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ACCESSING HEALTH SERVICES IN TOWNSHIPS: THE CASE OF BRAM FISCHERVILLE

Gawbeni, Siphosethu

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ACCESSING HEALTH SERVICES IN TOWNSHIPS: THE CASE OF BRAM FISCHERVILLE

SIPHOSETHU GWABENI 560984

DECLARATION

I (Siphosethu Gwabeni) declare that this research report is my own unaided work. It is being submitted in order to fulfil the requirements of the degree of Bachelor of Science in Urban and Regional Planning Honours to the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination to any other University.

……

(Candidate signature)

….. day of ……..

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LIST OF ACRONYMS AND ABBREVIATIONS

ANC-African National Congress

CSIR- Council for Scientific and Industrial Research

CHC- Community health centres

DoH- Department of Health

HDA- Housing Development Agency

PHC-Primary Health Care

NCDs-Non-Communicable Disease(s)

NHI- National Health Insurance

RDP- Reconstruction and Development Programme

SAHRC- South African Human Rights Commission

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1. CHAPTER 1: BACKGROUND

This chapter seeks to introduce the topic of accessing health care services in townships, using the case study of Bram Fischerville, will give an outline of the problem statement as well as the structure of this report.

1.1. Introduction

The post-Apartheid government had made strides to promote land redistribution in terms of the Reconstruction and Development Programme (RDP[1]) which was implemented in 1994. According to Todes et al (2015) the redistribution mechanism was focused on the provision of housing for the previously disadvantaged, especially the non-white citizens who were considered to be low income earners (earning a monthly income of R3 500 or less), as well as the delivery of basic services such as water, electricity and sanitation. The RDP houses provided were to help redress the land issue in the country as well as to promote secure land tenure through free-hold tenure for the previously disadvantaged among other major goals.

Housing policy and programmes adopted principles from the RDP programme such as understanding housing as a basic need. For example, the Housing White Paper of 1994 gave its interpretation of "adequate housing" as a basic need through its vision that housing is a:

viable, socially and economically integrated communities, situated in areas allowing convenient access to economic opportunities as well as health, educational and social amenities, within which all South Africa's people will have access to:

- *A permanent residential structure and with secure tenure, ensuring privacy and providing adequate protection against the elements; and*
- *Potable water, adequate sanitary facilities including waste disposal and domestic electricity supply. (*Department of Housing, 1994, p. 12 in Huchzermeyer, 2011*).*

In order to implement and deliver on the above vision there was financial assistance through a capital subsidy. The subsidy initially delivered houses which were said to

[1] The RDP was a manifesto of the African National Congress which came into power in 1994. However, most policies that were developed after this were aligned with the principles and notions developed within the manifesto hence it would be considered as a critical element in the development of policies in the country. Particular emphasis is put into the development of housing policies and programmes as the notion of the right to "adequate housing" stemmed from the manifesto.

have fallen short of what could be deemed as a dignified house, especially with regards to size and privacy (Huchzermeyer, 2011).

The initial RDP house underwent various changes, especially with regards to an increase in size as well as internally subdivision of the structure. However, what became prevalent in most of the RDP housing developments was the replication of Apartheid spatial layouts such as distant locations, insufficient delivery of services and facilities such as schools and places of employment, a characteristic which a number of scholars were scrutinising and critical of (Govender, 2011; Poulsen, 2010). This distant location was argued to be due to limited access to cheaper land which was closer to urban centres (Turok and Borel-Saladin, 2015).

From this vision, the notion of “adequate housing” would further promote settlements that offered a range of amenities and facilities although it fell short and rather focused on only the delivery of houses. This background thus sheds light on why the provision of health services is considered in relation to settlements, with a particular focus to post-apartheid low income settlements. This background then leads to the introduction of this research, accessing health care services in townships.

In 2004, the housing policy and programme was then revised through the introduction of the Breaking New Grounds (BNG) programme. This programme intended to address the loopholes of former housing policies in terms of new settlement developments. This new programme aimed to promote settlements that were integrated, that promoted social and economic infrastructure and facilities as well as to offer mixed use developments (Govender, 2011; Department of Housing, 2004).

In the midst of such strides and developments within the housing policy sphere, there still exist housing settlements that lack basic social facilities, physical infrastructure and are located on urban peripheries, further from economic opportunities. However, many of these settlements are still residential areas of the growing urban population as they offer cheaper rental accommodation, mainly through backyarding and offer better access to transportation modes and other vital urban services that are in limited availability in “informal” settlements (Todes et al, 2015). Hence these new settlements could be deemed to be experiencing better living conditions than “informal” settlements (Todes et al, 2015). According to Gardner (2015), what has characterised these housing developments has been the promotion of sprawl which is due to their

peripheral locations, increasing densities as well as the under development of public infrastructure.

Theoretically, housing or housing developments offer access to better economic opportunities, social infrastructure and other public and private facilities (Turok and Borel-Saladin, 2015). This can be argued to be offered to some extent in post1994 low income housing development, especially with regards to the improvement of access to public services such as water and sanitation, especially in the South African context. However, some of these settlements do not seem to anticipate the amount of growth in terms of population which could take place over a period of time, especially population growth through “informal” mechanisms such as backyarding. According to Turok and Borel-Saladin (2015), the “informal” housing trend has been a growing phenomenon in townships where township densities are increasing due to lower rental rates and offerings of better and affordable services such as water, electricity and sanitation.

1.2. Problem statement

In the context of South Africa, townships were historically designed to be mainly dormitory areas that offered a limited range of other economic and social activities and facilities (South African Cities Network, 2009). Townships were also designed to be residential areas that perpetuated spatial segregation as they accommodated non-white citizens on the urban peripheries. These were areas that consisted of matchbox houses that were uniformly built and designed, and mainly consisted of unpaved roads (Todes et al, 2015).

In the 1990’s, townships were argued to have experienced massive residential expansion due to rural-urban migration as they offered cheaper rental accommodation for the non-white migrants (South African Cities Network, 2009). From then, townships also experienced a shift in patterns as various income groups took residence in such areas, further shifting their status as areas accommodating low income people (Turok and Borel-Saladin, 2015). Although there were various changes, relatively little changed in most townships established in the first decade post-apartheid such as Bram Fischerville. Among those developed in the mid-late 1990s, Cato Manor[2] is an

[2] Cato Manor experienced forced removals in the 1950s and 1960s and with the breakdown of apartheid laws, the area saw a growth of unplanned settlements accommodating the poor (UN Habitat, 2002). In the early 1990s, Cato Manor Development Project (CMDP) was established and aimed to reverse the

example that showed to have good facilities and amenities. The overall goals for the development of Cato Manor were to promote service upgrades, introduce participatory panning and improve housing among other objectives (Ethekwini Municipality, n.d). Currently, the area is celebrated as one of housing success stories in the first decade post-apartheid as it has integrated and mixed use developments.

In the early 2000s, strides were taken to address the spatial implications of apartheid housing provision as well as the provision of housing largely falling under the Reconstruction Development Programme (RDP). These changes were mainly aimed at improving the delivery of RDP housing as it was highly criticised, hence the introduction of a revised housing policy-the Breaking New Ground (BNG) policy aimed at addressing issues such as distant location of housing settlements, lack of social and economic facilities, lack of settlement integration and the uniformity of housing typologies among other issues (Department of Housing, 2004). However, since its implementation, the policy outcomes have been uneven. For example, the settlement of Delft in Cape Town which was part of a pilot project of the BNG policy has experienced various issues related to locations distant from areas of employment, lack of services and severe criticism for limited or lack of delivery of sustainable settlements vision (CSIR, 2010). On the other hand, Cosmo City in Johannesburg showed different outcomes. The area is considered to be integrated and a mixed use development as there are partial subsidised houses, rental apartments as well as bonded houses (RSA, 2005). The area has also expanded to accommodate a number of facilities and amenities that are important for its residents such as schools, police stations, recreational parks and health facilities among others (Sisulu, 2016).

Post-apartheid, strides were also taken to transform both apartheid era and post-apartheid era established townships especially with regards to the provision of services and facilities that were seen to be lacking such as tarred roads, electricity, water, sports grounds and shopping malls. Although what became prominent in state interventions with regards to townships was the constant development of malls and shopping centres as a strategy to bring employment to the people (South African Cities Network, 2009). Other interventions from the local sphere of government included the

legacy of apartheid planning “worse practise” (UN Habitat, 2002). The project to develop the area was supported by the Ethekwini Municipality and the European Union with the help of an NGO (Cato Manor Development Association).

development of parks and the refurbishment of community halls as important recreational spaces. Such interventions, however, were mainly seen in older townships such as Orlando East in Soweto as well as Alexandra. From the mentioned interventions in townships, there is limited or no evidence in housing and township policy documents, plans and strategies that have given priority to health facilities as vital community services. Hence this is of significance for this research which focuses on this aspect of healthcare services in a post-Apartheid housing development.

Because townships experienced increasing densities and were considered as better living environments than free-standing “informal” settlements, limited emphasis was given to their demand and need for social services (Turok and Borel-Saladin, 2015). According to Boyko and Cooper (2011), the understanding of density is important in decision making, especially in disciplines such as planning, architecture, transport and urban development where density is defined as the number of units in a given area. This built form density then gives us an idea of a certain amount of population in the area, and this population could be calculated using an estimated household size per unit. Population density should thus be highly regarded in the planning of new settlements as it will determine what types of services and facilities could be provided (Boyko and Cooper, 2011). It is thus within this scope that this research draws its motivation as well as its relevance as it is looking to use a densfying township setting to investigate experience of residents in accessing healthcare services.

1.2 Key concepts

Key concepts will be discussed in relation to how they are understood throughout the report. The discussed concepts are access, RDP housing as well as township. These concepts are important to discuss as they have ambiguous meanings, mainly based on where they are used.

Access

According to Anderson and Kariberg (2000) stated in Mokgoko (2013), access is defined as the ability to seek and receive care from the provider of one’s choice as well as at the time one chooses. Another definition adopted from the Batho Pele policy of 1997 defines access as acquiring health care services easily, comfortably and promptly (Mokgoko, 2013). The definition stated in the Batho Pele Policy is a vision

that was later followed by the national health department although it is still quite vague as access, especially to health care services is complex.

The scope of access to health care services in this paper will be looked at by focusing on four dimensions of access that are later discussed in this report. The four dimensions of access are affordability, geographic access, availability and the acceptability of services. These dimensions of access will be drawn from authors such as Jacobs et al (2012), Angier et al (2014) as well as Plaks and Butler (2012) among other scholars.

Townships

The understanding of townships during Apartheid as well as post-Apartheid has shifted although some elements have remained the same through the transition from Apartheid to post-Apartheid. During apartheid, townships were mainly perceived as predominantly residential areas for non-white residents, had matchbox houses with similar designs, gravel roads and located on the urban peripheries (Maluleke, n.d). Post-Apartheid, there was change in the character of townships although they still mainly served as residential areas for many non-white citizens, and are often located on urban peripheries. However, land uses within townships have become more diverse and there has been significant investments in economic infrastructure, and residents have secure ownership of the land.

The term township will thus be considered from the post-Apartheid lens; as residential areas that we see accommodating mixed income groups, located on urban peripheries and currently experiencing infrastructural investments such as malls and parks. However, it should be acknowledged that some characteristics of apartheid townships such as gravel roads might be visible within these post-apartheid township settings.

RDP houses/housing

Post 1994, the ANC government implemented the Reconstruction and Development Programme(RDP) which was aimed at redressing racial inequalities with regards to land ownership, meeting basic needs such as water and sanitation and alleviating poverty among other factors. Post 1994, the ANC government developed the Reconstruction and Development Programme (RDP) as a response to meet basic needs (ANC 1994 in Charlton and Kihato, 2006). Although the programme was

multidimensional, it made housing delivery a key component where the delivery of housing was linked to the idea of alleviating poverty (Charlton and Kihato, 2006).The houses delivered under the programme were planned to accommodate low income earners and the previously disadvantaged non-white citizens. These houses were to be starter houses as they were 30 m^2 in size, provided in the form of a free-hold tenure basis, provided basic services and shelter but were predominantly located on urban peripheries (Todes et al, 2015; Charlton and Kihato, 2006). These houses were thus attached to the name of RDPs and continue to be referred to that way even in the current context. This report will continuously use the commonly understood nickname (RDP) for this housing typology or settlements although this is not an official designated name.

1.3. Research question

From the background given in the prior section of this report, there were a number of questions that were raised in order to further interrogate the issue of access to health services. The main research question that guides this report is:

Given the densification of Bram Fischerville, what are the experiences of its residents in accessing health services?

Sub-questions relating to main question are:

- What various health services are offered to Bram Fischerville residents and who are the providers of these health services in Bram Fischerville or in the nearby residential areas?
- Considering both conventional and unconventional services, what health services are mainly in demand in Bram Fischerville?
- What are the difficulties experienced by residents of Bram Fischerville in accessing health services?
- What are residents of Bram Fischerville satisfied with, with regards to how and where they access health care services?

1.4. Lens of interrogation used

This research report seeks to interrogate the idea of access to health care services in relation to the notion of density within township settlements. The notion of density is considered as township settlements are seen and argued to be areas that are

experiencing densification patterns over the years but often have a limited number of services to cater for this increase in population. The report will focus on interrogating how residents of a township setting experience accessing health care services, within their township or beyond.

1.5. Structure of the report

The report is structured as five chapters in order to better address and respond to the main research question leading this report. Chapter one mainly discusses the background and rationale of the research study, the research question as well as the definition of terms that will be used in the report.

Chapter two focuses on the literature review- the different views and ideas that are associated with health services, the notion of access as well as the settlements of townships. The chapter enlightens the reader about different ideologies and debates that arise, especially with regards to access and health care services, particularly in South Africa.

Chapter three introduces fieldwork processes as it discusses the type of research this report took- a qualitative research. The research took a qualitative lens as this method is argued to attempt to understand a particular social phenomena and is an investigative process (Creswell, 2009). Ethical concerns as well as the introduction to the case study of Bram Fischerville are also constitutes of the chapter.

Chapter four deals with the presentation of research findings and then using the literature review chapter to analyse the findings from the field work. The findings explore how people access health services, what types of services they access and barriers (if any) they encounter when they access the services among other things. In the analysis of findings, main themes and ideas from the literature chapter will be used to make sense of what is happening in the township of Bram Fischerville.

Chapter five concludes the report and reflects on the issue of social infrastructure-health services and its relevance to the planning profession, particularly in South African township settings such as that of Bram Fischerville. The chapter also reflects on the overall research study, including imitations and opportunities. The chapter then concludes that the residents of Bram Fischerville are able to access their required health care services but they have some level of restriction although it has not been significant.

2. CHAPTER 2: LITERATURE REVIEW- UNPACKING ACCESS TO HEALTHCARE

The focus of this chapter is on current debates and discussions that relate to the issue of access to health care and settlements. It is divided into three sections; firstly, the discussion about the notion of access, then a discussion on the state of the health system in South Africa, and thirdly, a debate on low income settlements in relation to health. The chapter is concluded by a conceptual framework that seeks to draw up and link up the aforementioned three sections of the chapter.

2.1. Introduction

Accommodating the urban poor has been one of the country's housing concerns where we now witness this group residing in townships that are located in far distances from the urban centre for cheaper accommodation, often in the form of backyard dwellings such as shacks and backyard rooms (Turok and Borel-Saladin, 2015). These increased densities require certain levels of services in order to enable fully operational communities. This chapter of the report thus seeks to look at literature that discusses the notion of access in relation to health services, the structure of the South African health system as well as debates that arise about the public and private sectors, as these are the most prominent and active sectors in the provision of health care services in the country.

2.2. Access to health services

Various scholars have discussed the notion of access to health services and highlighted four major components that constitute access; affordability, availability, geographic access and acceptability (Guagliardo, 2004; Angier et al., 2014; Jacobs et al., 2011). These dimensions of access are thus further discussed below:

- Affordability

According to Plaks and Butler (2012), affordability is the connection between the cost of service and the patient's ability to pay or the willingness of the patient to pay for the received service or the needed service. Issues associated with costs of medication, treatment or the receiving of health services is the biggest concern and of importance in areas where the majority of people are low income earners. In some cases, the high costs of private health care leaves out a portion of the population that cannot afford the services, such could be seen in the case of Soobramoney vs. Minister of Health (KwaZulu Natal) that is later discussed in this chapter.

When in need of particular specialised services, citizens are tested on their willingness to pay for the service they require. This is one aspect that affects the availability of services, especially specialised services. With regards to public-private dual costs, these could also pose as limitations to how people access certain services. In Angier et al. (2014) it is stated that some parents have difficulty in accessing certain specialised health care services as they do not have sufficient money for co-payment for services due to their health insurance payment limitations.

- Availability

Many developing countries such as Kenya experience a dire shortage of health professional in their public health institutions such as hospitals and clinics (Institute of Development Studies, 2016). This leaves most hospitals without adequate expertise such as dentists or specialised doctors to attend to the large numbers of people that attend or seek medical assistance in most public sector health institutions. Due to limited funding in the public sector health institutions, there are cases where there is limited supply of medication or treatment or a complete lack of needed medical supplies.

When we look at the private sector, this sector works with the demand of services in order to provide a service as well as to make sufficient profit for the “business” (Econex, 2013). Essentially, in areas with lower population densities, big businesses have more risk by investing as there would not be sufficient demand for their services, especially if the areas are predominantly low income. Lower population densities could thus be a constraint in the provision of vital services such as private clinics or hospitals in certain types of settlements.

- Geographic accessibility

Geographic access is associated with transportation time, geographic proximity and ease to reach service providers among other aspects (Plaks and Butler, 2012). Geographic access has been mainly a major issue when there are discussions in relation to rural areas and health service providers. Most health care services are located in distant locations that require a certain payment to get to due to their far distances (Plaks and Butler, 2012). These mostly hinder how people access vital health services they require, especially related to primary health care and emergency services. Emergency services are likely to take more time to get to people who need

it mostly and in some cases, people have to wake up in early hours of the morning to get to clinics where they have to wait in long queues for long hours. These are all issues that arise due to long distances travelled to access a required health service, in some cases, this inconveniences people who work and cannot take time off work as they would have to spend the rest of their work day in a clinic.

- Acceptability

Acceptability relates to whether patients are satisfied with certain features of the health care provider where the features include race, culture, language and competence of medical staff and interaction among other things (Plaks and Butler, 2012). The public health sector has been severely criticised for poor quality of service delivery; nurses claimed to be rude, hospitals and clinics being dirty or having poor physical infrastructure (Jobson, 2015). Such perceptions thus affect the acceptability of services provided by public sector health providers to a certain extent as it is related to poor quality. The attitude of health professionals and the relationship they have with their patients is another aspect of acceptability of services. If for example, health professionals such as nurses are very friendly and offer quality services to patients, patients are likely to have regular visitations in the clinic (Makgoko, 2013).

Community and cultural preferences have a huge role on how individuals access the needed health care services and the attitude they have towards certain services (Jacobs et al, 2012). In South Africa, an example could be shown through the various services providers that exist within our communities- private general practitioners, traditional practitioners as well as NGOs among others. Most people would thus attend to the service providers they mostly prefer.

Table 1 is a summary of the dimensions of access but expressed mainly as barriers to access to health services. The notion of barriers could be seen as limitations or restrictions that hinder access to services. For example, acceptability in table 1 talks of how cultural preferences and norms could limit people using a particular service. On the other hand, technological innovations could positively influence how people view and use the particular provided service. These are represented from both the supply and demand side within communities although there are overlaps in some of the points highlighted on both sides. As argued by Plaks and Butler (2012) it is vital

that all the four dimensions of access are to be considered if we are to improve access to health services.

Dimension of barriers (Peters *et al*. 2008)	Barriers (Ensor and Cooper 2004)
Geographic accessibility	
• Service location (S)	• Indirect costs to household (transport cost) (D)
• Household location (D)	
Availability	
• Health workers, drugs, equipment (S)	• Waiting time (S)
• Demand for services (D)	• Wages and quality of staff (S)
	• Price and quality of drugs and other consumables (S)
	• Information on health care choice/providers (D)
	• Education (D)
Affordability	
• Costs and prices of services (S)	• Direct price of service, including informal fees (S)
• Household resources and willingness to pay (D)	• Opportunity costs (D)
Acceptability	
• Characteristics of the health services (S)	• Management/staff efficiency (S)
• User's attitudes and expectations (D)	• Technology (S)
	• Household expectations (D)
	• Community and cultural preferences, attitudes and norms (D)

Table 1: Barriers to accessing health services (Jacobs et al, 2011).

According to Lou and Wang (2003), access to health services is affected by supply and demand factors of health; for example, the supply of physicians being based on where they are located and the demand by people based on where people reside. These two scholars further expand our understanding of access by breaking the term of access into the following four sections:

- Revealed access

Revealed access is the actual use of health care services by those who require it or are willing to pay for it. This is usually in relation to what is currently available on the market or to the people; clinics, hospitals as well as pharmacies among others. These are services that can currently be used by those who need it.

- Potential access

Potential access mainly deals with the probability of entry into the use of health care services. This aspect of access deals with issues that relate to costs and availability of services that either serve as opportunities or hindrances to access the required health care services. For example, some people may opt to go in distant areas rather than in closer locations to access health services, mainly influenced by the availability

of health care professionals. This is attributed to the availability (or lack) of healthcare professionals such as nurses and doctors; this further leads some people to avoid some closer healthcare services, especially hospitals and clinics (Guagliado, 2004).

- Spatial access

The issue of spatial access is related to that of geographic access previously mentioned in this chapter. It mainly relates to features such as distance and location of health services as well as the location of households from health service providers.

- Aspatial access

Aspatial access deals with non-geographic features such as age, income and social class of the people who are trying to access the needed health services among other main features. These are factors that determine our potential to access certain services as well as which services we acquire and where we acquire them(Lou and Wang, 2003). For example, people with lower incomes may be forced to acquire services from public clinics as they cannot afford services provided for by a GP or private clinic that will require service fees.

It could thus be seen that the above discussed components of access are linked or intertwined with the four dimensions of access that are discussed earlier in this section of the report. The four dimensions are namely; acceptability, accessibility, availability and geographic accessibility. The above components could rather be seen as umbrella components of the four dimensions.

According to Weinick et al (2000), access to health care services and their use should also be considered as a function of individual health status, demographic characteristics, and preferences to health care services among other things. To note, these are mainly aspatial factors that affect how people access healthcare services.

In American studies that were reviewed for this report, their relation to access to health have been focused on issues of race. Weinick et al (2000), for example shows that in 1996, most black Americans had high death rates from coronary diseases, breast cancer and diabetes as compared to their white American counterparts. This was argued to be related to issues of income and limited access to health insurance as few public hospitals offered health services for certain specialised conditions. In this case,

most black American people earned lower incomes and mainly had no health care insurance as compared to white Americans.

In the case of spatial analysis in relation to access to health services, Graves (2008) looks at spatial analysis of health and disease in relation to geographic environments in order to assess health outcomes. These studies were mainly conducted in America and focused on the Black American populations.

South African legal cases relating to access to healthcare

In South Africa, the country's Constitution stipulates the 'right to access to health services' in its Bill of Rights. According to Peter (2009), this is a socio economic right that is primarily a means to address historical imbalances as well as to promote equity. However, what this right actually means beyond the Constitution is a debateable issue as it is unclear how it could be translated on the ground.

For example, there were two prominent cases that were taken to the Constitutional court in the late 1990s and early 2000s with regards to the issue of healthcare as well as its access. In the case- Soobramoney vs. Minister of Health (KwaZulu Natal) in 1998, the Constitutional court ruled that the state could only provide access to healthcare if it was able to do so. Healthcare could not be denied to anyone in need of emergency medical treatment, in which Soobramoney's case was not an emergency which called for immediate treatment. In this case, Soobramoney suffered from renal failure and needed dialysis treatment which would cost the state approximately R60 000 per annum for a single patient if the patient were to receive the treatment twice a week (Juta and Company, 2015). Soobramoney thus could not receive access to health services due to personal costs as well as the state's inability to have sufficient funds for his renal condition.

The second case which was taken to the Constitution Court relates to the provision of HIV/ AIDS treatment to the majority of South Africans who could not afford the treatment, this case was at a time where the HIV epidemic was a big concern in development policy agendas. The Treatment Action Campaign (TAC) is an organisation that challenged the Department of Health (DoH) with regards to the provision of HIV/AIDS treatment as a means of reducing mother-to-child transmissions. This organisation fought for the access of HIV/AIDS treatment (Nevarapine) (Phillips, 2004). However, the DoH had argued that the drug was

expensive. With the court ruling that it was impossible for everyone to access the "core" service immediately. The court stated that what is possible and all that can be expected of the state is that it acts reasonably in order to provide access to socioeconomic rights that are identified in section 26 and 27 of the South African Constitution (Phillips, 2004). This means that the state had to work towards providing access to this group of people within its available resources.

Importance of access to health services

Having discussed the notion of access, this section comments on the importance of access to health services. Health services includes all services that deal with the diagnosis and treatment of disease or the promotion, maintenance and restoration of health (WHO, n.d).

Access to health services is argued to be vital for social as well as economic development of communities. As stated in the National Development Plan (NDP) 2030, South Africa currently faces a quadruple burden of diseases which includes HIV/ AIDS and Tuberculosis; non-communicable diseases (NCDs) such as cardiovascular diseases and diabetes; violence and injuries as well as maternal and child mortality (National Planning Commission, 2013; Sanders et al, 2011). This burden and prominence of these diseases thus have a direct influence on the types of services and treatments that patients demand as well as the services that the public health system needs to adopt in order to keep up with the challenges it currently faces, since the public health sector serves the most number of people in the country (Plaks and Butler, 2012). Some of these challenges include the shortage of professionals and deteriorating infrastructure (WHO, n.d; Edmeston and Francis, n.d) Hence it could be argued that access to health services is of importance in order for people to reach their full potential as well as improve their quality of life (Healthy People 2020, n.d).

In low and middle income countries such as South Africa and some African countries, women and girls have had various issues with regards to access to health care services. Most of these issues have risen due to traditional practices and societal norms that require women and girls to be child bearers and remain in the household to cook among other things (Hawkins et al, 2013). This has limited women and girls to gain insight and knowledge about health care awareness especially with regards to reproductive health care services. If women and girls take charge of their sexual

health, they are said to be shamed and discriminated for taking control and getting hold of reproductive health services (Hawkins et al, 2013; O'Reilly and Washington, 2012). The promotion of access to health services, especially at primary health care (PHC) level is thus of vital importance so as to encourage preventative care at early stages and further avoid long waiting times as well as the increase in referrals to district hospitals.

When people are more aware and educated about the dangers of certain diseases such as child immunisation, reproductive health, hypertension and HIV/AIDS, they might be most likely to be safe from it. Hence it would be critical to have a PHC service that is accessible and reaches out to a broad spectra of communities. Also argued by O'Reilly and Washington (2012), women and girls should be supported and enabled to access a comprehensive package of services, with particular emphasis on sexual and reproductive health care services.

2.3. State of the South African health system

This is the second major section of the literature discussion where the focus is on the state of the health system in the country. The South African health system adopted a Primary Health Care (PHC) approach as this approach was argued to be efficient and cost effective in improving people's lives (Department of Health, 1997). This approach was implemented through a decentralised district system in order to further promote the mandate of the World Health Organisation (WHO); promoting access for all in order to achieve appropriate promotive, preventive, curative and rehabilitative services at an affordable cost. The PHC model was endorsed by WHO in 1978 as a way of reducing disparities in health care as well as to further promote universal coverage of health care services to the majority of citizens, especially the poor (Angier et al., 2014). In South Africa, however, the approach was mainly adopted in the post-apartheid era as a means to address unequal access to health care services.

Legislation

The South African health system has been largely transformed through legislation measures that will further be discussed here. Disparities in the provision and access to health care services had been mainly due to racial discrimination during apartheid, where the non-white citizens had been generally provided with poorer health care in hospitals and quality services were received with higher costs (DoH, 1997). Public

sector facilities that were mainly used by non-white citizens were also argued to be in poorer conditions (Edmeston and Francis, n.d). Post-apartheid, the Health department was transformed so as to help redress the previous disparities and set out new legislation and policy. The Constitution was the piece of legislation that set the backbone of the transformation of the Health department where it enshrined in its section 27 that everyone in the Republic of South Africa has a right to access to health care. The Constitution set out health as a concurrent function of the national and the provincial spheres of government in its Schedule 4, Part A.

The National Health Act, 61 of 2003 is a prevalent legislation that acknowledges the past socioeconomic injustices and seeks to ensure the progressive realisation of the right to health care. This Act is highly influenced by the implementation of the South African Constitution which enshrined health as a basic human right. In the Act, attention was particularly given to vulnerable groups such as women, children, people with disabilities and the elderly as they had been deemed to have been highly disadvantaged and have major difficulties in relation to access to health care services (SAHRC, 2009). The Act mainly promoted the improvement of access to primary healthcare through free services, as PHC is argued to be one of the pillars of an efficient health care system, especially from a public sector perspective (SAHRC, 2009).

According to the South African Human Rights Commission (SAHRC) (2009) 7 out of 10 South Africans had consulted with traditional practitioners when their study was conducted. Their document, however, does not state when the study was conducted or how the study was sampled. Due to this statistic, it could be said that there was a consideration of the importance of traditional practitioners hence the introduction of the Traditional Health Practitioners Act, 22 of 2007. This Act seeks to ensure that equity, safety and efficiency of traditional services is regulated and maintained. This Act acknowledges and recognises people that include diviners (izangoma), herbalist (iinyanga) and traditional birth attendants and traditional surgeons (iingcibi).

The SAHRC document was primarily used in this discussion about health related legislation in South Africa as it had documented the most relevant information about health legislation. The SAHRC document is a report on the state of health care in the country hence its importance for use in this section.

Introduction to the South African health system

The public health sector is argued to be an important health system in developing countries as many individuals who have low incomes suffer from poorer health and cannot access services other that those provided by the state (Wolfe, 2004). The public sector provides health services through public hospitals, clinics as well as school health programmes among others.

In the case of South Africa, post-apartheid, the ANC led government transformed the health system so that it would function based on a district system so as to assist people to receive services in close proximity to where they stayed (SAHRC, 2009). In the draft of the implementation plan of the district system, there was a designation of 53 health districts that are to provide a range of health services and at different levels as it will be discussed shortly. According to Purcell (2005), one of the major transformations that targeted increasing access to health services was the abolition of user fees within the public health system.

PHC which incorporates the provision of services such as immunisation, the management of chronic disease, family planning and treatment of STIs/ STDs would be provided at clinics and community health centres. Clinic facilities are to be opened for 8 hours a day (usually from 8am to 4 pm) while the community health centres are to be opened for 24 hours a day, providing 24 hour emergency services as well as the provision of up to 30 beds (Cullinan, 2006). The services received in these facilities are to be offered free of charge. According to Jurberg (2008), PHC can be considered as one of the core pillars of the public health system as it deals with the prevention of sicknesses and injuries as well as tackles disease in early stages.

Hospitals are also another important component of the public health system as they are argued to admit people who need in-patient care as well as emergency attention. According to Cullinan (2006), hospitals also cater for more specialised functions and operations as compared to clinics and CHC. According to the Department of Health (DoH), adequate services cannot be provided without hospitals as these are sites where patients are referred to from clinics and mainly treated for curative and diagnostic services (DoH, 1997). In South Africa; hospitals are divided into three districts, each serving different functions and at different scales as discussed below:

- *Level 1*: District hospitals- These types of hospitals are usually open 24/7 and provide diagnostic, treatment, care, and counselling and rehabilitation services. Services offered at this level of hospitals include basic lab tests and x-rays; however, most patients need be referred to such hospitals from clinics.
- *Level 2*: Regional hospitals- These types of hospitals should provide at least five types of the following specialisations: surgery, medicine, paediatrics, orthopaedics, obstetrics and gynaecology, psychiatry, diagnostic radiography as well as anaesthetics.
- *Level 3*: Tertiary hospitals- These types of hospitals provide specialist and subspecialist care. These hospitals are largely academic hospitals that provide diagnostic procedures and treatment and they also serve as training institutions for health care professionals (Cullinan, 2006).

According to Edmeston and Francis (n.d), the South African public health system is currently struggling where the PHC tier is said to be failing. A failure of the PHC tier means that the higher tier-hospitals are put under immense pressure to service the majority of citizens who depend on the public health sector where the downfall of the PHC tier includes the failure to provide basic treatments.

The aforementioned health facilities, in the form of clinics, hospitals and CHCs are not limited to the operation of the public health sectors but are also provided by the private sector. However, these facilities function in a similar manner, in both private and public sectors.

Public, private and NGO sectors

The South African health system consists of a large public sector, a small but growing private sector and a Non-Governmental Organisations (NGO) sector (Jobson, 2015). Within this distribution, the public sector remains a large provider of health services to the large and increasing population, especially through PHC (Jobson, 2015; Ngoepe, 2016).

The public health sector has been associated with a significant amount of negative publicity that mainly highlights the deteriorating quality of health care services which is associated with underfunding, mismanagement, the shortage of professionals as well as poor infrastructure among other major issues (WHO Bulletin, n.d.). To stress the burden the public health sector carries, Jobson (2015) states that the ratio of

doctor: patient stood at 1: 4 219 in the public sector which is served by less than 27% of general practitioners that are registered in the country. On the other hand, the public health sector has also been trying to improve access for citizens although it is argued to be failing to provide adequate health care in terms of utility for the majority of the country's citizens (Meyer, 2010). This is seen in cases where many facilities operate with high staff shortages and limited supply of medication (Purcell, 2005).

The private sector on the other hand, consists of health care professionals that provide services on a private basis, is also funded by a certain amount of government expenditure, the subscription of individuals to medical aids as well as out-of-pocket payments (Jobson, 2015). According to Jobson (2015) this sector is primarily focused on curative health care services such as chemotherapy and is argued to be highly biased towards urban areas, in terms of availability and service provision. According to Econex (2013) the Minister of Health, Aaron Motsoeledi stated that the private sector is working at an advantage as it has more human and capital resources and only serves a minority of the country's citizens, hence it performs better than the state run public sector. This sector is argued to have developed due to the demand of quality health services and was a market response to the failures of service delivery in the public sector (Econex, 2013).

Medical aid schemes or health insurance are services which seek to protect individuals against the risks of incurring medical expenses once they fall ill as well as to assist individuals in paying for preventative treatment (Statistics South Africa, n.d.). In South Africa, it is stated that approximately 17% of the population is served by medical aids and the head beneficiaries are older than 35 years of age (Statistics South Africa, n.d.; Econex, 2013). It should be noted that there are some individuals who have no access to medical aid schemes or due to limitations in their medical aids, they are forced to acquire expensive health services from out-of-pocket payments (Econex, 2013). The need for medical aids and the need to pay out-of-the-pocket for medical services could thus be argued to be a great demand for high levels of expertise as well as high quality services that are offered by the private sector. It should also be noted that this sector is represented by other "unconventional" practitioners that are considered to be of importance in our society by the South African health legislation as noted above, this includes the services of traditional practitioners.

The NGO sector on the other hand is mainly focused on support systems for more severe conditions such as HIV/AIDS, Tuberculosis (TB) and cancer among others (Jobson, 2015). This sector is depended on donor funds from various interested bodies and stakeholders. As previously stated, this sector is relatively small in the country and is focused on certain types of illnesses and diseases in terms of outreach.

The National Health Insurance debate

The idea of the National Health Insurance (NHI) was introduced as part of the transformation of the health system in the post-apartheid era as it was mentioned in the White Paper on Health in 1997. The NHI is largely aimed to address the increasing gap between the rich and the poor in accessing quality health services. According to the WHO Bulletin (n. d) the NHI aims to close the gap between the rich and the poor and to further improving the provision of quality health care to the majority of South Africans who are dependent on the public health system. According to Minister of Health (Aaron Motsoeledi), the private health sector only serves about 17% of the South African population while the remaining 83% are dependent on the public health sector (Ngaope, 2016). The public and private health sectors receive an almost 50/50 split from the Gross Domestic Product (GDP) that is spend on health while approximately 70% of doctors and specialists work in the private health sector and the remaining portion of doctors are serving in the public sector (Econex, 2013). Figure 1 below thus shows the expenditure amount among the three prominent health sectors in the country; the public, private and NGO sectors. The private sector, in this case, could be argued to have more state funding considering that it serves a minority of the country's population.

In most developing countries, the majority of citizens use the public sector as a primary source of accessing health services. However, there are arguments that the public health sector (when we consider Figure 1) is not sufficiently funded, suffers from severe staff shortages as well as limited medication among other major issues. The public health sector is also argued to have a number of failures although the majority of people depend on it in the developing countries (Edmeston and Francis, n.d; Jobson, 2015). The introduction of a health insurance in developed countries such as the United States of America sparked debates on effectiveness, promotion of quality

health care as well as better access to health care services (Edmeston and Francis, n.d).

This thus split in expenditure in relation to the number of users between the two large sectors could be argued to show a lack of fairness and equity in the distribution of resources within the health system. It is thus within this scope that the NHI seeks to achieve the goal that is to promote universal access to quality health services as well as to promote efficient and effective service delivery in both, private and public sectors (WHO Bulletin, n.d.).

The NHI, however, fails to state how it seeks to address challenges regarding expensive medical care and surgical operations that are a major concern to even some beneficiaries of medical aid schemes. If operations such as dialysis cost millions to provide, as argued in the case of Soobramoney vs. Minister of Health (Kwa Zulu Natal) how then would a universal system seek to address and adequately provide such services without increasing taxes of the current labour force?

If we are to look and evaluate the current state of the public health sector, strides towards achieving universal access to health care have been huge from 1994. However, the bureaucracy of a complex system such as the health system will take time to be reformed, it would also take time to address issues such as mismanagement as well as staff shortages that hinder the success of the current public health system.

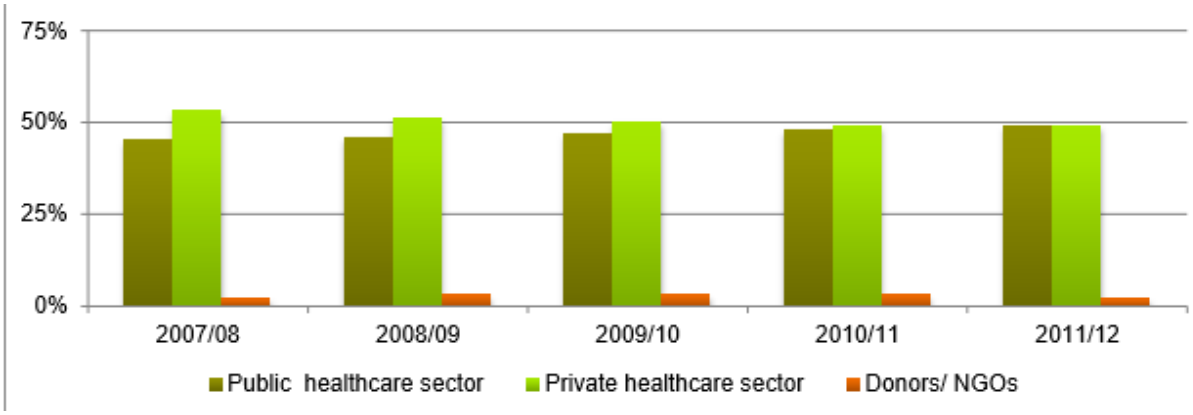


Figure 1: Public/private/NGO healthcare expenditure for years 2007/8-2011/12 (Econex, 2013).

2.4. Settlements in relation to access to health services

Having discussed the two major sections of the literature, this is the last major section and is focused on how particular settlements manoeuvre access to health services. Many areas of the world have mainly been biased towards their developments and

where they direct investment in the sense that investments are usually directed towards core urban centres and areas of the wealthier classes (Ren, 2011). Cities that are currently experiencing rapid urbanisation and population growth are mainly seen to be experiencing the development of new towns outside of their “main” core centres (Ren, 2011). Cities such as Shanghai are currently experiencing polycentric urban development trends where the new towns are located on the urban peripheries from the “main” centres (Ren, 2011). Ren (2011) further states that some of the older towns on urban peripheries had some level of social services and infrastructure but due to the population growth that is currently directed towards the peripheries, these facilities and infrastructure are experiencing severe strain as there are a few facilities that exist in these urban peripheries. Most of the limitation towards investment on urban peripheries is largely related to history where core urban centres were prioritised for development and investment.

Similar to South Africa, historically, investment and development were directed towards urban centres, leaving townships to be mainly dormitory areas that only experienced sporadic economic developments through spaza shops, salons and malls over the years (South African Cities Network, 2009). The availability of sufficient infrastructure, especially social infrastructure which is of importance in order to promote socio-economic development as well as to attract productive activities (Robbins, n.d). However, the monotonous function of townships is and has been addressed primarily through public investments in projects that promote economic development and growth as well as projects that seek to further promote livelihoods (South African Cities Network, 2009). This has put limited emphasis on social facilities and services that are also vital in order to promote a better quality of life for varied demographic groups in communities as well as improve socioeconomic profiles of people living in such areas. This is with particular emphasis to areas that continue to expand in population through densification processes such as backyarding which is characterised by shacks and formally built rooms in back yards (Todes et al, 2015). How this growing population accesses vital health services through various life stages is critical to their overall well-being, especially in settlements that may pose as environmental hazards due to the type of densification processes taking place in that area, as further discussed below.

A significant amount of research that relates to settlements and health is usually focused on “informal” settlements as crowded residential areas that pose a number of health hazards due to limited availability of water and sanitation services (Hawkins et al., 2013). “Informal” settlements are also argued to pose as health hazards due to their high population densities and overcrowded conditions (Housing Development Agency, 2012). Some of these settlements have poor drainage systems, poor sanitation and sit on environmentally hazardous areas such as river banks, hence posing as health risks to residents (Housing Development Agency, 2012). “Informal” settlement characteristics such as shacks as well as limited availability of water and sanitation also exist in backyards of some townships. On the latter point, the case occurs when some back yard dwellers cannot access ablution facilities and sufficient water or when the residents of the main house experience broken sewage pipes (Govender, 2011; Nhlabathi, 2011). These situations then pose of health risks for both adults and children, but especially children.

In most African countries, access to health services is still a major issue, especially with regards to girls and women that reside in low income settlements (Institute of Development Studies, 2016). According to the Institute of Development Studies (2016), difficulties in physical access, limited availability of facilities such as clinics and the lack of appropriate treatment are reported to be major concerns in numerous low and middle income settlements in Kenya. In many aspects, the health system in Kenya faces similar issues as the South African system where there is limited professional staff, although Kenya faces a direr situation of unavailability or limited availability of drugs and medication, especially HIV related health medication and support (Institute of Development Studies, 2016). A study conducted on women who reside in “informal” settlements in Durban had also revealed that the residents were not treated well in local clinics due to the area they resided in-an “informal” settlement. The respondents of the study were discriminated when they had to access reproductive health, this was largely based on the type of settlement they reside in (O’Reilly and Washington, 2012). From the study, the interviewed women argued that they received poor treatment, this then affected them negatively from receiving follow-up services or obtaining treatment.

South Africa could be said to have done a lot of improvements with regards to the provision of access to health services, especially for the country’s majority who depend on the public health sector (Edmeston and Francis, n.d). According to Jobson (2015)

the public health sector has attempted to address major issues it faces in order to improve the quality of services as well as to further promote more access through the development of physical infrastructure, provision of medical technologies, medicines and information systems. However, a study done in South Africa's old township, Khayelitsha in Cape Town found that non-communicable diseases (NCDs) and HIV/AIDS were prevalent health concerns in the country's township settings (Puoane et al., 2013 and Hawkins et al., 2013). It is also stated that most township residents are not employed in the formal sector and are likely to have limited access to health insurance in the form of medical aids (Hawkins et al., 2013). Although it could be argued that the public health sector has been immensely improved during the post-apartheid era, there are still prevalent issues that need to be addressed, especially in township settings that are major areas of residence for South Africa's low and middle income population.

What the study of Khayelitsha introduced, in relation to access to health care services is the importance of PHC. An intervention that took place in the township was through participation of community members to bring about awareness about NCDs and HIV/AIDS. The intervention was in the form of community health workers who held workshops to make the public aware of the dangers and preventative measures that could be taken to deal with the aforementioned conditions as well as to assist the elderly to receive their monthly treatments in their households. This intervention intended to expand the notion of access through community initiatives as well as to create a platform of interaction between health care practitioners and their patients. According to Puoane et al (2013), this PHC approach had a lot of potential to address NCDs as its focus was health promotion and disease prevention which are some focuses of PHC- a core strategy to minimise congestion in clinics and community health care centres.

According to a study done on the township of Bram Fischerville, Gardner in Todes et al (2015) suggested that there should be a direction of future public investment towards healthcare facilities as well as permanent schools in the township as he considered them as insufficient. This is an important point to consider in places that cater for various demographic groups, the young to the elderly in relation to access to healthcare services as various demographic groups experience various needs in terms of healthcare in their lifecycle. The availability and accessibility of such services

should thus be considered as paramount as it is stipulated in the country's Constitution.

These peripheral urban settlements are important to consider as it has been argued that it is difficult to provide sufficient infrastructure due to costs for departments (Cross, 2001). Considering this, it is important to note that these peripheral areas are now residential areas to large populations where population rates continue to grow annually and these populations require important services such as healthcare and education in order to improve their socioeconomic status.

A CSIR (2012) report on the guidelines for the provision of social facilities in the country's settlements states that due to the nature of our communities, not all services could be provided viably. The country's settlements present various landscapes, population densities and locations hence it is vital to consider facility location in strategic forward planning. The study also states that due to unequal development trends and biasness towards the provision of particular facilities in certain areas, the location of social facilities is critical in serving communities that need such facilities the most (CSIR, 2012).

The data in Table 2 is adopted from the requirements of providing social facilities in metropolitan areas such as the City of Johannesburg, that is, areas having a population of more than one million people. From the table, the provision criteria is noted by C/D where C is stated to be a compulsory provision and D is stated to be an optional provision. Clinics and district hospitals are shown that they need to be compulsorily provided and do not depend on undersupply as compared to the D criteria that needs to be provided only when there seems to be an under service (CSIR, 2012). Clinics and community health centres (CHC) are the most critical as they offer the basic of services and are required to be provided for within settlements of less than 50 000 people in a settlement. Essentially, these two types of health facilities could be provided for if the populations exceed the stated population densities.

A. Social Facilities required for **Metropolitan Cities/Regions** (Catchment size: > 1 000 000)				
FACILITIES	AVERAGE THRESHOLD (POPULATION)	ACCEPTABLE TRAVEL DISTANCE (KM)	PROVISION CRITERIA	COMMENTS
HEALTH AND EMERGENCY SERVICES				
Tertiary Hospital L3	2 400 000	Variable	D	
Regional Hospital L2	1 770 000	See comment	C/D	Compulsory above 1.5 million threshold but may be required in cities with a lower threshold such as 900 000+ if access distances are greater than 200 km to a comparable facility elsewhere
District Hospital L1	300 000 - 900 000	30 km	C	Not required if residents can reach (within 30 km) any higher-order hospital that is not overburdened
Community Health Centre	100 000 - 140 000	90% of population served within 5 km*	C	*National Department of Health target
Primary Health Clinic	24 000 - 70 000	90% of population served within 5 km*	C	*National Department of Health target
Fire Station	60 000 - 100 000	8 - 23 minutes (response time)*	C	Area coverage and reach versus people/land use in the specific area will have to be evaluated; *SABS standard
Police Station	60 000 - 100 000	8 km metro; 15 km peri-urban 24 km other	C	Central location is critical but demand factors and access of population will dictate location and size. SAPS Contact Points are used in areas not warranting a fully-fledged station but which are beyond the SAPS distance criteria of 24 km

Table 2: Summary of the location of health facilities in relation to population (CSIR, 2012).

2.5. Conceptual framework

In relation to the concept of access, the spatial limitation of access has been highly prominent. Access to health services is mainly argued to be a locational factor, however, there are other issues noted, such as aspatial factors; high costs of health care, gender as well as the availability of expertise among other factors. The aspatial factors are predominantly relevant in case of townships as they are categorised as mainly low-income settlements in South Africa. Their status as low-income settlements is related to historical foundations as well as the planning of townships during apartheid (Maluleke, n.d).

According to the two major cases taken to the Constitutional court, the state has been the biggest provider of health services for the poor in the country, this being mostly due to reforms made by the government post-apartheid (Grut et al, 2012). The poor and low-income who reside in the sprawling townships and peripheral locations of our urban centres are mainly dependant on the state provided services. According to the cases of Soobrymoney and the Treatment Action Campaign that were taken to the

Constitutional court; the limitations of the state, especially with regards to aspatial limitations (such as costs and unavailability of sufficient treatment) to access to healthcare have had a severe impacts on the transformation of South Africa's health system as well as the provision of medication for those who cannot afford it.

From the literature review which is summarised in Figure 2, it could be seen that access, types of health care services and settlement types are related. Access is a broad term that encompasses spatial and aspatial factors; these factors affect people's opportunity to receive as well as benefit from health care services. Figure 2 shows that affordability and geographic access are major attributes to how residents of low income settlements such as townships and "informal" settlements access health care services. The public sector facilities in the aforementioned settlement typologies are intensively used, where this usage might be highly attributed by the residents' socioeconomic status.

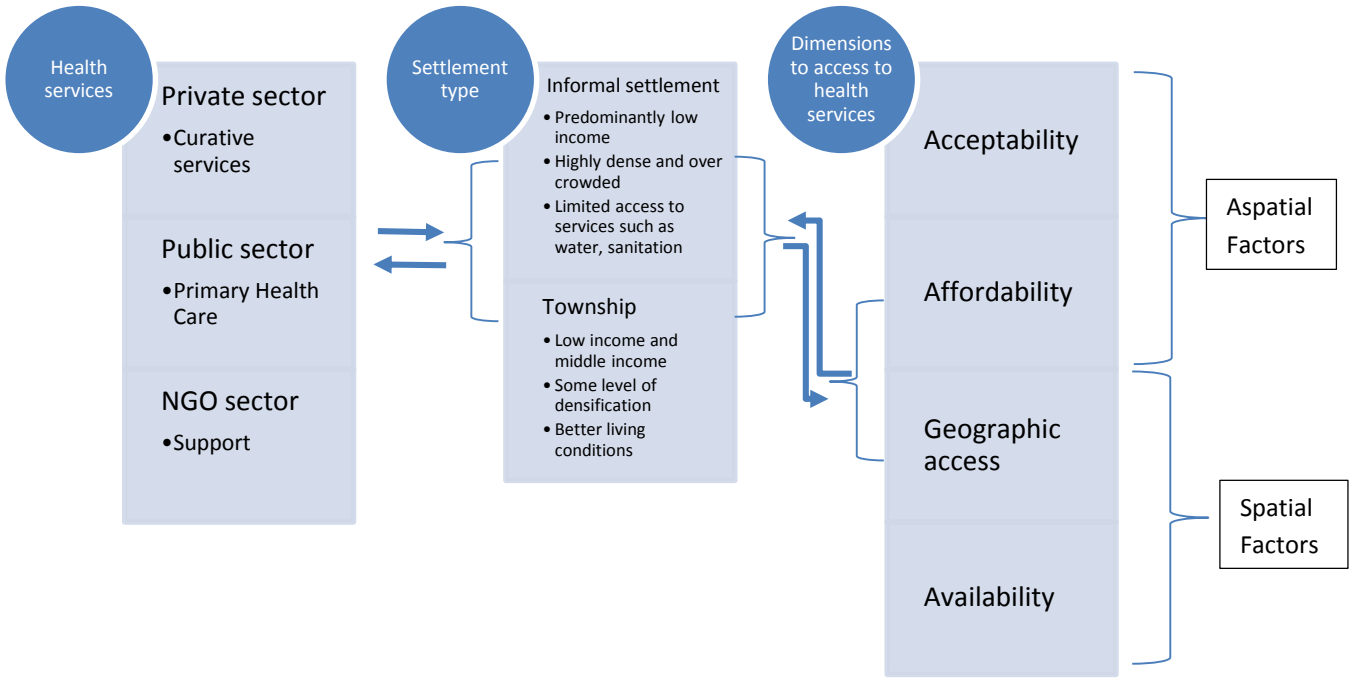


Figure 2: Link between health services, types of settlements and the notion of access (Author, 2016).

2.7 Conclusion

To conclude the chapter, addressing universal coverage and access to health care services is still a major issue in low and middle income countries. Studies from the USA also show us that initiatives such as the NHI are not the main response to addressing universal access as endorsed by WHO, but small interventions through PHC such as community participation may also have huge impacts on the promotion

of access as also seen in the case of Khayelitsha township, Cape Town. Support should be given to such initiatives (community participation and awareness programmes) as they could prove to be important complements to the success of an efficient health care system.

The realisation of the right to health care in the case of South Africa should also not only be put on the state and the public sector. From discussions in this chapter, the public sector is argued to experience problems such as staff shortages and limited levels of expertise hence individuals need to also take responsibility for their health, especially with regards to preventative conditions such as NCDs and regular visits to PHC facilities in order to avoid long term illnesses.

PHC should also be an area that is given a lot of attention and focus as it is argued to be one of the core pillars of an efficient health system (Jurberg, 2008). As argued by Edmeston and Francis (n.d), the PHC tier is currently experiencing severe failures that lead to a burden in hospitals. Preventative care is more essential than dealing with issues at a later stage when they are more complex and require curative services. The referral system which was adopted by the DoH through the district system has been seen to have partial effectiveness hence the burden experienced by hospitals, especially in public sector hospitals.

With regards to the expansion and growth of low income settlements, particular emphasis should be given to issues related to health, especially at PHC level. From the discussion above, it is seen that residents of low income settlements are the ones that could be argued to mainly suffer from the quadruple of disease that faces the country. The regular attendance to health facilities should be monitored and paid attention to as O'Reilly and Washington (2012) argue that patient revisits are mainly determined by the quality of services offered, affordability of services and distance between household and service provider among other things.

3. CHAPTER 3: RESEARCH METHODS

3.1. Research Methods

This chapter mainly deals with the technicalities that relate to field work. These include the type of research method that was used to collect findings, type of data collection technique used and type of data collected, ethical concerns and considerations as well as the introduction of the case study of Bram Fischerville.

3.1.1. Type of research

The study followed a qualitative research approach as this research method is argued to offer horizontal dialogue, a conversation that seeks to draw in-depth knowledge of the subject matter between interviewer and interviewee (Creswell, 2009). According to Creswell (2009), qualitative research is focused on participants' perceptions and experiences. Data that emerges from such research is descriptive as it is mainly reported in words and pictures. Of most importance, this type of research appreciates multiple realities by using tacit knowledge (Creswell, 2009). Basically, a lot could be extracted from the interviews and later unpacked in order to better understand underlying issues that relate to the subject matter as well as introduce new ways of thinking.

The research made use of a case study research method which requires an extensive and in-depth description of some social phenomena (Yin, 2009). According to Yin (2009) this is essential since a case study allows an investigator to preserve the holistic characteristics of real-life events such as neighbourhood change. The case study will take descriptive and exploratory lenses in order to respond to the research question and sub-questions. A case study is also useful as it is a means of addressing the need to produce new knowledge relevant to practice (Watson and Agbola, 2013). However, it should be acknowledged that case studies could not be generalised as only a single area has been studied and conditions of the research are focused on that particular area. This study used the township of Bram Fischerville as a case study in order to respond to the research question as this was a township established post-apartheid and had been thought to have shifted from the typical township development, especially with regards to the availability of certain services. The township was also chosen as it is was seen to be experiencing a level of densification through backyard development (Gardener, 2015).

3.1.2 Type of information needed

Information needed was with regards to what health services are there in Bram Fischerville, what residents seek in health services and what their experiences are. Various health services were looked at although the focus was on primary health care services as these types of services are primarily required by the majority of people and are the first attempt to receiving health care.

Identified facilities were considered at different scales-clinics and community health care centres, district hospitals and tertiary hospitals as a measure of health care delivery. These different scales are discussed in the state of the South African health system in Chapter 2 of this report.

3.1.3. Data collection methods

There were two data collection methods that were used for this study, semi-structured interviews as well as mapping and auditing.

- *Semi-structured interviews*

This method was used to enquire about the experiences of individuals with varying demographic profiles as well as their perceptions of provided services. The interviews were conducted with residents of various age groups. The author intended to interview 10-15 people in order to collect the required data, however, the author was able to interview a total of 16 people, but two of the interviews were regarded as insufficient. This was because one respondent hardly used healthcare facilities and the other had just moved into the area of Bram Fischerville and had also not used health facilities within the township. The interviews were conducted in people's homes through a door-to-door technique with people willing to participate. The participants were from two sections of Bram Fischerville, the oldest section of the settlement (Phase 1) as well as a newer area of the settlement (Phase 2) so as to compare the differences (or similarities) in experiences. The older section of the settlement was chosen as it showed lower levels of physical densification and limited health care services. The newer section on the other hand, was chosen as it displayed more variety in terms of physical density as well as had a number of health care services and service providers. Both of these selections were made based on initial observations in the area.

- *Mapping and auditing*

This method was used to look at various services available, types of services offered, operating times as well as the providers of the health services. In this case, auditing is about examining a particular area through observation. This was done through observation in the area, mapping services on a map as well as taking photographs of available services such as clinics and general practitioners. In order to acquire what services are offered in certain places; notes and photographs were taken. The information on the exterior of the practices was likely to show operational times as well the types of services they offered but in only in a broad sense, for example, they write that they offer male circumcision only although more services are being offered than only that.



Figure 3: Services broadly offered by the GPs in the area (Author, 2016).

The data collection was done through a group effort, with two other colleagues who were also doing their research in the area of Bram Fischerville. This was mainly to assist each other to communicate better and to translate when we came across people speaking different languages. The two colleagues that were doing the research in the same area spoke SeSotho and Setswana while the author of this report spoke the Nguni languages, being fluent in IsiXhosa and partially fluent in IsiZulu.

3.2. Ethical concerns

Before the research was conducted, an ethics approval procedure was followed within the School of Architecture and Planning, University of the Witwatersrand. The process included the submission of ethics forms, consent forms, personal information sheet as well as a sample of interview questions so as to verify if the author was on the right path to conduct field research. Only upon approval and clearance of the ethics process that the author began her field work through the interview process. The author had to

have her ethics clearance certificate, consent forms and interview questions during the field work.

Participants were informed of the intention of the study, participations was voluntary and participant identities were kept anonymous in the write up of the report findings. Considering that the research was conducted through a door-to-door method, respect of the participants and their environment was highly considered.

3.3. Sampling

The samples for the research study were planned to be done in a particular and rational method. Samples were to be taken in a similar way in both sections of the townships that were used as study areas for this research. The interviews were intended to be conducted in every second house in a street, with at least one person per plot participating. The interviews were designed so as to not only focus on the main house but in back yard rooms within the plots where they existed as each street had a particular fabric. The interviews were also to be conducted with people who had used a medical facility or had needed medical services within a period of five years and should have been staying in the settlement of Bram Fischerville. The time frame gives enough time for those people who do not regularly use health facilities and those who use them regularly.

The research was conducted on weekdays and weekends so as to try to get people who usually work during the week and are off work on weekends. In both phases, the respondents were found in the main streets as these streets proved to be much busier and had more people during site visits. However, what was evident is that, in Phase 1 of the settlement, the greatest number of people were not available most of the time. In some houses, there were high walls with high gates that were usually locked during the day, especially during week days. In some houses, there were dogs that roamed the yard. These thus limited the efficiency of the chosen systematic sampling method. Due to this limitation, the study only focused on residents who had used a health facility within the past five years, were residents of the settlement and were available at the time of the interview.

For the samples, the study wanted to have both male and female experiences, however, in the field, it became apparent that most male residents had argued that they do not usually use health services, especially clinics. Rather, most had argued

that they hardly got sick with illnesses that required medical attention and mainly used the local shop for quick-fix. This perception then gave insight on why most studies related to access to health care had focused on females. On the other hand, older male respondents had shown interesting responses with regards to issues of access, suggesting that the need for health services in males might probably come with age.

3.4. Introduction to Bram Fischerville

Bram Fischerville is a township located on the north western edge of Soweto and falls under the City of Johannesburg metropolitan jurisdiction, under Region C (Notununu, 2009). The township is located along the former mining areas closer to Roodepoort and surrounded by former mine dumps (Engineering News, 2002). These mine dumps are used as sites to mine gold residues by some residents who reside in the entrance area of the settlement. In the winter season, the settlement experiences severe dust that is from the old mine dumps that surround the area, these being based on observation during site visits.

From several attempts to draw from different sources, the basic demographics of the township of Bram Fischer were difficult to acquire. However, based on data from Naicker et al (2010), Bram Fischerville is a settlement that mainly consists of back African demographic group and has been experiencing population growth over the years, from its time of establishment. The study also failed to have an estimated number of the population.

According to Todes et al (2015), the township of Bram Fischerville was one of the first post 1994 “RDP” developments, mainly planned to accommodate households living in crowded houses, backyard shacks as well as informal settlements. The households moved in order to resettle in Bram Fischer were mainly located within the Soweto vicinity although the township also accommodated residents from other parts of the city, including those from Alexander township who had resided in the aforementioned conditions. Similar to other “RDP” housing subsidised developments, the beneficiaries of the houses were to be low income earners, earning R 3 500 or less on a monthly basis.

Like many “RDP” housing developments, all the subsidised houses in the area conformed to basic RDP standards which included 36 square metre brick finish, an asbestos roof that had no ceiling and had no internal division besides a small bathroom

(Todes et al, 2013). However, the beneficiaries of the houses were to have formal ownership of the houses by having a title deed. Bram Fischerville's initial fabric included 22 000 state subsidised "RDP" houses although it later grew to incorporate bonded housing as well as the development of additional rooms such as backyards which constitute of shacks and solid structures (made of mortar and bricks).

The Bram Fischerville development was part of the Focus Area Programme which was commissioned by the Gauteng Department of Housing, Greater Johannesburg Metropolitan Council and the Rand Leases Property (Ltd) (Notununu, 2009; Engineering News, 2002). The project had been meant to facilitate the development of Soweto towards Roodepoort CBD as well as to have a combination of bonded and capital subsidy scheme houses (Notununu, 2009; Engineering News 2002). According to Notununu (2009), in its initial stages, the development's units were to be divided into three phases. In its initiation in 1996 some of the units were to be occupied by approximately 3 500 people which were relocated from Alexandra township then the rest being occupied by residents of Soweto.

The area has been developing over the years as it started with three phases although it now has around five phases, as illustrated in Figure 5. Phase 1 and 2 are the phases that are much older while the other Phases are much newer, including the area with bonded housing.

According to Notununu (2009) who had done a study on the area, the area had been noted to lack a number of social facilities, experienced a breakdown of sewer and water infrastructure and had bad roads as that were mainly gravel. The area remained predominantly residential with sporadic opportunities for small business ownerships such as spaza shops, hair salons and eateries at street corners among other things. From observation, one sees a Bram Fischerville having the presence of big retailers such as Shoprite and Spar, a number of privately owned health care service providers such as general practitioners (GPs) and pharmacies, the built up of schools as well as the improvement of road infrastructure (primarily focused on the main roads) among other developments. The area is growing to accommodate various income groups as there are house improvements in some plots, various land uses as well as opportunities for growth and expansion through backyarding and house extensions.

Drawing from the social services aspect of the settlement, it is said that residents of the settlement mainly use the Dobsonville clinic which received a number of renovations a number of years back (SAME, 2013; Thamela, 2014). According to SAME (2013), the clinic was built to serve Dobsonville which had a population of approximately 56 000 at the time but it currently serves a growing population of Bram Fischerville. Among the renovations was the addition of a fully equipped 2 bedded resuscitation unit, specialists from the Gauteng Department of Health who visit the clinic on designated days. According to the news report by Thamela (2014), mothers as well as the elderly in Bram Fischerville felt the need for increased access to health services as it were a burden to travel to access such services especially with residents with limited incomes, some with physical body constraints as well as increased levels of sickness at times.

Why the township of Bram Fischerville as a case study?

What struck the researcher about Bram Fischerville was that it was a post-apartheid settlement that was designed and planned in a manner that was meant to respond to the ills and injustices that had been prevalent in apartheid settlements and townships. These injustices mainly relate to limited or lack of employment opportunities close to such settlements, monotonous dormitory function of townships as well as limited social and economic amenities.

The settlement had also been an area experiencing a certain level of densification through backyarding processes, especially when one considers it as a settlement of the periphery, although not as peripheral as Orange Farm. According to a summary of findings by Gardner (2015), the settlement had approximately 22 000 households occupying formal dwellings and there was little or no sign of secondary dwellings in 2001. However, by 2011, about 25% of the households in the settlement had secondary dwellings in the form of shacks and backyard rooms. The limitation of shacks in 2001 is argued to be mainly driven by government policy that did not allow backyard structures on RDP settlements at that time (Gardner, 2015).

The settlement has also shown signs of physical integration which may be a shift from being a low to a mixed income settlement. Besides the development of bonded houses, owners in the areas with RDP houses have shown to make improvements in their houses as well as to build “formal” backyard structures instead of shacks (as can

be seen in Figure 4). These improvements suggest that people with higher incomes may have bought houses in the area or beneficiaries of the subsidies shifted in income bands over the years to much better income bands hence the developments.



Figure 4: Various backyard developments, showing a growing need for housing and illustrating a level of densification in the area (Selepe, 2016).

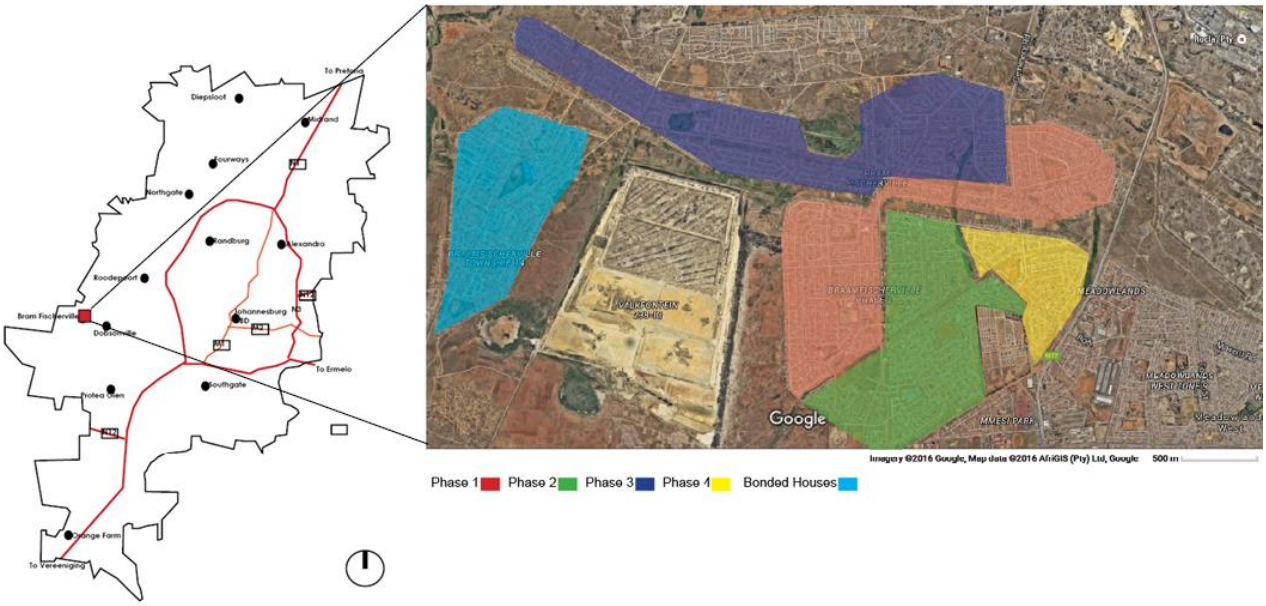


Figure 5: Location of Bram Fischerville in the City of Johannesburg context and showing of different settlement phases (Author, 2016).

The chapter has introduced us to the initial processes of conducting research as well as to introduce us to the study area. This chapter then opens way for the following chapter that deals with the research findings and analysing the findings.

4. CHAPTER 4: RESEARCH FINDINGS AND ANALYSIS

This chapter seeks to analyse as well as draw on findings from data collection methods done for this report; interviews as well as mapping and auditing. This chapter also aims to respond to the main research question and its sub questions that were posed in the first chapter of this report.

4.1. Findings

4.1.1. Health service providers

According to Econex (2013) there are three major service providers in the country; the private, public and the NGO sector. However, from observations with the township of Bram Fischer as well as from the responses from the interviewed respondents, the most prominent and available sectors in and around the township are the private and public sectors, with no indication of NGOs. This section of this chapter will thus analyse the available service providers, within the township as well as in the vicinity of the township.

Health service providers within the township of Bram Fischerville

From the observation done within the area of Bram Fischer, it was seen that there are health care providers within the area. However, these service providers are privately owned and include a number of general practitioners (GP), a private clinic and a pharmacy. From a tour and observation around the township, the researcher did not identify or see any practices by traditional practitioners, especially in the two sections of the settlement that the researcher conducted interviews in although there were posters that offered alternative means to receive medical assistance such as the termination of pregnancies.

Phase 2 is the area which predominantly has a number of developments including a Spar retail, a primary school that is being built and more general practitioners as compared to Phase 1, two GPs were identified within this area. The two general practitioners which are close to each other offer various services such as male circumcision and general consultations at market rates, an average of R300. The two practices open 6 days a week and are usually open from 8:00 am to 17:00. The assumption is that these practices offer services to beneficiaries on medical aid schemes as well as pay-out-of-pocket patients.

The clinic that is also located in the same vicinity as the two general practitioner practices is privately owned by Unjani Clinics. According to one respondent who have previously accessed services from the clinic, the clinic did not take medical aids but out-of-pocket payments for the provision of services. The respondent could not remember the costs of services as she claims that she had gone to the clinic quite a while ago although the amount was not as high as a that of a consultation with a GP, however, the respondent stated that she was surprised to find out that one had to pay to access services in the clinic. From my understanding, the respondent may have been surprised as she would be used to services provided by a public clinic.

There is also a pharmacy in Phase 2 that opens 7 days a week. The pharmacy mainly offers over-the-counter medication as well as serving prescriptions. Three of the respondents had used the pharmacy before although these respondents are from Phase 2, the area where the pharmacy is located. Some respondents, however, did not know a pharmacy existed within the area of Bram Fischer hence they had not even used it before. Logically, residents of Phase 1 may be better off in using a local and nearby shop for quick-fix remedies or go to the clinic directly than to walk to a pharmacy on the other end of the settlement to receive certain over-the-counter medication.



Figure 6: Location of where research was conducted and the location of facilities noted within Bram Fischerville (Author, 2016).

Health service providers around the township of Bram Fischerville

According to interviews with the Bram Fischerville residents interviewed for this study, there are public sector health care facilities around the area of Bram Fischerville. However, the mostly attended public health facilities are outside of the Bram Fischerville township and are Dobsonville clinic (Itereleng Community Health Clinic), Helen Joseph Hospital, Leratong Hospital as well as Florida clinic. According to 13 out of 14 respondents, they used the Dobsonville clinic for a number of required services and this is the only clinic that is available to them.

The clinic in Dobsonville was mainly used due to its close proximity to Bram Fischerville. For the respondents that stay in Phase 2, the clinic was easily accessible as it was within walking distance from them. However people from Phase 1 mainly used taxis to get to the clinic. Essentially, even if residents did not have enough money for a taxi, getting to the nearest clinic is not an issue for them, although some residents mentioned that they have difficulties walking to the clinic. The respondents who found difficulties stated weaker health and weather conditions as a restriction some times, for example, when it is raining and too cold outside they are not able to walk to the clinic.

With regards to the Dobsonville clinic, the clinic serves a number of settlements that deem it to be the closest clinic within their vicinity. According to residents interviewed, the clinic services residents from Bram Fischerville, Dobsonville, Meadowlands and Snake Park among other surrounding areas. These settlements carry large population densities to be served by a single clinic that provides basic level services that were earlier discussed in chapter 2 of this report. For residents in the aforementioned townships, attending the nearest clinic is of convenience to them as their case files are in the system of that particular clinic and it will cost them less to go to that clinic.

Three of the respondents also said that they used other public health care facilities that are hospitals. The most used hospital is Hamberg, Florida, a few kilometres outside the settlement of Bram Fischerville. The respondents used the hospital directly as compared to being referred to the hospital, they had mainly done so because of the nature of their ailments. A woman respondent who usually has complications with a caesarean section she had a number of years back stated that she did not need referral from the clinic to gain access to hospital, a doctor needed to look at her conditions whenever it gave her problems. For her, winter was the hardest time as her scars were usually painful, making it difficult for her to work hence her need to frequent the hospital for medical assistance.

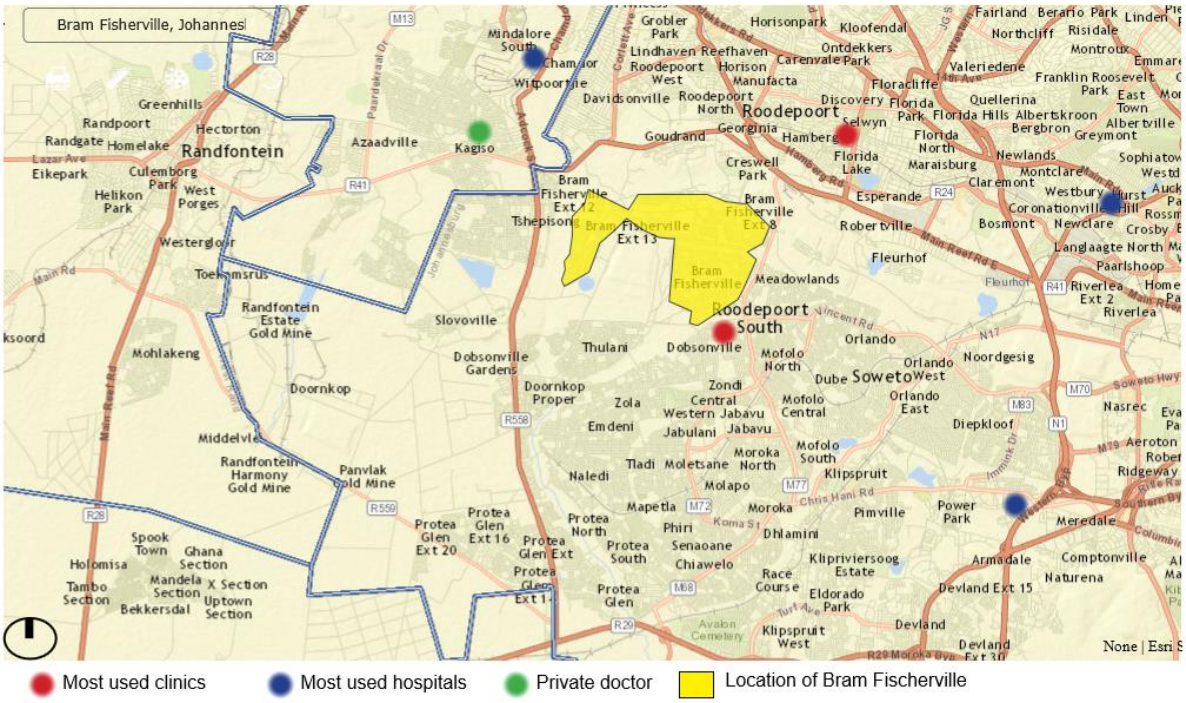


Figure 7: Location of most used health facilities located outside of Bram Fischerville that are used by respondents (Author, 2016).

4.1.2. Provided health services and their availability

The Dobsonville clinic which is primarily used by most interviewed residents is reported to open from 7:00 am to 4 pm. The clinic is argued to have experienced various improvements, this is according to the residents who have stayed in Bram Fischerville and used the clinic for more than 5 years. They state that the clinic now offers a wider range of services and has more doctors available than the previous years they had used it. The clinic now offers emergency services and more specialised services than it used to before. Interviewees who use the clinic responded to the availability of dental services and a maternity section among others, however, they say that specialised doctors are not available on a daily basis but on selected days of the week. Some respondents had used some of the specialised services such as dentistry although some only knew about their presence as they saw people going for such services at the clinic.

The Dobsonville clinic predominantly provides for basic services that include preventative and rehabilitave care. Most respondents who use the clinic to receive treatment for chronic illnesses such as hypertension while some use it for required child immunisation. The respondents who had used the clinic for child immunisation stated that they hardly attend the clinic besides for that and are likely to not attend the clinic after the child has reached an age to stop immunisation. They also highlighted that they will go to the clinic when their children get sick with other illnesses in the course of their childhood development. Two out of the 14 respondents stated that they mainly use the clinic for reproductive care on a regular basis, however, they stated that they usually started their reproductive care after they gave birth as it was given to them in hospital in the form of a birth control technique. They have thus been continuing with it.

For hospital users, the hospitals are open on a 24/7 basis. Interviewees reported that the hospitals offered varied services that relate to specialised services such as optometry, injuries and emergency care among others. Regular hospital users stated that the hospitals did not always have doctors, rather, the doctors would only be around for a certain number of hours.

The pharmacy users amongst the respondents stated that the local pharmacy was very basic although it had a pharmacist available. They said that the pharmacy did not

offer services such as glucose checks, blood pressure checks and such tests. To access such services, some respondents had gone to the clinic although some had stated that they hardly require such services on a regular basis. Those respondents who stated that they did not need such services on a regular basis stated that they only received such services when they are sick and need to receive a check-up that will consist of such tests.

A respondent who uses a GP located in Kagiso, a township north west of Bram Fischer (indicated in green in Figure 7) stated that his GP was available when he needed a consultation although he does not use a doctor regularly such as on a monthly basis. For this respondent, his GP was available through appointments although one could also pop in at the GPs practice.

4.1.3. Demand for services

The demand for services was mainly looked at using the criteria provided by the health care system (the hierarchy of health facilities). The demand was analysed in terms of the people who need and use basic health care, curative care as well as specialised services. The demand for services was looked at from within Bram Fischerville as well as outside of the settlement as some services such as specialised health care are only offered at a hospital level, where a hospital serves a whole district in most cases.

Basic health care services

Ranging with age and gender, respondents had similar services that they demanded or were in need of, especially from the public sector. In the study, most respondents had been female (ten out of the 14) and half of the females were mothers or parenting children under the age 10 within their household. From the respondents who were mothers, they were mainly single mothers who stated that their children had needed particular health care services until they got to a particular age. The respondents stated that their children required basic services such as immunisation that was mainly provided free-of-charge at public clinics or at the PHC level as planned by the district health care system.

With regards to the use of private sector provided services, GPs were not highly used by the respondents. From the socioeconomic profile of most of these respondents, money and the affordability of services offered by GPs had been the main issue, as

stated by Angier (2014). Most of the respondents had no formal employment if they were at all employed. However, some respondents mentioned that they would use the GP when their health worsened as they believed that GPs gave them “stronger” medication as compared to that provided by the public clinics at times, this was of prominence among the much older respondents, older than the age of 40.

According to the Department of Health, the health policy had to be re-engineered in order to improve primary health care (Tomlison, 2014). The re-engineering of basic health care had to focus on the expansion of PHC by promoting participation at schools and with community members than to exert pressure on clinics and community health care centres for illnesses that could be managed as well as with regards to educational programmes, for example; on issues related to family planning as well as diet and nutrition (Tomlison, 2014). Participation of schools and community members was argued to focus on preventative measures, especially through education and awareness programmes. This strategy was mainly targeted at reducing the spread of HIV/AIDS, teenage pregnancy and lifestyle illnesses such as diabetes among other issues that are prevalent in township settings (Puoane et al, 2007).

Most of the interviewed respondents did not spontaneously mention the knowledge of programmes they know or knew of, at their children’s schools or in the immediate community. Based on this information, it could be argued that the implementation of programmes such as that of Khayelitsha, earlier mentioned in the previous chapter were not prevalent or implemented in the township or surrounding townships. The Khayelitsha programme was focused on training community members that would assist the community by promoting awareness about Non-Communicable Diseases (NCDs) and HIV/AIDS as these had been prevalent health issues within the community. This lack of implementation could be blamed on limited knowledge of their importance or the lack of initiative from community members themselves.

However, one respondent indicated that community members from her street in Phase 2 had begun a programme to assist the elderly in order for them to receive their monthly treatment from the local clinic. The group had collected medication on behalf of elderly community members from the local clinic, helped them make better food choices so that they could reduce their chances of chronic illness as well as to started an exercise programme in the area. The respondent stated that they had tried to get

sponsors but the programme did not go far as they did not receive permanent sponsorship in terms of fresh produce and food. Another main factor was money to transport these elderly community members as they needed to get examined by a doctor from time to time. The respondent said that it was a disadvantage because the elderly community members also did not have formal employment and depended on their children or the old age social grant for money on a monthly basis. Essentially, they could not be supported by their children and later support other community members with the little money they got from their children. According to the respondent, most elderly members of the group were pensioners and their pension money is predominantly used to support their grandchildren and their children rather than to be channelled towards their own personal needs.

In relation to the need for basic services such as flu vaccinations and the treatment of flu symptoms, the private sector providers may be highly demanded as most respondents stated that they do not use the clinic for such illnesses. The respondents usually stated that it was better to go to the nearest shop than to spend hours at the clinic for flu medication. In this case, the private sector is not necessarily registered medical providers such as GPs and pharmacies but local stores as well. Medication and treatment of such conditions may thus be in high demand, whether from pharmacies or local shops and retail stores. Five out of the 14 respondents stated that they mainly used local shops and retailers for minor illnesses such as flu, aches and pain as well as minor injuries.

Specialised and curative health care services

From the advertisements written outside the GPs that were noted in the area, there was a range of services that they offered; the services including male circumcision, pregnancy sonar scans and family planning services among others. The aforementioned services may be some of the most demanded in the area as the private sector is argued to be driven by demand as well as gaps in certain service provision (Econex, 2013).

However, drawing from the interviews with the respondents, many of the respondents had not used any of the GPs within the township of Bram Fischerville. Rather, when in need of curative and specialised services, they went directly to regional hospitals such as Chris Hani Baragwaneth Hospital, Helen Joseph as well as Hamberg. Drawing

from this, it is essential to note that the element of costs for the receipt of services is of importance. Respondents had used hospitals that are further away from the settlement because it was cheaper for them than to pay for a GP within their vicinity to attend to their need.

It should also be noted that although the respondents hardly used the GPs in the area, there might still be demand of the GPs from other respondents. The GPs are still in the area, this may mean that they still have business coming in. The results of this study should thus not suggest that there is not a market available for the GPs within the township.

A number of respondents who had used the Dobsonville clinic were also happy that the clinic had improved the range of services it offers. From older residents of the township, they say that the clinic had undergone renovations to expand services as the clinic catered for a number of settlements within the vicinity of Dobsonville.

4.1.4. Difficulties in accessing health services

Public sector provided services

A number of respondents had highlighted that they use the public sector provided services, especially through clinics. They stated that they experienced long queues and slow service most times when they attend the local clinic. Some respondents observed that slow service was mainly experienced on Fridays, Mondays as well as pay day for the nurses (the day when staff receives their salaries, the story is that nurses usually rush to do shopping as well as to take an early day off work). In addition to being in long queues, all respondents who used the clinic stated that they have to wake up early and be at the clinic before it even opens. According to the respondents, the rationale is to get served first and leave early.

Most respondents did not consider this as something of great concern, rather, they had treated it as a “normal” situation that they were used to, and this was especially prevalent in respondents between the ages of 20 and 40 years of age. For them, the clinic they attended was a typical scenario of a “normal” public sector provided service and they did not know how the situation could be changed hence they have come to accept how things operate. To some extent, the clinic visits were also treated as a

social gathering for this age group as similar groups of people went for check-ups and treatment around the same times of the month.

On the other hand, for the older age group (i.e. people over the age of 40), the long queues and early arrival were a major issue as they are old to wake up in the cold in the mornings. What the respondents of this age group also raised is how the nurses are rude and do not seem to care, however, they state that they usually ignore such behaviour although they deem it as disrespectful as the nurses are much younger than them. They ignored such behaviour in order to keep their health statuses in check. For example, one lady stated that if she gets angry and starts shouting at the nurses, her blood pressure could rise up to a critical level and she would have to go to hospital. So, she chooses to ignore the nurse's behaviour to avoid such issues and complications.

All respondents who used the clinic had said that they wake up early to get to their local clinic but they stated that they were usually gone from the clinic by lunch time, between 12:00 and 13:00. For them, this showed that the services were provided for fast most times. The respondents had not recorded the amount of time they spent per consultation with a health practitioner but they were pleased with the quality of the consultation they received.

What became apparent in discussions with some respondents is that there was a differentiation of clinic cards in terms of colours. There were different coloured clinic cards for people who took treatment for HIV/AIDS to those who generally used the clinic. For these respondents, this was some form of victimisation as everyone who attended the clinic would see that one is specifically in the clinic to receive their HIV/ AIDS treatment. This was something some of the respondents were not happy with. This is not directly related to access but an interesting point that was raised by the respondents. To some extent, it may affect access where people who are HIV positive may be sceptical of receiving their treatment from a public clinic as they will be stigmatised due to the coloured card system. This point then goes back to the acceptability of access in Jacobs et al (2012) where user (or potential user) attitudes and perceptions can change how a service or facility is used.

Private sector provided service

With regards to the use of services from the pharmacy, some respondents (especially from Phase 1) were not aware that a pharmacy exists in the township. Those respondents had stated that they use pharmacies from town when they needed a pharmacy.

For most respondents, the issue of high costs from private sector provided services, with particular emphasis to GPs and private hospitals, was their main issue. A respondent who once used a local private clinic complained about the amount she had to pay in order to receive similar services to the locally available public sector clinic, located in Dobsonville. However, she stated that the amount paid at the clinic was not as high as a consultation with a GP.

Some respondents had stated that they had previously used private sector providers, a GP. However, what they noticed was they had paid for a consultation with the doctor and also had to pay a certain amount of money outside of the doctor so as to get the required medication that is prescribed by the doctor (if and when they have a prescription). For these respondents this was an inconvenience as they had to pay out of their pockets for the consultation as well as getting the prescribed medication. This scenario is different from when they use a public sector clinic or hospital as consultation is free and one only pays when they receive a prescription, if they receive one.

With regards to both public and private sector health care providers, respondents had stated that if they did not have money for a taxi, it became difficult for them when they were severely sick. Most respondents from Phase 2 had responded that they walk to the clinic in Dobsonville but their ability to walk to the clinic was determined by their degree of sickness as well as weather conditions among other things. For example, if it was raining, they would not be able to go to the clinic if they had not had sufficient funds to get a taxi that will take them to Dobsonville. If they were too sick to a point where they felt weak, they will also not be able to walk to the clinic. An elderly woman who suffers from arthritis also stated that if her arthritis is bad, she will not walk to the clinic. Essentially, the most used clinic is close by but residents also have personal constraints with regards to getting to the clinic, especially with regards to financial costs as most of these respondents did not have formal employment.

4.1.5. What satisfies residents with their health care facilities?

As stated in earlier sections of this chapter, most respondents use a public sector provided clinic-the Itereleng clinic in Dobsonville. Most respondents who used this clinic were happy with the services provided although they had stated that they have to wake up in the early hours of the morning to gain access to the clinic. This was because many people used the clinic so getting to the clinic early meant that those who arrived early will be responded to sooner and get to leave earlier as well. Most respondents said that they had never had to leave the clinic after 13:00 noon although the services would be slow at times.

Some of the respondents had said that they were happy that they received all the medication and treatment they needed. Some of the residents were happy with the routine tests that are done at the clinic; the routine test includes a HIV test, blood pressure and a pregnancy test. For them, the routine test had made them more aware of their current state of health, especially with regards to blood pressure.

One respondent who had access to a medical aid was happy with his GP and the hospitals he usually went to. According to this respondent, queues were not his concern when he had to see a doctor or go to a hospital and he got good medical care whenever he had to go to a hospital. This respondent still resides at “home” and has a family that happened to do renovations and extend their original RDP house. Essentially, this family would be said to have moved up in their income levels over the years.

Approximately three of the 14 respondents had directly used hospitals, for them, the public hospitals they used attended to their needs and they had not experienced complications or victimisation. For these respondents, a lot of doctors were available at hospitals as compared to the clinic hence they had rather used the hospital directly than a clinic. This was because of the need for specialised services such as skin doctors and dentists.

4.1.6. Preferences in accessing services

From the gathered data, most respondents (12 out of 14 respondents) in Bram Fischerville had used a public sector provided clinic although some residents had

preferred to use other means such as pharmacies. When respondents did not use the local clinic, they mainly used local shops and pharmacies. Their reasoning for not using the local clinic was mainly due to their levels of sicknesses, for example, four of the respondents said that they do not go to the clinic when they show flu symptoms such as a fever and blocked nose rather, they opt to get self-medication from the nearby shop or the nearest retail store.

With regards to the use of public clinics, most respondents considered clinics as having some problems such as long queues, as previously mentioned. However, the respondents preferred to continue to use the public sector clinics as they received sufficient medication and quality consultations. Most of this respondents mentioned how they always received the medication they needed, especially when it came to child care services such immunisation and child related illnesses. However, the elderly respondents stated that they did not always received sufficient medication, especially with regards to pain killers. One of the elderly respondent who suffers from arthritis stated that she was given 15 pain tablets and told to half them so that they could last her for longer as the clinic was running short of supply.

Of most importance, the clinic is close enough to walk for some residents and offered services free-of-charge, meaning that it is more accessible to a wider range of patients who are in need of certain services on a regular basis. However, it should also be noted that transport costs in the local vicinity is around R8 a taxi trip to the clinic, of which some residents do not usually have some days. Four out of 14 respondents preferred to use hospital services rather than clinic services as they said hospitals offered a wider range of services than the clinic. These respondents had preferred to use the hospital directly as their illnesses required services from specialised professionals which are mainly available at district hospitals. Two of the four of these respondents used Hamberg Hospital in Florida as it was closer to them and offered them better services, of these two, one needed help with a caesarean section she had a number of years ago and the other needed assistance with ENT (Ear, Nose and Throat) specialisation that was argued to be in relation to his old age. Another respondent had used Chris Hani Baragwaneth Hospital for her child as her child suffered from a severe skin condition, eczema. The forth respondent had used Helen Joseph Hospital as her child also suffers from a skin irritability problem.

With regards to the preferences of services between male and female respondents, most male respondents had not used clinics or hospitals, rather, preferred the use of over-the-counter medication from the pharmacy or local shop. Females mostly used services from the clinic, the services they seek included reproductive health, treatment for chronic illnesses as well as child care such as immunisation. It could thus be deduced that females in this study needed and used health facilities and services more than their male counterparts, especially when they are between the ages of 20 and 40.

From the interviewed respondents, one respondent had used a general practitioner when in need of health care services as compared to the use of clinics. This respondent used the GP because they had access to a medical aid and the usage of the GP was convenient for them because they used the GP when needed, at a time they are available at. For accessing the GP, they had to make appointments by telephone or directly visit their GP when the wanted to. Their GP is located outside of Bram Fischerville but they did not mind travelling to their GP as they (him and his family) had used this doctor for a number of years.

According to one of the older respondents, the GPs gave “stronger” medication as compared to public clinics, especially when her health was in a critical condition. For her, clinics usually gave one limited medication hence she used the GP (if she afforded it) when her health was in a worse state. For example, she stated that she would get about 15 pain killers to use for a month, nurses would instruct her to break them into half so that they last longer. The idea of “stronger” medication comes from the notion that, when one uses the same time of medication for a long time, it later becomes resistant in preventing the ailments one suffers from.

4.2. Analysis of findings in relation to literature

According to the National Planning Commission (2009), South Africa is facing a quadruple burden of disease; HIV/AIDS and TB, violence and injury, the spread of NCDs as well as maternal and child mortality. Most respondents in the study had mentioned their health concerns related to NCDs as well as child illnesses and vaccination. Because the study had not tried to focus on interrogating what diseases and ailments that people suffered from, respondents might have held back on sensitive issues such as violence and HIV/AIDS, rather, mentioning the prominence of NCDs.

The conclusions from the NPC (2009) cannot be clearly linked to this research or the township of Bram Fischerville as it could be assumed that the respondents were not very comfortable to discuss some issues such as HIV/AIDS and violence.

With regards to the notion of access, affordability can be argued to be the biggest barrier of access among the respondents. Most of the respondents had predominantly used a public sector provided clinic due to high costs of private medical care. GPs and a private clinic exist in Phase 2 of the settlement but deducing from the responses of the respondents, these facilities were not usually used as they were deemed them as expensive for the interviewed group. As argued by Jacobs et al. (2011), costs are a limitation and a barrier to accessing better health care services. As with the older respondents of this study, respondents believe that private doctors give “stronger” medication as compared to the public sector clinic but they cannot regularly gain access to a private doctor due to high costs. However, most respondents using the Itereleng Clinic in Dobsonville felt that they generally received good service.

When considering the geographic dimension of access, the respondents had not been severely affected by this. The clinic they used is quite close to them but the issue was mainly related to money for transportation, especially for residents who are unable to walk to the area. The aspatial aspects of age and level of sickness in relation to geographic access had been the main concern (Lou and Wang, 2003; Paks and Butler, 2012). Respondents stated that they could not access the clinic if they were severely sick or did not have money for transportation although the clinic is quite close to them. Essentially, although geographic access is not an issue, aspatial dimensions of access such as level of sickness are major determinants of accessing health care services.

What also became prominent with older residents was that they could walk to the clinic without that much fear as the settlement has grown and more people were visible on the street. This relates to the benefits that the settlement and population growth brought to residents of the township. This is not necessarily an improvement in infrastructure but an element of safety to navigate the township as well as to gain access to the required services one needed. It was unfortunate that this element of feeling safe could not be fully explored because of time constraints, for example, if people were able and felt safe to get to the clinic in the late afternoon or in the morning.

However, from the respondents, most people accessed the clinic in morning and some had even walked in the morning, this could further expand that clinic goers felt a certain level of safety as there would be a number of people going to the same clinic at the same time of the morning.

When it comes to the functions of the South African health system, it could be argued that most health facilities were improved post-apartheid and the enforcement of the district system is functional. The older respondents had stated that there are available emergency services through referrals from the clinic to the hospital, this was based on the referral system. This was aligned with the functioning of the district health system explained in Cullinan (2006). According to some of the respondents, emergency services such as ambulances were not always available as there are only two or so ambulances that operate under the Itereleng clinic. The ambulances are usually attending elsewhere when they are not available although this is particularly seen during the months of December where people mostly require emergency medical services. This could be deemed as insufficient when the clinic has to service three and more settlements as well as feed more than one hospital when a crisis took place.

Deductions from the study point out that women of various ages are the ones who require most health care services and these women continue to use health care services through their various life stages. Ten of the 14 respondents had been women who used various health care services; they needed reproductive care, treatment for chronic illness as well as children services such as immunisation. This trend thus shows why most of the case studies that relate to settlements, especially low income settlements focused on the needs of women as well as their experiences. However, as males aged, they also need certain levels of health care services as one of the older male respondents had stated that he often requires eye and ear care from time to time. From this study, it could be said that at different ages, people will require certain health care services.

The DoH needs to put more emphasis to reaching out to the majority of people, especially those who use the public health sector as seen through the respondents. As argued by Edmeston and Francis (n.d), the public health sector is the cornerstone of the national health system as most people use and depend on it. These scholars further emphasise on the putting more focus on Primary Health Care (PHC) as it is the

provider of basic services. In my view, this could be through improvements in education and awareness programmes in low income settlements such as townships and “informal” settlements. This would be to expand knowledge through preventative means that seek to curb and better manage lifestyle diseases that may be prevalent in such areas, as noted by Puoane et al (2007).

The improvement in child health services could also be said to increase regular clinic visits for children during their early childhood stages. Parents are more aware of the importance of immunisation and they are pleased with the availability of such services as some respondents stated that during “their” time, vaccinations were not something as prominent. This could be argued to be strides taken towards the revitalisation and improvement of health care post-apartheid, this also shows how widely accessible certain services have now become.

With regards to services providers within the township, two sectors were prominent, the public and private sectors. This relates to the point mentioned by Jobson (2015) that these two sectors are the most prominent and the NGO sector is a third sector in health in the country but is not that prominent. This point was further seen in this township as there was no mention of NGOs dealing with health issues were mentioned by the respondents or seen within the vicinity of the township. The lack of availability of NGOs within the township may relate to the work NGOs usually focus on, HIV/AIDS as well as TB (Tuberculosis) patients (Jobson, 2015). With this regard, the respondents had little mention of sicknesses related to HIV/AIDS and TB or it may be a bias that may be seen from NGOs where they focus on prominent areas such as Alexander and Hillbrow (this being based on observation).

From the preferences of the respondents, it could be argued that there is not much choice when it comes to certain services. Most of the respondents had gone to a public health facility because they do not have that much of a choice (especially financially). As argued by Jacobs et al, (2012) and Angier (2014), affordability is one of the biggest barriers to accessing health care hence the public health sector could be deemed as of importance in South Africa so as to assist in promoting access for the poor and those who cannot afford private health care (especially GPs and specialists in private hospitals).

From the respondents in this study, women who accessed health services from the clinic did not state any form of discrimination like that stated in O'Reilly and Washington (2012). This was maybe because they stayed in a more established settlement than an "informal" settlement which had shown to be attached to some level of stigma from O'Reilly and Washington (2012). What could be similar with the experiences of residents in this study and that of O'Reilly and Washington is that women are the main users of health services, whether it is for the need of their children, sexual and reproductive services or the need for chronic illnesses. What this study also gave insight to is the demand of health services among women of different ages, especially the ages between 20 and 40.

What also stands out from the study is the strides taken by the South African DoH, especially in comparison with other African countries. This is with particular emphasis to reproductive and sexual health care, especially among women. However, the progress with regards to reproductive health is prevalent at clinics and there has not yet expanded to other primary sources such as schools and communities through programmes. This then shows that the sphere involving community participation still needs to be enhanced in order to fully explore the prospects of PHC. As stated by Jurberg (2008), PHC is one of the core pillars of an efficient public health system.

With regards to the growth of the settlement, little has been changed, from the side of state interventions besides the renovations of the Itereleng clinic. As argued by Boyko and Cooper (2013), densification in an area is supposed to increase the provision of certain amenities, however, Bram Fischerville tells a different narrative. For example, from observations, people with disabilities that need to access health services can hardly be taken to the nearest clinic (if the family has limited financial support) due to poor roads that are characterised by gravel. The area also does not have alternative ways to provide services for the elderly community who are not able to physically go to the clinic for monthly treatments, what was seen was the availability of HIV testing stations in some areas of the settlement on some days, for example, around the Spar vicinity. Drives and initiatives that attempt to address other health issues such as the elderly to receive treatment as well as to cater for the disabled were not present. This further perpetuates the limitations of accessing health care services for such vulnerable groups.

4.3 Conclusion

To conclude the chapter, from the respondents in these findings, it can be seen that most users of health care facilities are women and children. One of the interesting aspects that this research wanted to look at while conducting the field work was the extent to which male respondents used health care facilities. What became prominent was the predominance of female users, either for their own personal well-being or to assist their children or younger relatives. The male respondents from this research had not even been care-givers or responsible to take their younger siblings to health care facilities. This finding posed a thought of whether males do not need health services or they are not well aware of the needs for health care or believed that they felt strong to go to health care centres.

From the two chosen sections of the settlement, it can also be seen that density may have played a critical role in Phase 2 of the settlement. Phase 2 had shown to have a varied number of health care services provided for the residents, this may have been due to the increased number of people residing in the area or because the area is central in terms of location and further making these residents have a wide range of health services providers that are accessible. From observation, the area seemed to have more backyard shacks and rooms as compared to Phase 1.

5. CHAPTER 5: CONCLUDING REMARKS

This chapter seeks to conclude the report, respond to the question of what this research means for the planning profession as well as to reflect on the research study as a whole.

5.1. What does this research study mean for the planning profession?

The notion of density is important to consider when there is a development of new settlements, especially with regards to the delivery of infrastructure. Density is of particular relevance as developers can anticipate the threshold of services to be provided.

What this research has given insight to is that the notion of density and the effects (both positive and negative) of densification in the township are slowly becoming evident in relation to issues related to health services and access to such services. The growth and expansion of the township has not yet shown positive effects in relation to infrastructural improvements such as roads but has shown to increase safety. For example, as the settlement grew, people felt safer to walk in the streets at various times of the day. The services offered in the local and most used clinic have expanded, this could be considered to have been an effect of large usage that relates to the growing population density as well as the need for health services. The majority of the respondents also have a good geographically located clinic that offered services freely that they were pleased with. Considering the four dimensions of access, people's overall access has been largely good.

What urban settings such as townships represent is, to some extent, the urbanisation of poverty as most respondents stated that they were unemployed, employed in the informal economy (street trading, piece jobs such as gardening and house helping) or are dependent on state subsidies and grants (see Annexure 3). According to Tibaijuka (2006), planners should thus attempt to find strategies that seek to address such urban realities, especially at a time where the country is argued to face a quadruple of disease including HIV/AIDS, NCDs, maternal and child mortality as well as violence. Townships should also be areas of study that are explored by scholars as they represents harsh socioeconomic challenges and are sites of residence for a large number of people in the urban landscape. Places of residence for the urban poor that

need to be considered for developments that promote social and economic development should not only be “informal” settlements but townships as well.

5.2. Reflections to the research study

The fieldwork had been mainly an interesting experience, especially considering that the author had drafted the questions herself and the research was to fulfil her individual work. To some extent, it gave insight to some level of growth and progress with the author’s academic work.

Limitations and lessons of the study

In the initial stages of conducting interviews as well as observation through the area, most health service providers were difficult to identify, especially those that can be deemed as “unconventional” such as traditional practitioners. These practices did not have banners or signs on the outside identifying which services they offered as well as how often they are available. These made it difficult to recognise the various types of services that are available to the public.

However, there seemed to be evidence of other alternative “unconventional” methods on posters on street lights, these included services by certain doctors that offered services in the termination of pregnancy and penis enlargements. These types of doctors could not necessarily be trusted, from a personal opinion as there have been stories in the media about backyard practitioners robbing people of their money.

With regards to the time at which the research study was conducted, it was close to election time (late July and early August). Most people in the township had been reluctant to talk to us as a group of researchers as they believed we were affiliated with certain political parties that were part-taking in the local elections. This made it difficult to conduct the research in some areas, those people who were willing to respond to the research interviews usually asked what would be in return for them before the interview had been conducted. However, some individuals were willing to assist in the research once they found out that it was for purposes of school and nothing else. Some individuals had even gone as far as saying that they are assisting in the research because they have younger siblings who are in university who might need such help from other people hence they would also help in part-taking in exercises related to work of academic work.

With regards to the content of the research, the interview questions had to be reworked as the mock interviews showed that the initial questions where not in-depth enough. Some questions were not thought of until they were raised in the field by responses that were given by the respondents. This showed how much fieldwork was a work in progress and a learning experience. The study also fell short on focusing on the supply side- the health professional at ground level. The focus on the supply side was mainly from published documents, this was mainly due to time constraints as well as the scope of this research that this perspective was not explored. To some extent, this aspect would be enriched if some engagement was done with workers from the clinic and some doctors who run the GPs in the area.

What this study also gave insight to is that some post-apartheid townships still resemble characteristics of the highly criticised apartheid townships. Bram Fischerville has not shown to be an image that has been instilled in me of post-apartheid townships and settlements such as Cosmo City.

5.3 Conclusion

To conclude, from the findings and literature, South Africa has taken strides to make improvements in the health system as compared to other areas of Africa. In terms of promoting access to the majority of South Africans, improvements have been in hospitals by adding advanced specialised services such as radiography, dentistry and optometry in hospitals such as Chris Hani Baragwaneth. According to Econex (2013), the Department of Health (DoH) has also worked with universities in order to promote students to take careers related to health and thereafter, to work in public hospitals. Areas such as townships and rural areas have access to primary health care facilities such as clinics and health care centres. This goes to show the effort put into improving access to health care, especially towards the poor.

From the findings, some respondents have stated that there are other medical services such as regular vaccination and improved family planning services that were not available when they were younger in public health facilities. Although there is a lot of complaints written in the media about the ill state of public sector facilities, most respondents from this study were satisfied with the services from the public clinic they used. The major concerns they had were related to long waiting times and insufficient medication at times, however, there were no issues with consultation and the services given by the health practitioners in the clinic.

With regards to Bram Fischerville, the residents are able to access a wide range of health care services and at reasonable distances from their place of residence. Based on this, the biggest dimension of access which is geographical access does no hinder how the majority of residents get to their health facilities for services they need.

The growth of Bram Fischerville (in terms of population density) has also shown to be a positive contribution to the users of the clinic, especially in the mornings (the time they usually attend the clinic). The Itereleng clinic had also improved services, perhaps this could be related to the population growth and the number of people using the facility. In general, the respondents of this study have been happy about the services they receive in their health facilities, which are mainly public sector facilities. It should also be stated that these findings may be completely different in other settlement of this nature. However, observing from the discussions with elderly residents, some form of assistance as to how they receive their monthly treatment could be considered as an alternative. As stated by another respond, a program they had begun to assist the elderly had failed although there is a need for additional assistance towards the elderly. A program such is that started by these community members could be expanded and supported so as to reap better results within the community in the future.

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8. ANNEXURES

Annexure 1: Copy of Ethics Clearance Certificate

SCHOOL OF ARCHITECTURE AND PLANNING
HUMAN RESERCH ETHICS COMMITTEE

CLEARANCE CERTIFICATE
PROTOCOL NUMBER: SOAP71/24/06/2016

PROJECT TITLE:	Accessing healthcare services in townships, the case of Bram Fischerville
INVESTIGATOR/S:	Siphosethu Gwabeni (Student No. 560984)
SCHOOL:	Architecture and Planning
DEGREE PROGRAMME:	BSc Honours Urban and Regional Planning
DATE CONSIDERED:	18 July 2016
DECISION OF THE COMMITTEE:	APPROVED
EXPIRY DATE:	18 July 2017

CHAIRPERSON
(Professor Daniel Irurah)

DATE: 18.07.2016

cc: Supervisor/s: Sarah Charlton

DECLARATION OF INVESTIGATORS
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to endure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

S Gwabeni 19/07/2016

Annexure 2: Sample of interview questions

Siphosethu Gwabeni Interview questions

General demographics

- Gender female ☐ male ☐
- Age 20-30 ☐ 31-40 ☐ 41-50 ☐
- How long how you been staying in Bram Fischerville?

- Where are you originally from?
- How many are you in the household?
- Does anyone in the household work? Who works and what type of work do they do (informal or formal sector)?

A. Available health service providers

1. Do you regularly use private or public sector provided service?
2. Which service providers offer better services for you, state provided or the privately provided and why?
3. Do you use other service provider besides the one you use?
4. If so, what is the difference between the two and why do you prefer using the one you use?
5. Which are the facilities that you usually use from these providers?
    - Clinics, hospitals, GPs etc?
6. Would you refer someone else to the facility you use, why?
7. Are there any other methods that you use to access health services besides the usage of clinics/ pharmacies/ hospitals?

B. Various health services and their availability

1. Are there any facilities that offer specialised services (dentistry, optometry) that you can access around Bram Fischerville?
2. If not, where do you usually go and how do you get there?
3. Which facilities do you usually use, why those specifically?
4. When is it an appropriate time to go to the above health facilities and why?

C. Demand of services

1. Which services are most vital for you/household and how often do you seek access for them on a regular basis?
2. Which member of the household usually needs the services you use?
3. What types of services are offered in the facility you use and how wide are the options offered in the facilities you go to?
4. What are you currently happy with, with the facilities you use?

D. Difficulties and ease in accessing health services

1. How do you get to the facility and how much time does it usually take you to get there?
2. What do you have to do in order to gain access to the health services you need?
    a. Do you make appointments?
    b. Do you need to have certain types of documentation?
3. How would you rank the services, in terms of satisfaction?

4. Do you have access to a medical aid or other type of health insurance?
5. If no, would you still continue to use your current facilities if you had a medical aid?
6. If you have a medical aid, are there services that you cannot access with it and what types of services are those?
7. What benefits does the medical aid give you and what do you do when it gets exhausted, if it does get exhausted?
8. If you had a medical aid, would you use the same provider? If not, why?
9. What problems do you usually encounter when accessing health services?
    a. Lack of nurses or doctors, long queues etc.?

Annexure 3: Summary of findings

Gender	**Phase within Bram Fischer**	Age	Provider and facility usually used	Regular illness	Type of dwelling	Employment
Male	1	Over 40	Hamberg Hospital(Public)	Teeth and ears	Old RDP house (beneficiary)	Unemployed, depends on elderly grant
Female	1	Between 30 and 40	Helen Joseph Hospital(Public)	Child with skin problem	Backyard shack (renting)	Formal employment
Female	1	Between 30 and 40	Itereleng Clinic (Public)	Reproductive care and child immunisation	Old RDP house (stays in family RDP house)	Unemployed depends of rental payment and child grant.
Male	1	Between 20 and 30	GP in Kagiso (Private)	Flu and minor ailments	Bricked and extended RDP house (his home)	Formal employment
Male	1	Between 30 and 40	Itereleng Clinic (Public)	Flu and minor ailments	Backyard room in family RDP	Depends on piece jobs (informal employment)
Male	2	Between 30 and 40	Pharmacy (Private)	Flu	Bricked backyard room (renting)	Formal employment
Female	1	Between 30 and 40	Itereleng Clinic (Public)	HBP Treatment	Old RDP house (stays in family RDP house)	Unemployed(depends on rental payment and piece jobs)
Female	1	Between 30 and 40	Itereleng Clinic (Public)	Child immunisation	Backyard shack (renting)	Informal employment

Female	2	Between 30 and 40	Hamberg Hospital (Public)	C-section complication	RDP house (renting)	Self-employed: sells in a stall (informal employment)
Female	2	Between 30 and 40	Itereleng Clinic (Public), Leratong Hospital	Chronic disease (HBP and diabetes)	Backyard shack (renting)	Formal employment
Female	2	Older than 40	Itereleng Clinic (Public), Pharmacy (Private)	Arthritis, HBP and child asthma	RDP house (beneficiary)	Unemployed depends on support from children and old age grant
Female	2	Between 30 and 40	Chris Hani Baragwaneth (Public)	Child with eczema	Backyard shack (renting)	Employed
Female	2	Older than 40	Itereleng Clinic (Public)	Child immunisation	Old RDP house (stays in family RDP house)	Unemployed (depends on rental payments)
Female	2	Older than 40	Itereleng Clinic (Public)	HBP Treatment	RDP house beneficiary	Unemployed depends on support from children