

---

1. When was the last time you used an ambulance?

   ……

   ……

   ……..

2. Was this for you or a family member or someone else?

   ……

   ……

   ……

3. What did you need to use the ambulance for? (was it for an emergency case or another reason?)

   ……

   ……

   ……

4. Which healthcare facility did you need to go to?

   ……

   ……

   ……

5. How far was this facility from your community or the place you or the person needing the ambulance?

   ……

   ……

   ……

6. How did you try to make contact to get an ambulance to come to you?

   ……

   ……

   ……

7. Would you say the process was difficult or easy? (Please elaborate or explain why you say so)

   ……

   ……

   ……

8. Is this how you would normally make contact – what was different, etc?

   ……

   ……

   ……

9. How long did it take to get a hold of the ambulance?

   ……

   ……

   ……

10. How did it impact your (or the person whom the ambulance was called for) access to a healthcare facility?

    ……

    ……

    ……

11. Did the ambulance come (please elaborate on the time it took for it to come etc.)

    ……

    ……

    ……

12. If no, what alternative transportation did you use?

    ……

    ……

    ……

13. What were some of the consequences of the ambulance coming on time/ delayed/not coming?

    ……

    ……

    ……

14. How did this impact your (or the person the ambulance was being called for) health and well-being?

……

……

……

15. Do and Why do you believe there is this ambulance crisis?

……

……

……

16. What do you believe needs to be done to solve this crisis?

……

……

……

17. Is there anything you would like to add or clarify?

……

……

……

IN-DEPTH INTERVIEW QUESTIONS: Ambulance drivers

Research topic: The impact of ambulance availability on access to public health care in Lusikisiki, Ingquza Hill Local Municipality.

Questions:

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1. Could you briefly tell me how long you have been an ambulance driver?

   ……

   ……

   ……

2. What are the processes that you follow as a driver to get to people who need ambulances?

   ……

   ……

   ……

3. What are some of the reasons (or cases) you fetch people for?

   ……

   ……

   ……

4. What distances do you typically cover as a driver? Per trip? In a day?

   ……

   ……

   ……

5. How long are your trips?

   ……

   ……

   ……

6. How are the conditions on the road?

   ……

   ……

   ……

7. What are some of your experiences in terms of safety on the road /and in communities?

……
……
……

8. Do you only take one patient at a time? (or do you have to accommodate several?)

……
……
……

9. Which facilities do you take people to or from?

……
……
……

10. Do these facilities always take/admit the patient brought (in the case of emergencies)

……
……
……

11. How many trips do you make a day?

……
……
……

12. How many drivers are there?

……
……
……

13. Are there paramedics that you always work with or travel with? (describe or explain if the driver themselves and the paramedics are trained/ skilled for this)

……
……
……

14. During the COVID-19 pandemic, were there more ambulances available?

……

……

……

15. Were there more ambulance drivers during this period?

……

……

……

16. Are these ambulances (and/or staff) still in place today/post covid?

……

……

……

17. What are some if any, challenges have you come across?

……

……

……

18. In the event an ambulance needs to be repaired, how long does it take?

……

……

……

19. Could you briefly tell me about the current state of ambulance availability in Lusikisiki, Ingquza Hill Local Municipality?

……

……

……

20. Would you describe the current ambulance availability as good or bad?

……

……

……

21. Are there any changes that have been implemented regarding the state of ambulance availability?

……

……

……

22. Are there any changes you believe should be implemented?

……

……

……

23. Is there anything you would like to add or clarify?

……

……

……

IN-DEPTH INTERVIEW QUESTIONS: For Union Representatives: Nurses/Ambulance Drivers

Research topic: The impact of ambulance availability on access to public health care in Lusikisiki, Ingquza Hill Local Municipality.

Questions:

---

1. Could you tell me about the current state of ambulance availability in Lusikisiki, Ingquza Hill Local Municipality?

   ……

   ……

   ……

2. How long has this been like this and why? What are the reasons for this?

   ……

   ……

   ……

3. What are some, if any, challenges nurses/drivers have come across due to the {limited/unavailability} of ambulances?

   ……

   ……

   ……

4. What are some of the experiences brought to the union by nurses/drivers, etc?

   ……

   ……

   ……

5. Has the union brought this issue to the attention of the health department?

   ……

   ……

   ……

6. Are there any reports on the state of ambulance availability by the union or health department?

……

……

……

……

7. Have any changes been made to the ambulance availability in Lusikisiki, Ingquza Hill Local Municipality? If so, what impact have they had?

……

……

……

8. Are there any changes that the union believes should be implemented regarding the state of ambulance availability?

……

……

……

9. Is there anything you would like to add or clarify?

……

……

……

IN-DEPTH INTERVIEW QUESTIONS: Councillor/ Chief

Research topic: The impact of ambulance availability on access to public health care in Lusikisiki, Ingquza Hill Local Municipality.

Questions:

---

1. How would you describe the current state of ambulance availability in Lusikisiki, Ingquza Hill Local Municipality?

   ……
   ……
   ……

2. What process do people in your community follow to contact an ambulance?

   ……
   ……
   ……

3. Would you describe this process as easy or difficult?

   ……
   ……
   ……

4. How long does it take to get a hold of an ambulance?

   ……
   ……
   ……

5. Do ambulances come to the community when called or needed? Why/not?

……
……
……

6. What type of cases do people in your community need/ use an ambulance for?

……
……
……

7. Is there a priority or triaging of cases process that you are guided by or follow?

……
……
……

8. Is there any alternative transportation in place in the event there is no ambulance available?

……
……
……

9. How far is the community from healthcare facilities?

……
……
……

10. How do people from your community come back from these healthcare facilities?

……
……
……

11. Are there any challenges experienced by the members of your community regarding the current state of ambulance availability? (What are they?)

……
……
……

12. What do you believe is the reason or reasons for this crisis?

……
……
……

13. According to your knowledge, has something been done about this? (please explain your answer)

……
……
……

14. What do you believe can be done about this either by the state or as a community?

……
……
……

15. Is there anything you would like to add or clarify?

……
……
……