Exploring primary healthcare services for informal workers: a case of South African women informal/ street traders in the City of Johannesburg Region F

by

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DECLARATION

By submitting this research, I Duduzile Ellen Dube (student No. 1774938) declare that the entirety of this research report titled "*Exploring primary healthcare services for informal workers: a case of South African women informal traders in the City of Johannesburg Region F"* is a record of work I created myself. All other information obtained from literature and quoted have been duly recognized in the report and a list of references provided. The research report is submitted in partial fulfilment of the requirements for the degree of Master of Management in the field of Governance (Public and Development Sector Monitoring and Evaluation) with the University of the Witwatersrand, Johannesburg. The results embodied in this study have not been submitted to any other University or institution for any degree, diploma, or examination.

Signature: 

Date: March, 2023

DEDICATIONS

First and foremost, I devote this undertaking to God All-powerful my Maker, my solid support point, my wellspring of motivation, information and understanding. Throughout this project, He has been my support, and I have only soared on his wings. Great is thy faithfulness!!!

Next, I dedicate this research study to three loved ones who have meant a lot to me and will continue to. Even though they are no longer here, my life is still governed by their memories. To my eternal cheerleader and never fading memories of my beloved mother the late Rachael Lillian Dube (Ma'am Dube) an education champion who instilled in me the value of education. I hope this makes you smile *'Ray',* I know you believed in all my dreams, and I owe it all to you mama. The best mother.

My paternal grandfather the late Boy William Dube whose unwavering devotion to me knew no bounds, who taught me the value of hard work and created ever growing interest towards mysteries of a living world in my mind. Sincere gratitude *'Baba'* forever in my mind and heart.

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ABSTRACT

It is important for research to understand the lived and perceived primary healthcare (PHC) access and health seeking experiences for women informal traders. This is a population that occupies the lowest end of the social gradient of the informal labour market and is prone to various forms of social exclusion. Good health is a key asset for women informal traders. In South Africa (SA), they also have rights of access to health/ healthcare, as Section 27 of the Republic of South Africa (RSA) Constitution shows, the state is obliged to provide minimum healthcare to citizens. Globally, access to healthcare remains an imperative right for all, irrespective of the sector in which one is employed – formal or informal. This study aimed to explore South African women informal traders' experiences in seeking and accessing PHC services. The study also explored women informal traders' use of Social Rights of Citizenship (SRC) in meeting their healthcare needs, in the context of local government.

This qualitative study employed is rooted in a phenomenological design. Narrative data were gathered through four, sex stratified Focus Group Discussions (FGDs). A total of 28 participants were recruited through using non-probability purposive sampling method. Data was gathered using a semi-structured FGD interview guide and observations.

Most participants recounted negative reports of PHC seeking and accessing experiences. Furthermore, the women did not identify or attach any meaning to the SRC in their health seeking behaviours.

The study's findings suggest that South African women informal traders experience conditional citizenship in their health seeking behaviours. The conditions can be observed in relation to challenges in: access, use, experiences, and participation. Women informal traders also face difficulties in enjoying their freedoms, SRC, and responsibilities in relation to PHC services. This is despite SA's ambitious free health for all policy. It is important that the government adopts mechanisms to ensure and maintain positive and quality healthcare throughout all primary care centres to realise RSA Constitution Section 27 to preserve SRC in healthcare provision, and instil confidence on health service users.The study recommends social inclusion of women informal traders into the wider society. One way to achieve this is through ensuring

adequate access and improving women informal traders experiences when seeking PHC services.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS:	Acquired Immunodeficiency Syndrome
CBD:	Central Business District
COJ:	City of Johannesburg
COVID-19:	Corona Virus Disease of 2019
DED:	Department of Economic Development
DRC:	Democratic Republic of Congo
FGD:	Focus Group Discussion
GDP:	Gross Domestic Product
GP:	Gauteng Province
HIV:	Human Immunodeficiency Virus
HSRC:	Human Sciences Research Council
ILC:	International Labour Conference
ILO:	International Labour Organisation
JICP:	Johannesburg Inner City Partnership
MDG:	Millennium Development Goals
NDP:	National Development Plan
NHI:	National Health Insurance
OECD:	Organisations for Economic and Co-operation and Development
PHC:	Public Health Care
PHC:	Primary Healthcare
RSA:	Republic of South Africa
SA:	South Africa
SAMJ:	The South African Medical Journal

SDG:	Sustainable Development Goals
SDH:	Social Determinants of Health
SRC:	Social Rights of Citizenship
UHC:	Universal Health Coverage
UK:	United Kingdom
UN:	United Nations
UNICEF:	United Nations International Children's Emergency Fund
USAID:	United States Agency for International Development
WHO:	World Health Organisation
WIEGO:	Women in Informal Employment: Globalizing and Organizing

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CHAPTER ONE: INTRODUCTION

1. Introduction

South Africa (SA)'s state funded public healthcare system is argued to accommodate the bigger population of people living in the country (Mohapi & Basu, 2012). The government intends to be inclusive of those who cannot afford medical insurance, the unemployed, and those informally employed (Mohapi & Basu, 2012). Coovodia et al.'s (2009) study observed that SA's healthcare system and health service delivery are characterised by inequality, violence, gender, and racial segregation. White supremacy and racial segregation are central in SA's politics and health services history. For example, the contentious 1913 Natives Land Act imposed forced removal of Black families from their native land, to reside in the Bantustan. Thus, making it difficult and illegal for Black people to live as cultivators in the 90% land mass that was appropriated by the White minority regime. This consequentially limited the land ownership for SA's Black majority population.

However, there is still an absence of logical and systematic data which hinders the attempts to argue for the remaining health vulnerabilities of those who are poor, socially marginalised, and neglected in urban settings. The current study aimed to explore women informal traders' precarity, regarding their access to primary healthcare (PHC) services in the City of Johannesburg (CoJ), Region F (inner-city). Thus, the study focused on access to PHC services and health seeking experiences for precarious social groups, women informal traders. The study also explored the implications of this phenomenon on the Social Rights of Citizenship (SRC) as enshrined in Section 27 of the RSA Constitution and obliging the state to provide minimum health, education, and welfare services to citizens.

What is currently known is that public PHC services are under immense and increasing pressure. Therefore, the government tends to refer to the streign and justify its failure to properly meet its statutory obligation to provide the healthcare needs of many living in SA.The current study explored access from the user's (patients) perspective (Peters et al., 2008; Reibling, 2010).

1.1 Background

This study focuses on the health of South African (SA) women informal traders. Globally, informal trading is dominated by women and youth. In the sub-Saharan Africa context, the informal sector makes up more than one-half of total non-agricultural employment. It constitutes 66% of employment in sub-Saharan Africa and 82% in South Asia (ILO & WIEGO, 2013). Africa and Asia are urbanising at a rapid pace, and this is linked with increasing rates of rural-urban migration and increase in natural population. The rapidly expanding urban areas are economic growth hubs, but here there are also large marginalised groups who are subjected to abject poverty and have limited prospects for formal employment. Hence, there is continuous increase in informal labour market In recent times the increase in informal labour market has resulted from various developments such as the world economic downturn, diminishing growth in formal employment, globalisation and the repercussions of the COVID-19 pandemic.

More than one-half of the informal workforce in many developing countries is self-employed – in which street trade is one of the most obvious and visible occupaion (Roever & Skinner, 2016; Vanek et al., 2014). Davies and Thurlow (2010), argue that in SA informal trading makes up to 7% contribution to the national Gross Domestic Product (GDP) and 22% of total employment in the country. Nevin (2004), argues that in SA, informal trading generates up to 32bn year-on-year. Therefore, informal trading may be serving as a means of much needed employment for many in SA.

Many global cities are influenced by global economic trends that are informing the informal trading activities. Informal trading is the act of trading legal goods and services outside clear national rules and regulations (Lyons & Snoxell, 2005a; Moore, 1995). In most cases, informal trading activities are governed by the local authorities – such is the case in Johannesburg inner-city, where the study was conducted. SA's local authorities are legally bound by the national Constitution, to set forth an enabling and suitable environment for constituents to secure decent living standards and advance development (Constitution, 1996). Furthermore, the Constitution stipulates the government's obligation to deliver comprehensive healthcare for all. To ensure comprehensive healthcare for all, government authorities need to have a comprehensive understanding of the accessibility and various population groups' experiences when using the PHC services.

Activities in the informal economic sector, such as informal trading, allow social precarious groups, in urban and rural areas, an opportunity to earn a living (Bhowmik,

2005). An important observation is that local government is a key stakeholder through which informal traders negotiate, but this is not the case with other informal economy's sub-sectors. In addition, Steel (2008) argues that here is a clear link between the informal economic sector and urban poverty. From this connection, literature has coined the ideology of the urban working poor.

Precarity has become a common feature in contemporary democracies such as SA. The scholarly debates on precarity are divided into two approaches: (1) those who view it in the context of work or labour such as Standing (2011) who argues that precarity is a continued state of insecurity where matters of employment and/or income are concerned and (2) those who view it in a broader life discourse such as Barchiesi (2011). The orientation utilized in the current research is that which views precarity in the context of work, whose argument is based on wide ranging and rapid changes in the global labour market. This orientation considers globalisation and lays emphasis on the flexibility of labour markets, privatisation, deregulation, and flexible employment relations. Thus, precarity results from a "fundamental change in the nature of work leading to a fragmented and uneven labour market consisting of work that is often precarious, lacks benefits and has low wages" (Webster, 2006:1).

Precarity directly informs the difficulties that are faced by informal traders in securing adequate public provisions such as healthcare services. Informal traders are exposed to extreme health hazards that are associated with their occupation. Moreover, women informal traders are at higher danger of cumulative exposure to numerous occupational threats resulting from their non-specific work undertakings (Amegah & Jaakkola, 2014). For example, maternal health is adversely affected by physical exhaustion, abuse, and inherent stress that is associated with informal trading activities (Emmanuel'O et al., 2012). Consequently, accessing healthcare through the public healthcare sector is important for the health outcomes of these social precarious groups. This claim is supported by Dunga (2019), who argues that women's needs for primary healthcare are inevitable because of reproductive encounters and chronic illnesses.

The present study also wanted to understand the effectiveness of Section 27 of the RSA Constitution in informal traders' realisation of the SRC by meeting their social needs, such as, PHC services. In this regard, social citizenship refers to the government's obligation to provide minimum provision for health, education, and welfare services as an entitlement for citizenship. Feminist scholars argue that, in general, women acquire

political first, followed by civil, and lastly social rights (Lister, 1997). As democracies in developing countries such as SA are transitioning, scholars are channelling debates towards how women are attempting to gain rights through democratisation (Basu, 1995; Jelin, 1996).

In sub-Saharan Africa women are starting to make use of political rights to force governments to advance a gendered approach to reforms (Tripp, 2000). Although there are few traces in studies suggesting that women in transitioning democracies are seeking to improve their citizenship rights, these studies do not explore women's citizenship rights relative to women informal traders' access to and experiences with PHC services.

The current study deliberately focused on women informal traders in Region F inner-city. This is because Region G inner-city has the city's fastest developing informal sector, and women have a greater representation (HSRC, 2015). Through observations and focus groups discussions (FGDs) with women informal traders, this study explored, captured in detail, and understood access and health seeking experiences of SA women informal traders, upon becoming sick or in need of medical treatment in Johannesburg inner-city, in the context of Section 27s constitutional provision on the right to healthcare.

1.2 Research Problem statement

Most studies on informal traders focus on their economic activities and hostility by authorities towards them. Some of the common topics researched in relation to informal traders are evictions, merchandise confiscation, abuse, stringent, and repressive laws (Mbeve et al., 2020; Roever & Skinner, 2016). These studies point to the idea that informal traders are highly regulated and have little-to-no protection. However, there is limited literature that focuses on the informal traders' experiences of accessing PHC services when they become sick. There is also a need for more research that explores the connections between women informal traders' access to primary health services and SRC in local governments.

Informal trading reflects a major shift on how labour markets are being organised in the middle-income economies such as SA. Labour market shifts are significantly influenced by global socio-economic disruptions including the outbreaks of deadly pandemics such as coronavirus 2019 (COVID-19) and HIV/ AIDS (Mbeve et al., 2020; Morse, 1995).

Labour markets are also affected by financial crimes such as corruption and money laundering activities as reported in the public and private sectors. Further, in SA a substantial number of citizens live in poverty due to many reasons, including being a highly unequal society whose Gini coefficient ranges from 0.660 to 0,696 (NDP, 2030). Furthermore, in SA, the apartheid system skewed development and urbanisation processes to the economic disadvantage of the majority (Pick et al. 2002). As such, informal trading emerged prominently as a livelihood and survival strategy for many in the absence of alternative economic opportunities.

Developing countries such as SA have displayed a severe decrease in formal employment yet there is a decrease in work related social benefits. This has resulted in a sharp increase in precarious and unprotected informal work (ILO and WIEGO, 2013). Informal trading in Region F accounts for 24% of informal trading activity in the city (JICP, 2012). The extent of informal trading in Region F inner-city suggests undeniable links between the informal economy and local government. Thus, informal trading is an employment or business that may have substantial implications in shaping the local trading policy. Noteworthy, currently SA does not have a policy framework that governs the informal sector and this prohibits direct legislation for informal trading at local government level.

In 2001, Region F was estimated to have 433 054 people (Census 2001, Stats SA). Region F also has the fasted growing City of Johannesburg (CoJ)'s informal economy. From 1996 to 2011 Region Fs informal trading growth was reported to be approximately at 210% (HSRC, 2015). Further, CoJ's informal trading is composed of traders born locally, internal and international migrants (Arias, 2019; Mbeve et al., 2020; Social Law Project, 2014).

In most countries, women are the majority population in the informal economy (Akinbode, 2005; Brown et. al, 2009). This places them at most risk and vulnerability in the sector (Pick et al., 2002). Previous studies in cities such as Dar es Salaam and Johannesburg have shown that workers in the informal economy sector are subjected to many dangers such as physical, biological, ergonomic, psycho-social, yet they are poorly protected (ILO, 1993; Mbeve et al., 2020). Therefore, the current study was important to conduct, to understand the implications of women informal traders' access to and experiences with PHC services, and the relevance of the SRC in meeting their healthcare needs.

Further, women informal traders' precarious employment status means that their focus is primarily to secure their immediate basic needs, thus, a livelihood survival strategy. Therefore, they are unable to build financial savings and make provisions for their other needs such as health insurance and retirement. As such, most women informal traders are entirely reliant on the public sector services to meet most of their social needs. Research shows that local authorities are yet to consider social protection interventions for informal traders (Linares, 2018). The current study focused on SA women informal traders in Region F inner-city and explored what happens to them upon becoming sick or in need of medical treatment.

The study also wanted to understand the social inclusion of informal traders in the wider South African society – a key feature of which is their ability to access public provisions such as PHC services as a constitutional entitlement. Available literature suggests that informal workers are socially excluded and considered invisible, although their contribution to the fiscus of many economies is recognised (ILO and WIEGO, 2013). The resulting invisibilisation has led to informal traders receiving minimal-to-no attention from decision makers. Hence, the global governments usually do not design systems to mitigate challenges confronting informal workers (Linares, 2018). In SA, literature on labour studies shows that informal traders remain underdeveloped, barely supported, neglected by scholars and labour movements.

Perry et al. (2007), argues that there are instances of exclusionary practices towards informal traders by authorities. Unless highly organised, which is rare for informal workers, they are unlikely to be targeted beneficiaries of policy decisions such as urban development plans (the Growth Development Strategy 2040 [GDS]), programmatic, and representational initiatives by municipal authorities. As such, the integration of informal traders would be a viable pathway for social inclusion and cohesion. One way of realising their social inclusion would be through adequate access and their improved PHC seeking experiences.

Women informal traders in Region F inner-city are well positioned to participate in the current study. This is because Region F inner-city houses SA informal traders who are likely to make use of SA citizenship rights, such as the right to vote. Furthermore, Rgion F inner-city's context has many conditions that are likely to increase the social precarious nature of informal traders – whose situation recently worsened owing to the surfacing of the COVID-19 outbreak (Mbeve et al., 2020).

Furthermore, Region F inner-city offers a much-needed awareness on the development and advancement of SRC in a transitioning democracy such as SA. Thus, transitioning from once having been governed through colonialisation and the apartheid regime. Results of the threats that surfaced under colonial and apartheid rule may possibly imply that women may tend to exercise restraint towards the perceived newly acquired political rights to secure their much needed rights (Fallon, 2003).

1.3 Research purpose statement

The purpose of this interpretive study was to explore what happens to informal traders upon becoming sick or in need of medical treatment in an urban setting, since the working conditions in informal work are unfavourable and a health hazard (WIEGO, 2013). The study aimed to assess access and PHC seeking experiences of SA women informal traders in the context of Section 27's constitutional provision on the right to healthcare. The study also intended to understand if these groups attached any meaning to Section 27 of the constitution in their realisation of SRC, to meet their healthcare needs.

Data on health and health outcomes of informal workers, in urban settings (cities), is not readily available (Horn, 2011). Thus, there is a glaring knowledge gap on the health seeking behaviours of urban informal traders, although there is clear evidence of their unique exposure to health hazards at home and work. The knowledge gap identified on the unique health needs of women informal traders shows how difficult it is for authorities to develop polices and systematic interventions that are contextually relevant. This study contributed to filling this gap and and a body of knowledge in literature on South African women informal traders on issues of access and PHC seeking experiences.

1.4 Research objectives

This study aimed to explore what happens to South African women informal traders upon becoming sick or in need of medical treatment in the CoJ Region F inner-city. The study focused on understanding access and PHC seeking experiences in the context of Section 27's constitutional provision on the right to healthcare. Furthermore, the study sought to understand the applicability of Section 27 of the constitution – thus, if there is any realisation of the SRC for social precarious groups (women informal traders) in meeting their healthcare needs.

Research objectives:

a. Highlight perceptions that South African women informal traders have on accessing primary healthcare (PHC) services.
b. Understand the unique health seeking experiences of South African women informal traders of PHC services.
c. Examine if labour force status that is, employment in the informal economic sector is associated with SRC in meeting the healthcare needs of social precarious groups.

1.5 Research questions

Primary research question:

- What are the similarities and differences in the access and PHC services seeking experiences of South African women informal traders in the CoJ Region F inner-city and how significant is Section 27 of the Constitution in relation to the exercise of social rights of citizenship for social precarious groups in meeting their healthcare needs?

Secondary research question:

- What are the similarities and differences in the access and PHC seeking experiences for South African women informal traders of in Region F inner-city?
- What can be learnt from the contrasting experiences of women informal traders in relation to social rights of citizenship as reflected in Section 27 of the Constitution?

1.6 Significance of the research study

Those who work in the informal sector can only make an income when they go to work (WIEGO). This makes health and healthcare a key requirement to work and generate an income in the informal economy sector. Yet, workers in the informal economy, such as informal traders, are always confronted with hazardous and deplorable working conditions (WIEGO).

The value of the current exploratory study is to contribute and advance the scholarship on precarity, informal trading, access and experiences on public PHC services in Region F inner-city. Furthermore, existing literature falls short in understanding the lived and varied PHC service seeking experiences for South African women informal traders and

the exercise of social rights of citizenship by social precarious groups in meeting their healthcare needs.

The study zoomed in and generated insights on what happens to informal traders upon becoming sick or in need of medical treatment. This study's findings may be used by the CoJ and/or government as directed by Section 27 of the constitution and related frameworks, to endorse adequate health and healthcare outcomes for women informal trader.

1.7 Research organization

This study consists of seven interlinked chapters. Chapter 1 is an introduction. It provides the background, purpose statement, research objectives, significance of the study, research question(s), and the research organisation. Chapter 2 provides an extensive literature review on the concepts that are associated with and relevant to the studied phenomenon, to show the existing research gap.

Chapter 3 discusses social policy as a critical analytical framework, which is the theoretical framework that is underpinning this study. Chapter four (4) discusses the research methods that were used in this study. A multi-faceted approach was adopted for data gathering. This included focus group discussions, using semi-structured interview questions and participant observations. The chapter also outlines the limitations of the study and how these can serve as inputs for further research.

Chapter 5 presents the study's findings and the research setting. Chapter 6 is an extensive analysis of the study's findings. Chapter 7 is the summary and conclusion of the study. The summary assimilates the findings and presents the final interpretations.

CHAPTER 2: LITERATURE REVIEW (CONCEPTUAL FRAMEWORK)

2. Introduction

Citing from the world renowned '*Beatles Group'* song, my literature review journey can be described as a *'long and winding road'* directing me to several interesting sites and detections, unplanned detours/ diversions, look out points, and sometimes what I could say was a feeling of impasse with no destination pre-programmed.

2.1 Informal Sector/ Economy

Broomley (2000) observes that the informal economy dominates several African cities such as the CoJ. Compared to formal economy, the informal economy provides income for the urban poor, and enables adequate provision for cities. However, most African governments and authorities disregard the informal economic sector (GDS 2040, 2007). The expression, informal sector is often used synonymously with informal economy, and this is how these will be used in this dissertation. Most initial literature on informality refers to an analysis by Keith Hart, a British scholar who devised the expression 'informal sector' in 1971. Preliminary work on the informal sector phenomenon focused primarily on two approaches namely, the economic (for example unofficial or black economy) and statistical (for example non-observed economic perspectives of the informal economy) (Hart, 1973).

Defining the informal sector is contentious hence the existing definitions vary (Dell' Anno, 2016; Hart, 1973; ILO, 2021; OECD, 2002). According to Pick et al. (2002), most definitions incorporate the following elements: profit, cash flow, magnitude of the workforce, aspects of management, accounting, administration, and legal status. Even though there are synonymous links between the definitions of informal economy, it remains difficult to develop measures to control the informal sector (Ligthelm & Masuka, 2003: 3; Skinner, 2008b: 228). Arguably, the definitional debates on the informal economy make a significant proportion of literature on the phenomenon. *Table 1,* below, describes the major differences concerning the old and new views on the informal economy (Chen, 2005).

Table 1: Illustration of the old and new views of the informal sector/ economy

Old view	New view
The informal sector is the traditional economy that will wither away and die with modern, industrial growth.	The informal economy is "here to stay" and expanding with modern industrial growth.
It is only marginally productive. It is a major provider of employment, goods and services for lower-income groups.	It contributes a significant share of GDP.
It exists separately from the formal economy.	It is linked to the formal economy – it produces for, trades with, distributes for and provides services to the formal economy.
It exists separately from the formal economy.	It is linked to the formal economy – it produces for, trades with, distributes for and provides services to the formal economy.
It represents a reserve pool of surplus labour.	Much of the recent rise in informal employment is due to the decline in formal employment or to the informalization of previously formal employment relationships.
It is comprised mostly of street traders and very small-scale producers.	It is made up of a wide range of informal occupations – both "resilient old forms" such as casual day labour in construction and agriculture as well as "emerging new ones" such as temporary and part-time jobs plus homework for high-tech industries.
Most of those in the sector are entrepreneurs who run illegal and unregistered enterprises in order to avoid regulation and taxation.	It is made up of non-standard wage workers as well as entrepreneurs' and-self-employed persons producing legal goods and services, albeit through irregular or unregulated means. Most entrepreneurs and the self-employed are amenable to, and would welcome, efforts to reduce barriers to registration and related transaction costs and to increase benefits from regulation; and most informal wage workers would welcome more stable jobs and workers' rights.
Work in the informal economy is comprised mostly of survival activities and thus is not a subject for economic policy.	Informal enterprises include not only survival activities but also stable enterprises and dynamic growing businesses, and informal employment includes not only self-employment but also wage employment. All forms of informal employment are affected by most (if not all) economic policies.

Source (Chen 2005:5)

The current study inclined towards the new view of defining the informal economy because this idea is most suitable for the current nature of SA's informal economy. A significant defining feature of the informal economy is that it occurs outside clear rules and lacks social protection. Furthermore, the informal economy is "not only the

recognition of labour but also the accompanying ways in which the uncertainty of securing a livelihood bleeds into other aspects of life" such as health and healthcare (Parry & Hann, 2018: 334).

Pieterson (1982), argues that the informal sector emerged from the inability of the formal sector to absorb the ever growing populations of people seeking employment in urban areas such as the CoJ Region F. Informal economy is also influenced by instances of a country's heavy taxation and high levels of government regulations. As such, a large number of people tend to find innovative ways to generate their income through employment in the informal sector. In SA there is a high rate of unemployment, in 2011 it was at 34,4 % and had been on the rise since 2000 (Horn, 2011).

The informal economy activities are dominated by informal trading (The Rockefeller Foundation). Many vulnerable urban dwellers resort to the informal economy to secure their livelihood (Skinner, 2008). Noteworthy, employment in the informal sector can be by choice and voluntary for those who have an entrepreneurial spirit (Loayza, 1996). This largely includes owners of businesses who find pleasure in the freedoms that come with self-employment.

Informal traders form part of informal employment. "Informal employees are those who do not have a written contract of employment, are not registered for income tax or value-added tax, and do not receive basic benefits such as pension or medical aid contributions from their employers" (Statistics South Africa, 2011: XVII). Additionally, informal traders include those whose skills set is inadequate to obtain jobs in the formal economy and people whose employment in the formal economy has since been lost. Furthermore, informal traders provide jobs, goods, and services for themselves and other urban residents (Bhowmik, 2005).

In SA, by 2010 about 2.2 million people were employed in the informal sector (Quantec Research, 2011). Proper regulation, legislation and recognition of the informal sector is necessary for poverty eradication, among informal workers such as informal traders. However, the law alone is not sufficient to realise decent work. Informal traders are already likely to be poor. Thus, they can be viewed as the urban working poor (Skinner, 2008). Moreover, informal workers are not adequately positioned to accumulate financial savings for medical insurance and/or pension, compared to those employed in the formal sector (Roever & Skinner 2016). Workers in the informal sector are aware of

the importance and need to save for for their needs such as the medical aid and pension, but this is not feasible for them, because of their low-income. This suggests that they are mostly reliant on government provisions such as PHC services.

The continuous growth of the informal sector in developing countries, suggests that more workers are vulnerable to health hazards and receive unstable income. Since informal workers are usually poor they tend to be found in marginalised areas of urban settings such as informal settlements where they are susceptible to factors such as dangers, varying access to amenities such as clean drinking water, hygiene and ablution facilities, poor access to healthcare services and decent housing. Another key challenge faced by informal traders is the lack of access to medical health insurance in countries that do not provide access to free healthcare or social health insurance. As such, the absence of health insurance or free access to care services translates to out of pocket costs by informal traders to meet their healthcare needs, thus putting more strain on their scanty resources.

Besides the financial obstacles to access healthcare, informal workers must choose between working for much needed income to survive or seek healthcare , thus, the dual implications of seeking healthcare (Maphumulo & Bhengu 2019). In retrospect there is an association between high opportunity cost for care with informal traders owing to many of them seeking care when the sicknesses has escalated, and they are too sick to work (Coovodia et al., 2009). Thus, the sickness may have developed to such a degree that it needs expert care services hence more costly to treat. This explains the importance of public health provision for informal traders who are living in an age of precarity.

2.2 Primary Healthcare Services

The current study focused on access and PHC seeking experiences for women informal traders in an urban setting. The study uses the term access in relation to a person's perception and use of healthcare services, characterised by availability, acceptability, accommodation, and affordability to achieve the best health outcomes in the CoJ Region F inner-city, for women informal traders (Mclaughlin & Wyszewianski, 2002).

The 1978 Public Health Care (PHC) international conference that was spearheaded by the WHO and UNICEF, determined that the root causes of poor health are linked to

poor social and economic conditions (WHO, 1978). The informal sector exemplifies this assertion. The 1978 Public Health Care conference made an urgent call for world governments to expedite the protection and promotion of the health of the people globally (WHO, 1978). This strategy also incorporated other factors such as housing, education, agriculture, provision of adequate sanitation, and clean water (WHO, 1978). This means that, addressing health concerns also involves discussions and implementation of other associated factors, to yield a holistic approach to healthcare service delivery.

The 1978 public health conference put forward the recommendations for a holistic approach to healthcare service delivery because there were detrimental inequalities and disparities in the global population's health status (WHO, 1978). Those who experienced the most detrimental effect were those in the informal sector, thus the social precarious population.

The current study defines primary healthcare services (PHC) based on the World Health Organisation's definition which says:

> *"PHC is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion, disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment"* (WHO and UNICEF 1978).

The sustainable development goals (SDGs)'s agenda 2030 target 3.8 hopes for the world to achieve Universal Health Coverage (UHC).

Keleher (2001), argues that PHC is a public health strategy that is founded on a social health model which is premised on the idea that health gains are enhanced through the fulfilment of people's basic needs first. As such, social determinants factors such as unemployment, access to education, and access to basic living conditions are key in the considerations for PHC strategy for women informal traders. Thus, PHC is beneficial and developmental, because it links health provision to social-economic systems (Dookie and Singh, 2012).

PHC is founded on a commitment to social justice, equity, solidarity, and participation (WHO 2011). It is based on the recognition that the enjoyment of the highest attainable

standard of health is one of the indiscriminate fundamental human rights (Osypuk et al. 2014). PHC requires governments, at all levels, to understand that actions made beyond the health sector, such as policies, play an important role in human health (WHO and UNICEF 1978).

2.3 Overview of South Africa's Healthcare System

SA's healthcare system reflects its political and cultural administration, economic and financial capabilities (Van Rensburg, 2004). Coovodia et al. (2009) claim that the history of SA has a prominent effect on current health services, policies, and welfare of the country's citizens. The colonial and apartheid eras facilitated racial segregation of healthcare services through the South African Public Health Amendment Act of 1897 (Coovodia et al., 2009). During apartheid "the political, economic, and land restriction policies organized society according to race, gender and age-based hierarchies, which significantly shaped the structuring of social life, access to basic resources for health, and health services" (Coovodia et al., 2009: 817). Segragation also resulted in the fragmentation between the co-existing private and public healthcare provisions (Coovodia et al., 2009).

SA's private healthcare is small but has high quality care, and is administered by private institutions. The public healthcare is large, administered, and subsidised by the government – but it usually has poor quality of care (Harrison, 2009).

The latest census survey estimated that by 2015 SA's population was 54 959 900 (Stats SA, 2015). More than 80% of this population accessed its healthcare through the public sector – thus, the government's ideal mechanism for PHC provision (Harrison, 2009; Stats SA, 2015). Due to the high levels of unemployment and poverty amongst citizens, healthcare provision predominantly burdens the state (Coovodia et al., 2009). Noteworthy, health is one of the few functions whose competence is present in all the three levels of the South African government, thus National, Provincial and Local government.

However, the scale of healthcare provision in SA remains highly unequal and it is amongst the worst in the world (Coovodia et al., 2009). Similarly, Meyer (2010) argues that SA's majority healthcare services are not easily accessible, do not have clear legislative frameworks in place and there is limited guarantee that the sector will uphold

the patients' human rights. In addition, Pieterse (2014) argues that SA's healthcare system is underequipped, overburdened, under-resourced, and understaffed.

Kerber et al. (2007) state that the structure of SA's public health system is made up of five tiers of PHC, these are: clinics, district, regional, tertiary, and central hospitals. The health system is divided into three levels, in which the the first level includes population-orientated services such as outreach and/or outpatient services that are offered through mobile and/or static clinics (Kerber et al., (2007). The second level comprises of district, regional, and tertiary hospitals. In this second level, in most instances patients are either transferred or referred from local clinics as and when complicated or specialised treatment is required (Kerber et al., (2007). The third and last level involves academic hospitals where treatment and diagnostic procedures of a complex nature are conducted (Kerber et al., 2007).

2.3.1 Constitution of the Republic of South Africa

RSA's constitution outlines the basic human right to access healthcare, but it also acknowledges the public healthcare system's resource constraints (Constitution, 1996). The interpretation of the constitution is through the National Health Act of 2004 and it incorporates entitlements of access to PHC services for all. These may include free PHC for all, (National Health Act, 2004).

The RSA constitution posits that "every person the right of access to healthcare". It simultaneously places a duty on the government to ensure progressive realisation of these rights through Section 27. The constitution states that every person has the right "to have access to health care services, including reproductive health care" (Constitution, 1996). Also, no person "may be refused emergency treatment" (Constitution, 1996). Table 2 below, describes some SA policies/legal frameworks in health governance and it outlines a person's right to access health services in public health institutions. However, everybody has the choice to access and make use of private and/or public healthcare services. However, access to private healthcare services depends on one's ability to pay.

Table 2: Healthcare polices of South Africa

Constitution of South Africa Chapter 2, Section 27	Every person has the right to access healthcare services inclusive of reproductive healthcare
Constitution of South Africa Section 28 (1) (c)	Affords basic healthcare for all children
Patient Rights Charter	Obligation to be adhered to by every clinic and hospital
National Health Act 2003	No person by any means should be refused emergency treatment

Noteworthy, the right of access to health, access to social security such as medical aid scheme cover and National Health Insurance (NHI) is applicable to all. According to WHO (2011), SA still falls behind on key health outcomes, although its financial spending on health is higher comparable to fellow BRICS nations.

In SA the realisation of the right of access to healthcare is through Section 27(2) of the Bill of Rights. The state is obliged to firstly, "take reasonable measures", secondly, "progressively realise" health rights, and lastly, "undertake such realisation within available resources" (RSA constitution, 1996). Thus, resource constraints should not be a reason for the state to fail delivering health services (Klinck, 2011). According to Olivier et al. (2004), the constitutional duty involves "devising, formulating, funding and implementing, as well as constant review of comprehensive, coordinated and well targeted programs". Issues such as staff shortages at top level in the NDoH may play a role on the coordination of the programs that address access to healthcare.

Importantly Section 27 of the Constitution does not work in isolation. It is one among a group of rights that directly and indirectly deals with health provision. The current study's focus is on healthcare services(Section 27(2)). Furthermore, Section 27 acknowledges that healthcare access is a basic human right. As such, provides for the state to respond to the health requirements of all people in SA.

2.3.2 Local Government

Informal trading is a business category in the informal economy and is affected by the government legislation such as the bylaws (Rachbini and Hamid, 1994). Government legislation on informal traders, generally, is an attempt to provision for regulation and to

control their existence in public open spaces. Local government plays an important and influential role in the affairs of informal traders. Political and administrative authorities governing the jurisdiction where people exercise their work activities influence directly on issues of health and the work environment, as such, for those trading on public spaces, become a key stakeholder to the local authorities, who they engage and negotiate. Thus the local government is also suppose to become an important player in the informal traders' health and healthcare. This makes a major difference to the health security of informal traders since the local authorities put in place resources such as water provision, good sanitation, refuse removal, and healthcare services (Bond, 1997). However, Bond (1997) there is non-existance of this important link between local government services and informal traders.

2.4 Informal Trading in Context

Hart's (1973) analysis of urban Ghanaians' income generation through informal trading activities is the cornerstone for understanding the informal economy (Cross, 2000). It may be argued that informal trading is a significant activity in the informal sector (Mittulah, 2004).

2.4.1 Defining Informal trading

Informal trading takes various formations because it is fluid. This claim may be attributed to the uncertainty of the economic climate that informal traders operate in (Bass, 2000). A growing body of literature has examined and tried to define the phenomenon of informal trading. The CoJ states that "the act of selling, offering or rendering of services in a public space shall constitute informal trading" (City of Johannesburg Metropolitan Municipality Street Trading By-laws). A wealth of research have been conducted and agrees that informal trading is an activity that finds expression in public spaces and a significant quantity of individuals make an income from the activity (Bhowmick, 2005; Bromley, 2000; Cross, 2000; Mbeve et al., 2020; Mittulah, 2004). Informal trading activities are characterised as survivalist entities (table 3 below)

Informal traders make up 15% of employment in urban settings with 25% of urban informal employment in low-income regions as well as 2% to 11% of urban informal employment in middle income countries (ILO and WIEGO, 2013). This makes informal

trading a dominant, substantive, and key part of several workforces in urban areas such as the CoJ Region F.

Table 3: Characteristics of survivalist enterprises

Survivalist enterprises
(Street businesses, Community of the poor, [Microenterprise,] Informal own account proletariat, Sub-subsistence)
Ease of entry, low capital requirements, skills and technology
Involuntary entrepreneurs
Female majority
Maximizing security, smoothing consumption
Part of diversification strategy, often run by idle labour, with interruptions, and/or part-time
Embeddedness in social relations, obligation to share

Source (Berner et al. 2012)

2.4.2 Informal trading in South Africa

Roever and Skinner's (2016) study argues that in SA, informal trading is notably the largest sub-sector of informal work, and it constitutes trading of any good and/or service in public spaces for a financial reward. The phenomenon surfaces as a sovereign response to economic opportunities, a creative substitute for low earnings in formal work, and a desire for freedom (Roever & Skinner, 2016). In the South African context informal trading largely involves Black women, who are forced into the informal sector owing to anguish and livelihood demands (Roever & Skinner, 2016). Additionally, informal trading activities mainly take place in unreserved and unprotected spaces, which limits informal traders' income generation and escalates their vulnerability to chronic disease, injury, and illness (Woodward et al., 2011). Thus, informal traders have minimal access prospects to affordable, sufficient, and correct healthcare outcomes for themselves and their families. In some instances they end up not actively seeking healthcare, especially when they must consider potential costs that are associated with healthcare or loss of income owing to the amount of time they may have to spend away from trading – to seek medical care or treatment (Woodward et al., 2011).

2.4.3 Characteristics of an Informal Trader

Informal trading can be identified as self-employment, that is informal traders operate on their own, and usually their work is not associated with labour-intensiveness (Pillay, 2004). Additionally, women's dominance in informal trading, is attributed to factors such as inferior formal education, levels of tradeable skills or skills development (Mitullar, 2003). Age is not a significant variable in informal trading. A study by Mitullar (2004) determined that the age levels vary between 20 and 50 years. Mitullar (2004) also determined that informal traders may include young people who have to provide for their families. However, one of the health concerns is that informal traders tend to work for too long hours, partly owing to low profit returns (Skinner, 2008b). Furthermore, in most instances informal traders in SA opt to trade goods instead of services because goods are readily available, always in demand, and cheaper (Mitullar, 2003; Skinner, 2008b).

Generally, informal traders consider themselves to be relatively healthy and may display high tolerance for their own sicknesses. As such, they normally afford their health little priority. They also often avoid taking time off from their work to avoid losing their income, but this results in delayed healthcare (Roever & Skinner 2016). Moreover, the cost associated with healthcare remains a big obstacle for informal traders. Despite some countries availing free public healthcare services such as SA, some informal traders still complain about being charged user fees for care services, frequently unavailable medicines prescribed by doctors, and being subjected to out of pocket payment for treatment medication at private pharmacies (Akazili et al. 2018). There is also vast information gap on care benefits, no information regarding care on when one can seek healthcare when in sickness, which leads to traders forgoing their care need or paying healthcare costs (Kuenburg et al., 2016).

2.4.5 Socio-economic issue of informal traders

Informal trading in SA may be regarded as an activity that is dominated by two social precarious groups, namely immigrants, women, and children. The current study placed particular focus on South African women informal traders. This because in many instances women participate as informal traders and head their households to sustain their own and their families' livelihood. Additionally, health is a key feature for women informal traders, considering the precarious working conditions that they are subjected to.

Lund (1998), observes that globally, there is a clear gender division on those who participate in informal economic undertakings. Generally, women are the majority population in informal trading activities. However, it is important to consider that while women take part in informal trading, they may also hold other roles such as being wives and/ or mothers (Pillay 2004). This means that the extensive hours that women spend trading goods and/or services overlap with other home duties such as cooking, and care giving.

Existing research suggests that informal traders in the global south are susceptible to unacceptably high levels of hostility and dangerous environments (Racaud et al., 2018). Crush et al.'s (2015) study found that a major hostility problem towards informal traders was demonstrated by the state itself (law enforcement authorities). The research findings report confiscation of informal traders' goods and payment of bribes to authorities (Crush et al., 2015; Mbeve et al., 2020). Crush also reported that authorities tend to not warn the informal traders each time that they come to raid and confiscate their goods. This may be perceived as looting. Crush et al. (2015) also observed that the extortion of money by authorities from traders is a continuous problem.

High levels of crime is also among the pressing issues that are faced by informal traders in SA. They are exposed to robberies and muggings by criminals. They are easy targets for criminals because criminals know that traders often have hard cash on them (Maharaj & Sidzadane 2013). The lack of storage facilities is another difficulty confronting informal traders. Informal traders struggle to secure sufficient storage space that has proper security to safeguard their stock because this is expensive in many inner cities such as in Johannesburg (Willemse, 2011). Thus, it becomes difficult for traders to expand their establishments and income.

Another challenge faced by informal traders is limited security of tenure, which is a political obstacle that is characterised by over regulation and minimal interaction with political and administrative authorities, and exclusion from decision-making processes that affect them (Roever, 2016). The lack in security of tenure exposes informal traders to evictions, relocations, merchandise confiscation, and harassment. This has a negative effect on their businesses.

2.4.6 Systems of support for informal traders

One of the main challenges that are faced by informal traders is poor working conditions that result in precarious work. This is enough justification for the need of the allocation of support to informal traders ingovernment policies and non-governmental organisations' strategies. This may be the case for policies and strategic documents such as the National Small Business Act 1996, GDS 40, and NDP. However, the design and implementation of these strategic documents shows that there is limited state support for informal workers (Salter, 1998). Currently SA does not have a strong policy that governs the informal sector.

2.5 Precarity

The general understanding of precarity in literature is divided into two ideologies. The first positions precarity as an approach that is workplace based. The second ideology views precarity as transcending beyond the workplace to include reproduction. Since precarity is a broad concept, the current study sort to unpack and understand how precarity is created, its forms, and how it is experienced by social precarious groups (informal traders). In addition, precarity is linked to concepts such as precariousness, precarious work, and the precariat (Vosko et al., 2009).

The upsurge of neo-liberalism, and its narrative on flexibility of the marketplace, has transformed work from traditional employment to the newfound atypical forms of employment (Webster, 2006). Resultantly, precarity is used interchangeably with atypical forms of work (Markey et al. 2000). Furthermore, precarity is associated with non-standard types of employment such as temporary and casual employment. Tucker (2002), states that the phenomenon of precarity is associated with complexity. It is also multifaceted and can be linked to any form of employment that is standard or non-standard.

2.5.1 Defining precarity

Broad approaches on the concept of precarity, stem from scholars such as Judith Butler. Various scholars attribute different definitions to the term precarity. For Butler precarity represents a "politically induced condition in which certain populations suffer from failing social and economic networks of support and become differently exposed to injury, violence, and death" (2009, p. ii). Those who experience and/or associate with precarious situations are characterised by a lack of sense of agency/work. Similar

sentiments are expressed by Ettlinger (2007), who suggests that precarity is a generalised and permeating feature of a contemporary security, displaying elements of insecurity and contingency. Scholars such as Banki (2013), associates the term precarity with vulnerability that is, a situation of exposure to harm and/or exploitation.

2.5.2 The emergence of precarity

Various factors contribute to the emergence of precarity. These include pandemics, the lack of stable employment, low chances of social mobility, lack of social security provisions, no collective organising, and an increase in debt for survival needs (Prakesh, 2021). In recent times precarity has emerged through the coronavirus 2019 (COVID-19), which is arguably the first of its kind in history (Prakesh, 2021). In other instances, precarity emerges from a certain geographical context such as the Ebola virus in the Democratic Republic of Congo (DRC).

2.5.3 How precarity is experienced

Precarity may be experienced through instances of high rates of unemployment such as those in SA (Banki 2013). Similarly, securing 'decent employment', continues to be a global challenge. Furthermore, insecurities may be experienced through an increase in low-wage and casual work, inequality, social exclusion, and impoverishment. These insecurities result in economic hardships and seem to be suffered by many informal traders. Wiate (2009), interrogates experiences of precarity from social spaces such as residential status – which cause vulnerability for some migrant groups. Social security for some of these migrant groups has resulted in gendered dynamics of precarity. Poor urban and rural women from different parts of SA are pressured to move to major cities such as the CoJ, in pursuit of informal economic opportunities (Posel, 2005).

2.6 Social Rights of Citizenship

Informal trading is notably the largest sub-group among others in the informal sector. However, the increase in their numbers has not come with parallel development for their citizenship status (Skinner, 2007). Many scholars use Marshall's (1950) definition of citizenship. Marshall's (1950: 28-29) definition is, "citizenship is a status bestowed on those who are full members of a community. All who possess the status are equal with respect to the rights and duties with which the status is endowed". Essentially, these

are entitlements that are purely granted on the bases of being a citizen of the society. Marshall (1950) theorized that there are three historical dimensions of social citizenship and related institutions. These incorporate civil, political, and social rights. Civil rights is the first to be conceptualised and merged together the rule of law and equality. These rights are mainly associated with individual liberties and may include freedom of speech and association, right to own property, and the right to justice.

Second, in Marshall's (1950) conceptualisation is the establishment of political rights and involved the right to vote, which was limited to men and only in later years applicable for women. Additionally, political rights are represented by democratic practices that are seen in elements such as the electoral system, parliament, legislature, and councils. Lastly, Marshall (1950) conceptualised social rights. Social rights are closely associated with the welfare state. A strong characteristic of social rights is that they are supposed to ease inequalities that are caused by market economies and not to necessarily terminet the markets. Marshall further referred to these as welfare and economic rights.

Marshall’s perception of citizenship is mainly about advancing equality through the three spheres of rights. What should be carefully considered in Marshall’s approach is that the aim is not to advance equality that is absolute but, for the current study, to generally reduce insecurity and risks associated with informal traders where health seeking behaviours are concerned. In essence, it is the quality of status that is advanced more than income equality, which will always differ because people’s backgrounds are not the same. Thus, equality is that of the progressiveness of people’s chances in life. It is not possible for citizens to be equal in wealth, but the idea is to attempt to narrow the gap between the rich and the poor.

Marshall’s social liberal framework differs from those shared by critics in the right wing) who argue that entitlements of social citizenship are a costly burden to the state, and citizens should secure their social needs through markets (Friedman, 2007; Hayek, 2001). New right-wing theorists have problematised the welfare state on the economic and moral aspects. They argue that public welfare provision, such as the SA’s R350 social relief grant, undermines the market, because it affords people who are outside the labour market, an income . However, informal traders generate much needed income. Furthermore, the right wing views state provided welfare as having an undesirable impact on investments and individual savings. Some right wing theorists

argue that a welfare state advocates against the authority of men as breadwinners, and is pro feminism (King and Waldron, 1988).

An argument posed by feminist scholars is that in general women first gain political, followed by civil, and lastly social rights due to their domestic responsibilities that de-limit their public participation (Lister, 1998). This results purely from women gaining voting rights after men, that is, male suffrage (Basu, 1995). Women continue to use political rights in governments to improve their citizenship rights and status (Fallon, 2003). However, Marshall (1950) observes that social rights are premised primarily on pre-existing political and civil rights. This argument is based on the perception that for the longest time women were regarded as second-class citizens to men on a whole range of issues including property ownership.

The current study aimed to consider a gendered approach to social citizenship by focusing on South African women informal traders' access and PHC seeking experiences. The study also explored the relevance of Section 27 of the Bill of Rights of the constitution in supporting informal trader women's protection of social rights of citizenship, and access to public healthcare services.

A careful assessment of these rights suggests that they inform one another. Thus, ideally if all citizens are equal before the law, then they should be able to influence and/or chose the law makers. Furthermore, every citizen should be positioned to be prepared, well-informed and adequately protected to enjoy their civil and political rights while satisfying responsibilities that accompany these rights (Craske 1999). If this is the case, then in the current study, adequate healthcare provision must be an aspect of citizenship. As such, a view is established that social citizenship does not suppress the concept of individuality, but in conjunction with other features of citizenship, strengthens the basis on which social citizenship may be democratical. Thus, allow citizens in their individual capacity to fair well (Fallon, 2003).

The reduction of inequality has the possibility of improving social inclusion, which is another component that the current study explored The concept of social integration is key to social citizenship (Marshall, 1950). Advancing equality will allow informal trader women more economic independence. Social equality necessitates the establishment of high standards of PHC so that no gap exists between public and private health provision. This will eliminate stigma associated with informal traders who are poor.

Social citizenship focuses on status and horizontal equality (Marshall, 1981). This means that the phenomenon of work is central to citizenship which is the case with women informal traders.

2.7 Conclusion

This chapter discusses the interface between PHC services, the informal sector, informal trading, precarity, and social rights of citizenship at local government level. By probing existing literature on the phenomenon understudy, this chapter shows that there is a need to embrace a holistic approach in improving women informal traders' access to and experiences in public healthcare services. Additionally, to better understand the precarious lives of women informal traders, research analysis must be expanded to include reproduction. This is because the experiences of women informal traders have strong connections between production and reproduction. This demonstrates that health and healthcare is key to women informal traders. Furthermore, to improve healthcare, there should be a strong political will and support (Marshall, 1950).

CHAPTER 3: THEORETICAL FRAMEWORK

3. Introduction

Several theories and schools of thought shape cities, globally. Schwandt (1997) defines a theory as a proposed explanation and/or assumption of how things or situations around us unfold. Theory affords us the opportunity to have a clear perspective of viewing the world. The current study borrowed from an existing theory which was perceived as necessary and appropriate to derive ideas from. The study did not seek to identify a theory and prove it, instead it first identified an area of study and then related concepts or processes were allowed to develop organically. The developed concepts and processes were then utilised to understand and investigate the research problem, data collection, and analysis.

3.1 Social Policy

The theoretical framework underpinning this study is premised on 'social policy' as a critical analytical enquiry. The reason for choosing this framework is based on the idea that, social policy finds expression in most empirical governments and is significantly used to articulate social issues holistically – thus, socially diverse social conditions in diverse social arenas. Social policy in some way can be said to be a classical response to issues of precarity, these may include poverty and racism (Titmuss, 1951).

Moreover, social policy may assist in realising respect for the dignity of citizens, especially the disadvantaged, and this will necessitates extensive government support. Noteworthy, reforms to social policy can happen through the third state, thus aside from government (Alcock, 2001). This can be seen when community and/or social formations work in aid of support to those that are disadvantaged. Furthermore, social policy is a descriptor of social actions and responds to collective social problems. It may have real consequences for the social organisation of society in attempts to mitigate against social marginalisation of informal traders. This assertion is attributed to Richard M. Titmuss who pioneered conversations and debates on the social policy phenomenon.

According to Titmuss' (1951) inaugural lecture, social policy is the:

> *"study of the provision of services to promote welfare and well-being. A concern with – those services, both statutory and voluntary, with the moral values implicit*

in their actions, with the roles and functions of the services, with their economic aspects, and with the part they play in meeting certain needs in the social process."

Mkandawire asserts that “social policy is collective interventions in the economy to influence the access to and the incidence of adequate and secure livelihoods and income” (2004: 25). These definitions are similar because they both showcase the economic context of social policy but Titmuss’s definition goes on to reference social needs and moral values as key components of social policy. My consideration of social policy is that it is a concept that aims to facilitate the wellbeing of citizens in any setting. It also aims to improve the lives of people without consideration of variables such as class, and race because social concerns affect all of us. What may differ is the extent or impact thereof – that is the social division of welfare. The key issues of social policy as determined by Titmuss include welfare and wellbeing, health, poverty, economic policy, public policy, assistance programs, inequality, and economic development.

3.2 The three aspects of Richard’s social policy framework

Titmuss’ framework is premised on three fundamental aspects that are: moral, political/institutional, and economic. Firstly, the moral argument is that, “in the growing power of altruism over egoism” (Ginsberg, 1953: 24; Titmuss, 1958). Titmuss (1958), proclaims that, people inherently have ‘basic needs’ that are made necessary by mutual relations, that arise from belonging to a community. As such, when access to these needs is denied, people’s individuality will be negativey impacted and this may cause social and psychological distress. These basic needs may include decent shelter, decent education that will enable one to secure employment, and to also be an informed citizen, of importance to this study is to gain adequate access and experiences to healthcare services. Titmuss (1958) further argues that the derivation of these needs cannot be from philosophical principles nor cast in stone. Therefore, there should be informed political processes on a continuous basis.

Another aspect of Titmuss’ moral argument is that delivery of these basic needs is mostly crucial for the government, should be non-judgmental, and non-stigmatic. In attempts to strengthen the moral argument Titmuss further raises the issue of institutional quality. This means that determining a theoretical need or a right in law was just not enough, instead the emphasis should be on human dignity and be within the

purview of the law and its subsequent interpretation or service administered institutional quality. In addition, Mkandawire (2004), observes that it is on the moral aspect where social policy builds citizenship in a society, and attempts to advance moral and physical fortitude. In this regard, what should be considered is that both moral and physical fortitude necessitates mental strength.

Secondly, political theory) argues that, to enable a viable democracy, government should be able to guarantee that basic needs are fulfilled with utmost humanity. This would stimulate confidence in a respective political system, and ensure good governance to make democracy viable (Titmuss, 1958). Lastly, in the economic theory Titmuss argues that markets have limits in financing basic needs – thus market failure. Titmuss and Abel-Smith identified a few market failures, and this was before economists displayed interest in these developments. For example, employers play a key role in the provision of some welfare such as, medical aid and pension. If this development is not to be associated with major inequality, the state needs to ensure that minimal occupational benefits are present to all. This assertion does not cater for the employment status of those who engage in the informal sector. The central argument is that, the moral, political, and economic elements connect to form one framework, the social policy.

3.3 Conclusion

This chapter shows that, trusted legal systems, individual freedoms, economic and market inclination are determined through a stable government, and secure contracts. These are dependent on the government's ability to ensure that morally central features of any life are not disallowed and/or ignored. This can be attained through government's involvement in the methods in basic rights/needs are met. Markets cannot independently achieve this. Joint networks and partnerships need to cohere through improved coordination across agencies, in dealing with social problems and activities. Key is that all this cannot be possible if government's efforts are exclusively targeted at the poor. Thus, "separate discriminatory services for poor people have always tended to be inadequate quality services" (Titmuss 1967 Lecture). Central to the current study, is the assumption that social policy is necessary in interventions for the health and healthcare outcomes and improvement for social precarious groups such as women

informal traders. Extensive literature review determined social policy as the theory that is relevant for the study.

CHAPTER 4: METHODOLOGY

4. Introduction

This chapter explains the research strategy and steps that were adopted in the study. It describes the research paradigm and approach, processes, and methods employed to collect, process, and analyse data. Furthermore, the chapter discusses the research site, unit of investigation, ethical considerations, and limitations.

4.1 Research paradigm

The research drew inspiration from interpretive research paradigm. Interpretive paradigm assumes that reality is socially constructed and meaning is determined through the understanding of events (Creswell, 2009). Truth is seen as based on context and subjective nature of knowledge (Garner & Kawulick, 2012). Through interpretive paradigm, the current study puts forward individualised, women informal traders' lived and varied PHC services seeking experiences. This is enabled by focusing on their personal claims instead of generalisations and verifications (Chilisa, 2011).

Interpretive paradigm positioned the researcher as a social actor to notice and appreciate differences between people. The study gravitated towards interpretive epistemological perspective, since the primary objective was to collect data from participants' worldview (Bryman, 2012). It is important for one to be mindful knowledge gathered using interpretive approach cannot be generalised because it is context driven. Thus, according to Weber (1989:151), "an understanding of human behaviour achieved through interpretation contains varying degrees, above all, specific qualitative self-evidence".

Considering the above justification, a researcher intending to use an interpretive paradigm must be reasonably familiar with the context where the phenomenon understudy develops or has developed. As such, the researcher's interaction with participants in her capacity as an insider (having experienced selling goods as a teenager with her late mother) and an outsider (researcher), greatly informed her understanding of women informal traders.

On ethical grounds, the researcher revealed my biases through reflexive bracketing and continuous consideration as suggested in qualitative research. Thus, she clearly

outlined for the reader to appreciate how certain conclusions where reached. This is discussed extensively on the reflexive bracketing **(see section 4.7)**.

4.2 Research approach

The study adopted qualitative research design. As suggested by Creswell "qualitative research is an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem" (2014:32). Similarly, Babbie and Mouton (2005), mention that a qualitative study is an attempt to study human actions from a social perspective. In the current study, qualitative approach helped in explaining the fine details of the secluded, and unexplored social life aspects of women informal traders.

Qualitative methods allowed the researcher to put forward the access and PHC services seeking experiences from the subjective perspectives of women informal traders. The current study focused on ways in which women informal traders interpreted and made sense of their health seeking behaviours. It also examined the world in which they live, and it can be argued that women informal traders' world is deeply entangled. Moreover, the qualitative approach aimed to describe and understand instead of explaining access and PHC services seeking experiences for women informal traders. The study also precisely explored the use of SRC in meeting their healthcare needs.

Qualitative approach provided contextual, rich, and revealing data. The qualitative approach incited refined, sophisticated and 'thick descriptions' of experiences and subsequent responses to access and PHC services seeking experiences for women informal traders – this would not be possible using quantitative methods. Denzin explains 'thick description' as a description that:

> *"goes beyond mere fact and surface appearances. It presents detail, context, emotion, and the webs of social relationships that join to one person. Thick description evokes emotionality and self-feelings. It inserts history into experiences. It establishes the significance of an experience or sequence of events, tor the person or persons in question"* (Denzin, 1989a:83).

Rich explanations of this nature are imperative and needed in understanding how women informal traders understand and decipher their access and experiences of PHC services, and the use of SRC in meeting their healthcare needs. The access and

experiences of PHC services cannot be quantified. As such, the collection of data through qualitative methods was the most suitable and pragmatic exploration tool for this study.

4.3 Research design

A phenomenological design was employed in this study. The purpose of this research study was to "understand an experience from the participant's point of view" (Leedy & Omrod, 2001:157). To understand experiences, the study focused on the perceptions, views, and experiences of the participants on a specific situation. According to Creswell, phenomenological design is adopted when a study is in pursuance of a "central underlying meaning of the experience and emphasise the intentionality of consciousness where experiences contain both the outward appearance and inward consciousness based on the memory, image and meaning" (1998:52). This research design is personal, a world or phenomenon, as experienced by the individual, not necessarily the relationship between people. Fundamentally, phenomenology is an approach to research that is used to understand and/or explain experiences.

the current study's data collection method was primarily interviews, to gain an understanding, interpretations of participants' perceptions and/or experiences established through the meanings of a particular event. The study collected data which led to determining common themes and sub-themes generated through participants' perceptions, views, and articulations of their experiences.

The current study's goal was to gain insight into access, lived, and varied experiences in relation to PHC services for South African women informal traders in the CoJ Region F inner-city. The study was conducted within the context of Section 27s constitutional provision on the right to healthcare making. This made the phenomenological design a suited approach for the study. Furthermore, phenoenological approach allowed the researcher an opportunity to garner insight and understanding of participants' past, lived, and varied experiences as they recount them.

4.4 Research procedure and methods

This section discusses the data collection methods and processes for the current study. The section includes a discussion of data collection instruments that were used, the unit

of investigation, and the sampling techniques that were employed. Furthermore, the section discusses ethical considerations, data collection and storage, data processing and analysis..

According to Bryman (2012), a data collection instrument is a tool that is used by a researcher to solicit insight and relevant information needed to respond to research questions on a studied phenomenon. Data collection methods are reliant on the chosen research approach that is, qualitative or quantitative, and if primary or secondary data will be utilised (Kumar, 2014). Primary data is information that is recorded first-hand from the source of collection and may be internal or external for example, interviews and observations. Secondary data is produced and processed by others, and can be made public after collection, this data can be in form of census reports and government publications (Wegner, 2016). It is also important to note and consider that in qualitative research the researcher is the data collection instrument (Bryman, 2012).

4.4.1 Focus Group Discussion (FGD)

In a study where a researcher wishes to gather narrative data from a group of people, a focus group discussion may be utilised. In the current study, data collection was conducted using semi-structured interviews for flexibility during the Focus Group Discussions (FGD). This aided me in extracting rich data with thick descriptions to be able to explore emotional responses from participants. Furthermore, for a holistic understanding, the study collected more than one kind of data by including participant observations.

Primary data was collected during the months of July and August 2022 making through semi-structured FGDs. A total of 4 FGDs were conducted, and for each group the minimum number of participants was six, and the maximum was eight. The FGDs took place as follows; FGD 1 (July 10), , FGD 2 (July 16), FGD 3 (July 29), and FGD 4 (August 6). Semi-structured questions were used with the intension to solicit participants' views/opinions/thoughts on their access and experiences in relation to PHC services (Creswell & Creswell, 2018). Semi-structured interviews are a popular technique because they enable the ability to adjust and structure the interview according to the participants' responses (Bryman, 2012).

The FGD participants displayed common characteristics, that defined them as a target group. The purpose of using FGDs in the current study was to stimulate, collect, and make use of the social dynamics of women informal traders in revealing their underlying attitudes, feelings, opinions, and perceptions, at a subjective and personal level, for a flexible exploration.

The interviewing process was conducted using a semi-structured FGD interview guide which detailed key open-ended questions (Appendix A). The interview guide used in the FGDs helped guarded the researcher against and resolved common limitations, such as diversions, that can be posed by unstructured and or semi-structured interviews (Turner, 2010). The researcher designed the interview questions such that they respond to the primary research question and the current study's two sub-questions (Kvale, 2008). The researcher segregated the interview questions and put them into themed probes that were relative to how women informal traders understand their access, lived, and varied PHC services seeking experiences. In certain instances of the FGD interview process, the researcher encountered difficulties in complying with the interview guide. Thus,the researcher had to "sacrifice uniformity of questioning to achieve fuller development of information" (Weiss, 1995:3). In so doing, she was able to form a flexible environment and converted the FGD interview into a conversation where participants started to give a narrative account of their life stories and perceptions with a clear focus on the research objectives. This resulted in sacrificing the FGD interview guide and some FGDs advanced into organic discussions. Furthermore, some participants surfaced interesting and emergent matters which required follow-ups that the researcher respectively entertained. Additionally, the researcher was observant of the participants, and when she noticed some level of unease through participant's facial expressions and body language, she made a decision to avoid pursuing other questions that were in the FGD interview guide. This was a way to respect participants' autonomy.

Disadvantages of Focus Group Discussions in this research

In- work poverty risks are particularly high among informal workers such as women informal/ street traders. Reference is made to issues of health/ healthcare in this research arguably being a sensitive issue. Definitions of the concept of sensitive research highlights the anxiety to those individuals, stemming from the private or personal nature of the issues under investigation as well as the potential for

embarrassment, offence and/ or social censure on disclosure of associated attitudes and/ or behaviours (Lee, 1993).

Expensive to execute

Having revealed to the participants that I was in the employment of the CoJ carrying out the research the participants had an expectation to receive compensation to take part in the discussion. I took the time to make a clear statement that my employment in the CoJ has no bearing on the research that I was conducting and that it was conducted for academic purposes. The block-leaders also assisted in conveying the message to the participants. Also, the block leaders negotiated that at least I could offer refreshments for the women for their participations. After extensive negotiations myself and the block leaders determined and agreed that I provide water and mints during the discussion and lunch at the end of each discussion. This came at a cost that I had to incur for the sole purpose of gathering data from the unit of investigation for the research and with due consideration of the physiological needs of the interviewees which has no baring or influence on the nature of their participation.

Participants cant voice the opinions freely

FGDs have a tendency to have one feeling that you are under a microscope. People with introverted personalities find it difficult to voice their opinion freely. This is the idea of some voices being more dominant than others. As such, this may tend to bias the quality of information obtained.

Hard to get honest insight for sensitive topics

FGDs tend to be not effective in the case of sensitive topics because participants are hesitant to answer such questions. Hence, getting them to share their honest opinion gets complicated and requires skill and patience on the part of the interviewer.

Might not be a true representation of your target group

FGDs consist of a sample of the audience which is not an accurate societal representation. Opinions expressed by the participants might not represent the views of society as a whole.

4.4.2 Data storage

The FGDs were recorded using a tape recorder and a backed-up recording through the researcher's personal mobile phone. At the end of each session the recordings were transferred to an external hard drive on the researcher's laptop. Furthermore, the two devices where password-secured and no one other than the researcher had access to these devices. The devices were protected by a matrix-code system with passwords that were known only by the researcher (Bryman, 2012). The files of the FGD data was saved as FGD 1-4 each followed by their respective date of the meeting. This was done to maintain organisation and facilitate ease of access to the data.

4.5 Participant observation

Howell (1972) crafted four phases in participant observation. These are: (1) establishing rapport with the unit of investigation, (2) o immersing in the study and its context, (3) recording data and observations, and (4) consolidating and analysing data. This aides thematic data analysis which is the chosen data analysis method.

4.5.1 Why use participant observation

Participant observation is used to study the participants in their natural context, without manipulation. In participant observation, the setting has a significant contribution to understanding the phenomenon under study. Therefore, in the current study the researcher took significant precautions to warrant a proper depiction of what was observed and participated.

4.5.2 Methodological challenges met doing this research with vulnerable women, thoughts from fieldwork experience

Qualitative research has various methodological challenges. Some of the challenges were observable in the current study's examination of the vulnerable population, which is women informal traders. In most cases, researchers are not ready or equipped to study these vulnerable populations (Thummapol et al., 2019). These challenges may adversely impact the physical and emotional demands on the researchers. This section articulates the researcher's reflexive accounts of fieldwork experience, in relation to encountered methodological challenges.

The liability of disease and sickness that is, ill-health, fall more on vulnerable groups (women) compared to the general population (Derose et al., 2011; WHO, 2015). Often, women of ethnic communities are vulnerable and disenfranchised members of society. They are most adversely susceptible to a disproportionate burden of social marginalisation and disease/ill-health (WHO, 2015). As such, there is a great need for attempts in the development of knowledge from the experiences, perspectives, and perceptions of vulnerable women towards a move to inclusive development and approach in the use of research in order to eliminate eventualities of social exclusion, poverty, social injustice to mention a few (Hankivsky, 2012).

Explicit articulation of methodological challenges (emergent and anticipated) that are encountered in the process of data collection is important in exploring access and PHC services seeking experiences for SA women informal traders. As such, the research experienced two challenges:

- Selection of a study field site and obtaining access
- Recruiting of research participants and building trust

These reflections are drawn from pieces that were recorded in the researcher's journal. The journal captured interactions, emotions, questions, dilemmas, and thoughts as encountered through engagements with the participants. These should ideally put to the fore some of the challenges and thought-provoking moments of the researcher's presence in the study site.

4.5.2.1 Selection of a study field site and acquiring access

Challenges in this regard included instances of gatekeeping and burden to access the participants. Approaches that were used to mitigate these challenges included contacts to identify gatekeepers and field visits. One of the key activities in conducting research is choosing an ideal research site and obtaining access. However, this can be a key setback in the research process (Kondowe & Booysens, 2014). Past and present research demonstrates that discussing issues of, and gaining access to the research site can be challenging – and more challenging for vulnerable populations (Liamputtong, 2007). As such it was a challenge to access the research participants in the current study because they were a vulnerable group, thus, South African women informal traders.

This study's site was the CoJ Region F inner-city. This was because the researcher had professional contacts with the champions of informal traders in the CoJ Metropolitan Council (Angrosino, 2007). South African women trading in the Region F inner-city, were identified as the most under researched population, on issues of health and healthcare in the CoJ.

Entry to the study site was determined through formal engagements, calls, and emails with CoJ informal trading officials from officies such as the Department of Economic Development (DED). The researcher also had informal engagements and calls with informal trader block leaders in Region F inner-city (Johl & Renganathan, 2009). After initial contacts, the gatekeepers at different levels were respectively identified and approached. In research, access to vulnerable groups such as women informal traders is secured through attaining the trust of respected informal trader block leaders who the study identified as gatekeepers.

A research field trip was carried out preceding data collection, to engage the informal trader block leaders (gatekeepers) in attempts to negotiate access to the study site and participants. The block leaders held positions of authority and were well respected by fellow informal traders. This allowed the researcher to gain access, and the block leaders began introducing her to potential research participants (Liamputtong, 2007). Additionally, the research field trip allowed the researcher an opportunity to engage the block leaders. It also allowed the researcher to make available and share the research questions, and discuss the research project with a focus on the research purpose, objective(s), methods, the intended use of the research, in a clear, positive, and respectful manner (Caine et al., 2009). During this visit, the researcher also presented the participant information sheet (see Appendix B). Part of the engagement was captured and reflected in my research journal as follows:

> *Met the block leaders and potential women participants. Was welcomed but the connection was not instantaneous, after extensive deliberations a mutual ground was reached. I was very much relieved and re-iterated that the research is carried out on a personal capacity and that I was not in any way representing the CoJ Metropolitan Municipality in this regard since the block leaders demonstrated concern the moment, I stated my employment with the City. The block leaders cited instances of mistrust on the part of CoJ authorities where informal traders and trading was concerned. After extensive deliberations with the block leaders*

an understanding was then reached. I was relieved! The block leaders then agreed to my request and gave the go ahead to proceed. Also, they committed to assisting me to identify potential participants upon my return for data collection (Dube, 2022).

Once the field trip was completed the block leaders granted the researcher, access to the research site and made a commitment to introduce her to potential participants. Two of the women block leaders who also participate in informal trading activity in the the Region F inner-city, agreed to assist the researcher with the recruitment. The research site visit, afforded the researcher an opportunity to gain a deeper understanding of the cultural and social norms of the Region F inner-city. Thus, it facilitated familiarisation with the setting, and helped the researcher to establish rapport and trust with the research population (Caine et al., 2009).

Furthermore, the researcher believed that networking and building professional relationships with the CoJ informal trading officials was instrumental gaining credibility and acceptability in the study site. This greatly assisted the researcher to gain trust as articulated in her journal's extract below:

Permission duly granted by the block leaders. I questioned, though, would the block leaders be so sympathetic and receptive to support me if I did not have my CoJ network, honestly, I am quite sceptical (Dube, 2022).

4.5.2.2 Recruiting and building trust

Strategies to recruit participants for the current study, included the use of purposive sampling, block leaders, and face-to-face meetings. The methods that were used for building and maintain rapport with participants included giving full research information, ensuring that participants had a clear understanding of their rights to participation, flexibility in scheduling FGDs with a consideration of the participants' work conditions and demands.

Recruitment and retention of participants can be a challenging and time-consuming activity (Liamputtong, 2007). The activity is more challenging when research is undertaken with marginalised and vulnerable women such as informal traders. Smith (2008) argues that there is a need for extensive and constant support for women to take part in research. As such, relations with research participants must be carefully

structured and managed, because they can affect participation and subsequent retention (Liamputtong, 2007). However, this process needs to be carefully considered since it is not clear. This is done to advance integrity in conducting research. Furthermore, the researcher must clearly describe their research intentions, expectations, outline the benefits for participants, consider cultural nuances, and guarantee confidentiality.

In the current study, the techniques used to establish and maintain respect for participants included member checking, flexibility in scheduling interviews and acknowledging that participants were the experts of their experiences, as the researcher testified in the journal:

> *Conducting the study trip and through professional networks, I got the sense that I had been accepted and welcomed. Making myself known. Started to converse with some of the women. They were responsive and sociable, and some even offered me snacks during my visits! It took some time to realize that I had been absorbed by the women's lives (Dube, 2022).*

Another reflection by the researcher was the awareness that contrary to popular belief, participants exerted some degree of power in the study. In research, participants hold solid power, since they possess the knowledge and experiences about the studied phenomenon. They also control what and how much personal knowledge that they share. Therefore, they can withhold participation at any point with no consequences or added obligations (Dun-comb & Jessop, 2012).

Participants were identified and recruited using purposive sampling, the researcher's professional network, face-to-face meetings and the research outline (Roper & Shapira, 2000). At first, the researcher described the research purpose, questions, the study process, and provided the study outline to her professional network and block leaders. Potential participants were identified through block leaders. The researcher than directly contacted them to provide more information about the study, and they could determine their willingness to participate. The researcher also used face-to-face engagements to recruit participants at the informal trading sites.

4.6 Reflexive bracketing

Reflexive bracketing insinuates the researcher's awareness of their role in the research process. Reflexive bracketing was an important element of the current study. Because of it is a qualitative study that explored South African women informal traders' varied access and lived PHC services seeking experience, in the context of Section 27s constitutional provision on the rights to healthcare. It can also be argued that, because of the precarious status of the participants' lives, their citizenship status could have been contested. Therefore, it was key for the researcher to constantly and carefully consider her thoughts and actions and, the role that she held in the research process and topic.

The researcher's interest in informal trading was ignited when she was employed by the CoJ, DED. However, she had already been interested in informal trading since she had personal experience with family members who work in informal trading. During the past many years, the researcher noticed and experienced my family that contending with the triumphs, challenges, and difficulties that are caused by informal trading. The researcher wanted to explore the topic by focusing on what she believed to be a key feature in informal trading – thus, health and healthcare service delivery with relevance to the CoJ informal sector. It was also important, at the local government where informal traders negotiate in most instances.

The researcher's personal intension was to showcase access and PHC services seeking experiences for women informal traders. However, the researcher was cognisant of the potential ploy where her bias would likely surface. This likely bias of collusion with the phenomenon understudy and the research participants could have been mostly being on the researcher's lookout for the 'unpleasant experiences/stories' considering the prevailing negative perception levelled against public healthcare services. The researcher was also fully aware of her value that she held in relation to informal trading and PHC services, handling this was not going to be an easy task.

The researcher's main challenges was to carry out the study without 'memory or desire'. Memory or desire is an expression that was framed by Bion (1988), warning that one's memory or desire impacts their interaction, thus the researcher and participants, for this study. When the researcher attempted to immerse herself in the data that she collected she could easily fall into a 'catch.' The researcher was attracted to one of the

participant's recitations about their experience. The researcher's eagerness and intrigue in the interview, was noticeable.

Therefore, the researcher realised the importance for her to be more careful and reflect reflect on her reations in the interviews. Thus, she made a conscious decision to examine her thoughts, feelings, observations, reactions, reflections, and scribed comprehensive notes. It was also at that moment when she realised that the idea of memory or desire could also imply the understanding to work instantly. Furthermore, the researcher believed that it was important for her to always be open and susceptible to receiving information that was delivered in its natural form and permit the organic emergence of events. In addition, by employing 'self' as a research instrument, implied that the researcher had to be reflective throughout the research process to be able to detach 'her stuff' from her participants 'stuff'.

4.7 Research site

This study was conducted in the CoJ Region F inner-city, Gautent Province (GP), South Africa (figure 1 below). Cross et al. (2005), observe that, the CoJ is arguably the largest city in SA. GP in which CoJ is located, is home to the highest population in SA. GP boasts a cosmopolitan population that includes citizens and non-citizens, and this is the population that characterises Region F inner-city (Peberdy et al., 2004).

Figure 1: Map of South Africa

Source: www.joburg.org.za

Since research reveals that informal traders in Gauteng are often organised and concentrated in inner-cities, it appeared befitting to conduct this study in Region F inner-city (Cross et al., 2005). Furthermore, there is a high population of informal traders in

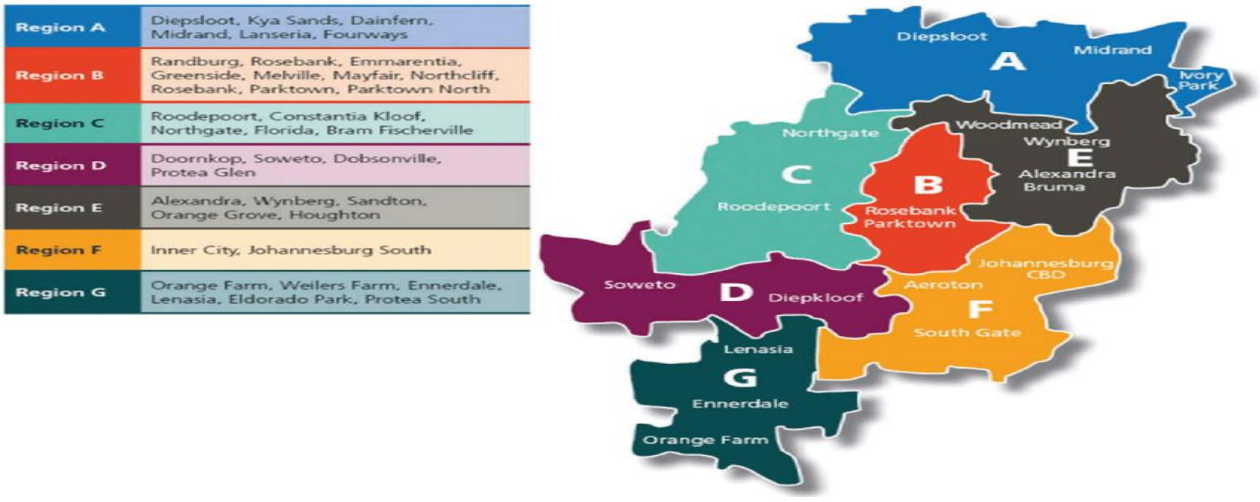
Region F suburbs. The high population of informal traders from across SA in the Johannebsurg inner-city made it considerably easy to sample and recruits participants.

4.7.1 Research location (street market)

The street market chosen for the current study is situated in the CoJ Region F inner-city (figure 2 below) Joubert Park and President Street (figure 3 below). This market had a solid distribution of participants as was advised by the informal trading champions of the council, the block leaders/gatekeepers, and observed by the researcher during the initial research trip. During the time of the study, the street market did not have an infrastructure besides a top deck. However, informal traders along President Street did not have a top deck over their trading spaces.

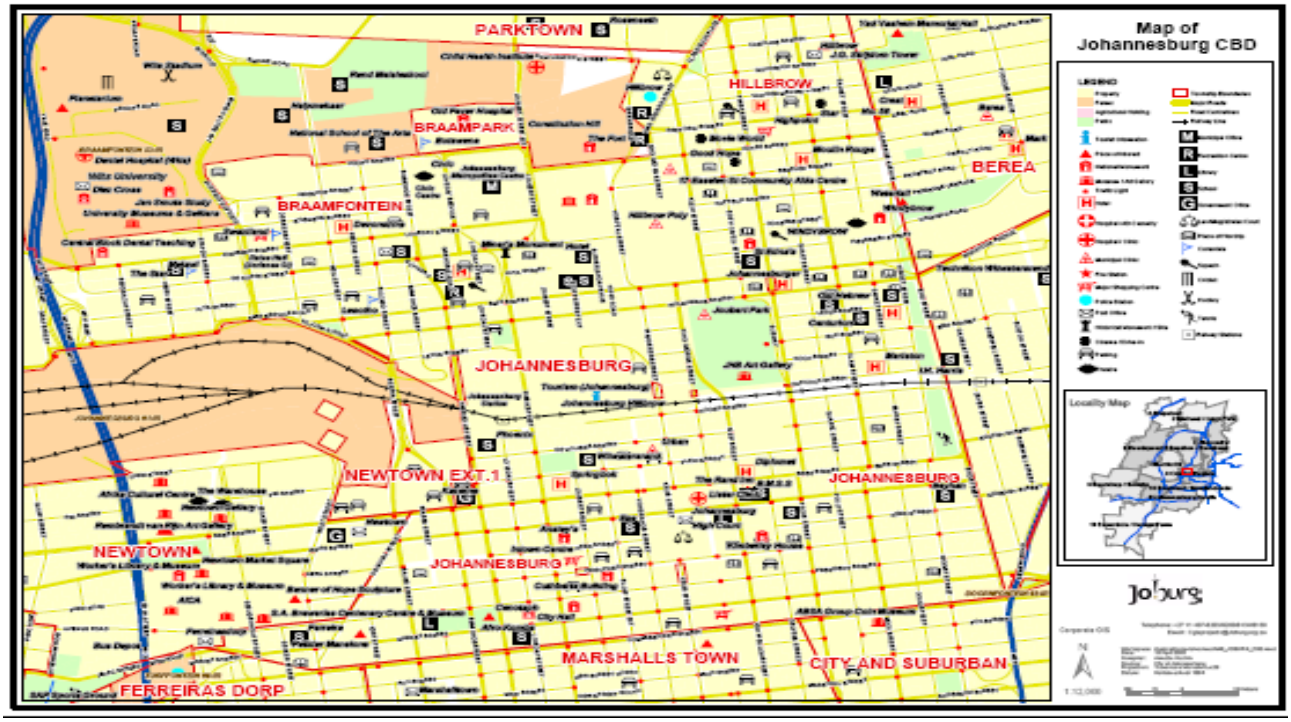
Since the market did not have infrastructure, whatever that the informal traders created on site was their own improvised creativity. These included umbrellas, tents, boxes, tables, and crates. These objects that were used were isntalled and uninstalled at the beginning of the day and at the end of the day respectively. The researcher's characterisation of these trading spaces was that they were highly undefined and small. Participants who formed part of the FGDs indicated that the trading spaces were allocated to them by the CoJ council. The researcher's general observation was that this was a preferred location because there was no obligation by the traders to pay rental fee for the space that they used. Another advantage was that the location had significant volumes of pedestrian footprints daily basis. Additionally, the informal traders reported that their incomes from their buisinesses had been decreasing.

Figure 2: Map of Joburg showing the seven regions



Source: www.joburg.org.za

Figure 3: Map of Joburg CBD



Source: http://www.joburgcentral.co.za/map.php

Every informal trader is allocated an average space of 2m by 1m (2 square metres) this also depends on the goods that are sold. Informal traders expressed different sentiments on the space allocation. The researcher observed, a painted white and yellow line on the ground, which retrospectively defined the allocated space for each trader. There were no storage facilities that were provided for informal traders to store their goods. Therefore, they independently arranged for storage of their consumables in the city centre vicinities that were privately owned. The storage rentl was paid to the owner(s) on weekly or monthly basis.

During the research field trip one of the women block leaders who also became a participant, explained that for her, there was a value chain that linked informal traders in Region F inner-city. She explained that she had a bakkie[1] that she had since hired a driver to use for collecting and delivering traders' consumables on daily basis – thus, she had created employment. She further explained that the disturbance of informal trading processes had a ripple effect on the lives of those who engage in the sector and their families as well as other partcipants and activities that are not visible on the streets.

[1] This refers to a personal vehicle (van)

In essence informal trading creates employment – thus, the block leader was an informal trader who was also an employer.

Furthermore, there were other informal traders who were trading smaller goods or services, and were of the view that their merchandise did not necessarily warrant spending money on storage. Therefore, they opted to carry their consumables to and from trading everyday. The storage amount payable was dependent on the goods that were being stored. In addition, the were no designated toilets to be used by the informal traders. Hence, they made use of public toilets that were available near the street market precinct and facilities of big business.

4.8 Targeting and sampling strategy

4.8.1 Target population

Bryman (2016) defines a target population as a sequence of units in which a study sample may be chosen. It is characterised by homogeneity and heterogeneity of a population. For the current study, the target population constituted South African women informal traders who were aged 20 years and older. They were also supposed to be conducting their trading in Region F inner-city. Additionally, the study participants included individuals who were accessing PHC services and in pursuit of medical care and/or treatment in the CoJ Refion F inner-city. Participants were well positioned to recount events of access and health seeking experiences in PHC services.

4.8.2 Sampling strategy

According to Kumar (2011:365), “sampling is the process of selecting a few respondents (a sample) from a bigger group (the sampling population) to become the basis for estimating the prevalence of information of interest to you”. Bryman (2012) suggests that a sample is characterised by a series of individuals who are positioned to respond to research questions. For this study, a non-probability sampling technique was utilised. Non-probability sampling techniques “are used when the number of elements in a population is either unknown or cannot be individually identified. In such situations the selection of elements is dependent upon other considerations” (Kumar, 2011:340). The researcher used purposive sampling, which involved a deliberate selection of participants who were deemed knowledgeable about the studied phenomenon (Johnson & Waterfield, 2004).

Through purposive sampling, the researcher pursued only people that she believed were most likely to possess the required knowledge and were willing to effectively respond to research questions. Furthermore, the researcher used purposive sampling to reach a specific sample that fulfilled specific characteristics. In this regard, she included access and experiences of healthcare services by a specific socio-economic group. Additionally, purposive sampling was preferred and useful because the study intended to show a historical and present reality, describe a phenomenon and/or develop an understanding on a topic that is barely explored (Kumar, 2011).

4.9 Data processing and analysis

4.9.1 Data processing

Creswell (2013) asserts that data processing is initiated in the early stages of the data analysis process. In the current study, data was organised through an electronic filing system to facilitate ease of access and reference. This process of organising data into electronic files is important in qualitative research. This is because qualitative data can take up large volumes. The current study followed Creswell's (2013) assertion, hence, all the study's FGDs electronic files were labelled as FGD 1-4 and each file name was followed by the date of the interview, to enable ease of reference and use. To augment this action, the concept of data coding was introduced and it involved reading and memorising the collected information. The researcher ensured to read all the transcribed notes for familiarisation with participants' responses. This was followed with the organising of responses into main concepts before the coding process (Creswell, 2013).

4.9.2 Data analysis

Marshall and Rossman (1995:111) suggest that the idea of data analysis is "the process of bringing order, structure, and meaning to the mass of collected data". According to qualitative research, the data analysis can start concurrently with the data collection process. This was done in the current study where the researcher scrutinised the responses that were deduced concerning what could be learnt and recommended as areas of improvement so that the interview guide could be revised accordingly. Furthermore, the data analysis process enabled the researcher to better understand the studied phenomenon, amplify the theory, and contribute to the advancement of knowledge (Neuman, 2014).

4.9.2.1 Recording and transcription

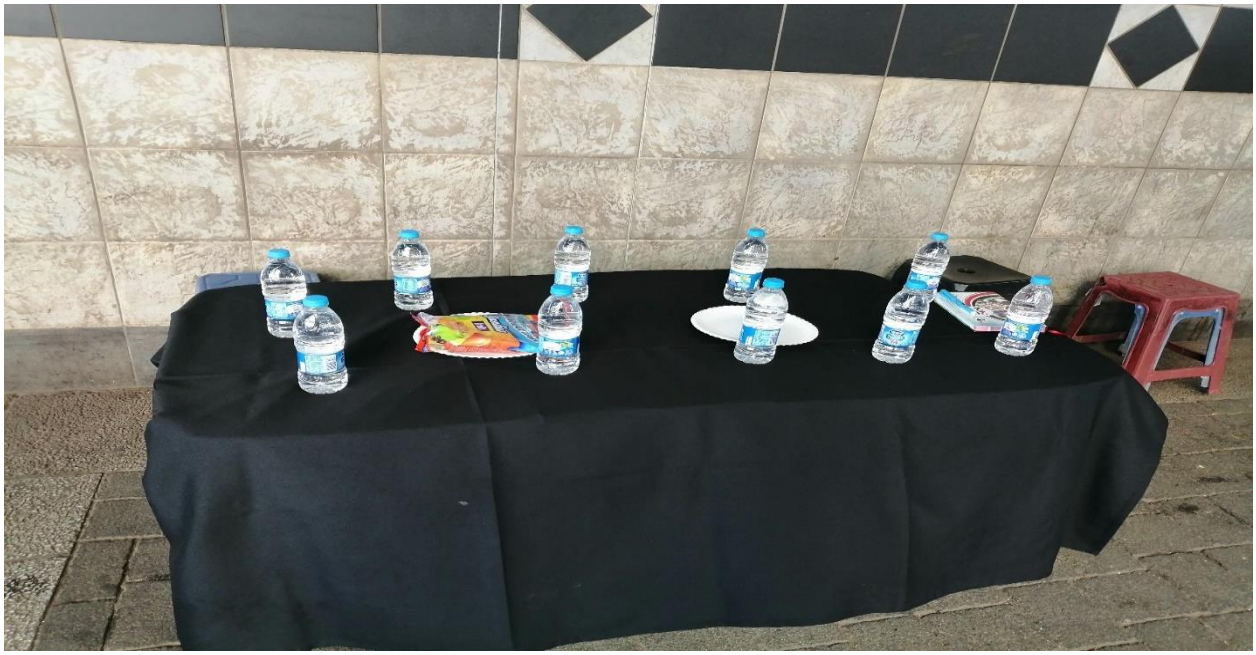
After securing consent from participants, the FGDs were tape recorded (Leavy, 2017). Recordings captured FGDs in their original and raw context. This allowed ease of reference in the data analysis process. Furthermore, to augment the recordings and in attempt to evade any parody and distorting data that may result from forgetfulness, the researcher scribed field notes during and after leaving the interview venues.

Since the study utilised four FGDs data had to be transcribed into written format to facilitate thematic data analysis. The current study adopted Bird's idea that transcription is "a key phase of data analysis within interpretative qualitative methodology" (2005:227). Additionally, the transcription process was used to put meaning to data, instead of putting verbal, spoken words to paper.

Arguably it is in the recording and transcription processes were elements of privacy and confidentiality must be prioritised, and it was the case in the current study. Strategies that the researcher employed to uphold privacy and confidentiality involved the selection of direct quotations, the use of pseudonyms, practical considerations, with the inclusion of selecting interview sites and embracing the situational context. Thus, the researcher arranged the FGDs in settings that were thought to provide privacy and were considerably easy to access for the participants.

As advised by the block leaders, FGDs were conducted on Tuesdays at 11am. However, owing to the reasons beyond the researcher or block leaders, during the field days, it was impossible to start any FGD at 11:00am. It was at this point that participants demonstrated power in the research process, and the power that participants have and at times exercise in research. Nonetheless the sessions did happen on the planned Tuesdays although the commencement times for the sessions always after 12h30. FGDs took place in the Region F inner-city along President Street outside open area (see figure 4). Through negotiations with the block leaders, it was agreed that the researcher arranges a table, tablecloth, and refreshments (water, mints, and lunch). During the FGD days, each respective participant was requested to bring a chair/crate to sit on.

Figure 4: Data collection setup



Source: (Researchers impersonation)

From time to time during the FGDs, uninvited guests/individuals (for example, male informal traders, traders who were non-citizens, and bystander) appeared and wanted to listen to the discussions. Additionally, there were inner-city ditractors and distractions such as, cellphones, noises from cars, carriages, and passer-bys. Therefore, the researcher had to find a way to proceed with the FGDs amid all the distractions and interruptions. The researcher's journal extract below indicates:

> *My goodness, what a throng of people! What could they possibly want? Was very frustrated. But I noticed from the participants' facial expressions that they did not mind (Dube, 2022).*

The researcher acknowledged that the audience that the uninvited guests presented had the potential to negatively affect participants' responses in giving authentic and direct information. However, having to ask people to excuse themselves or give us space would have been improper and offensive. In this instance it proved to be challenging to ascertain the ethical code lines. Although participants were not deterred about having to express themselves in the presence of others (uninvited guests), this caused frustrations to the researcher, because it seemed that there were high possibilities of the breaches of the ethics code of privacy and confidentiality. Therefore, when necessary, the researcher decided to pause a session and ask if the participants

want to continue with the FGD in the prevailing circumstances or rather reschedule the session for another date and time. To the researcher's surprise participants requested that the FGD must continue. In respect of the participants' choice the researcher proceeded with the session The researcher's actions to address the challenges of destruction for the FGD was recorded in the journal as follows:

> *I had to learn to be more patient, resilient and, be open and flexible to the cultural setting of the inner-city from the participants (women's) perspectives which are very much unique, and I was not accustomed to (Dube, 2022).*

In her attempts to ensure privacy and confidentiality, the researcher had to consider the situation's context (for example, the research topic and participants' concerns), apply logic in analysis and select responses that were well thought out culturally and ethically appropriate (Woolgate et al., 2017).

4.9.2.2 Thematic analysis

Braun and Clark (2006: 79), state that thematic analysis is a contextualist method that is used for "identifying, analysing, and reporting patterns (themes) within the data". As such, thematic analysis reflects reality, and unpicks the surface of 'reality' (Braun & Clark 2006:9).

The current study adopted Braun and Clarke's six phase thematic analysis. However, the steps were altered to properly deal with the big data sets. FGDs where transcribed from digital audio recordings and translated by a professional transcriber. The researcher then collated and reviewed the FGD transcripts, recordings, notes, observations, and reflections. This was an iterative process where the researcher immersed herself in the collected data, so as to make sense and logic of it. The process of data analysis also, involved searching for meaning and patterns permeating through the data. This was an exercise of familiarising herself with all the aspects of the collected data.

Secondly, the researcher also embarked on a process of generating initial codes. She used inductive/open coding to extract the codes. These codes set out data that was of interest to the researcher and referred to "the most basic segments, or elements, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon" (Bayatzis, 1998:63). The researher coded a considerable number of

potential patterns. During the coding process the researcher was cognisant of the contradictions and/or inconsistencies – thus, complementing experiences and divergences within the coding patterns, to produce a coherent argument. It was also important for the researcher to preserve narratives breaking away from the commanding story.

Thirdly, after coding the data, the researcher embarked on a process of searching for themes. This process involved analysing the quotes, with the consideration of how various codes may synthesise to configure overarching themes. The researcher used pile sorting to develop overarching themes (Bernard, 2006). Fourthly, following the preceding exercise of devising themes, the researcher refined the themes. This involved checking for meanings and coherence of the data while ensuring clear and noticeable contrasts between the themes. Upon completion of this process, the researcher had a decent idea of the different themes that were developed.

Fifthly, the researcher defined and named the themes. This action involved defining and refining the themes that she had set out to present in the final analysis. This finalised the data analysis with the refined themes. This meant pointing out the essence of each theme and establishing what data aspect did it capture. At the end of this process was to precisely define the emergent themes. Lastly, was the interpretation of the data. Meaning that the researcher established her qualitative analysis by way of thorough and detailed analysis of what South African women informal traders articulated regarding the themes and what they may potentially imply in so far as wider social outlooks and norms. Importantly, consistently repeated themes in the responses during the FGDs were explored contextually and within the research objectives, and in the discourse of informal traders and health.

4.10 Ethical considerations

In research, protecting participants is important, and this is normally done through the appropriation of ethical considerations. Since the current study involved human respondents, it was imperative that research ethics endorsement and approval was obtained. Before commencement of the study, an ethics application was made to the University of the Witwatersrand Human Research Ethical Committee (HREC) non-medical, and an ethics certificate (Protocol: WSG-2022-18, also see Appendix D).

Before the begining FGDs all participants were afforded the opportunity to thoroughly go through the participant information sheet (PIS) and the consent form. The PIS articulated all the required information about the research. It described the research purpose and processes. A depiction of the letter was sent to potential participants indicating the researchers name and explaining her intent (Appendix B).

4.10.1 Informed consent

Denzin and Lincoln (2011), argue that ethical research is premised on the idea of informed consent. In the current study, participants were fully informed of what was going to be asked from them and how the qualitative data was going to be used. Also, in all the FGD session's participants provided clear, signed consent forms to partake in the study by being interviewed (Appendix C). They also consented for the FGDs to be tape recorded (Appendix C). The signing of both conent forms was after the researcher's detailed explanation and participants' understanding of their rights to access their information, and to withdraw from the at any point.

4.10.2 Risk of harm, anonymity, and confidentiality

In this study, it was important that the participants' identities were kept confidential and anonymous. The declarations included protecting the participants' names and avoiding the use of statements, quotations, and information that was self-identifying since involvement in the study was a private and a voluntary undertaking. Participants were guaranteed that they would not be subjected to harm of any form by participating in the study. This was done in respect for a person's autonomy, and protecting those with diminished autonomy, that is, social precarious groups such as the South African women informal traders. The the current study's research design conceded the potential risks to the participants. The risks included resource loss in form of time spent away from trading activities which resulted in decreased profits during the FGD sessions. However, paricipants were made aware of this risk.

4.11 Research limitations

This study managed to accomplish its main purpose and intention. However, worth declaring limitations were encountered. Firstly, due to the limited geographical venue to conduct the study and a reasonably small sample for exploration, the subjective

perceptions of PHC services access and experiences, the examination of the use of the SRC to meet the health needs of participants may not necessarily be representative of all South African women informal traders in the country's inner-cities. Secondly, this was not a comparative study between South African and migrant women informal traders, although it is also crucial to explore migrants' experiences. Thirdly, there are other theoretical frameworks that were not considered in the study but could expose an alternative understanding of the studied phenomenon. Some of the noticeable alternative theoretical frameworks are the new public management theory and social exclusion. Lastly, the researcher is South African, who herself has significant experience in informal trading. Therefore, there were many similarities between the researcher and participants, this lead to high likelihood that participants would manipulate their responses to appease the researcher. Conversely, the researcher was able to appropriately probe for further information and explanations in the FGD to guard against inconsistencies on the participants' responses.

CHAPTER 5 - EMPIRICAL DATA PRESENTATION

5. Introduction

This chapter's analysis focuses on a sample of emerging themes from qualitative research conducted in the CoJ Region F inner-city (table 4 below). Probes one to three set out in the FGD guide will not be discussed because these were leading probes. In this chapter, the researcher presents and discusses the study's findings to provide a rich, and context specific narratives on the access and health seeking experiences of PHC services by South African women informal traders and their use of SRC in meeting their health and healthcare needs. Four sex stratified FGDs were conducted with a total sample of 28 South African informal traders (table 5 below). Participants were identified and recruited through purposive sampling and partnerships with informal trader block leaders. Data collection was conducted between July and August 2022.

Table 4: Emergent themes

Interview questions/probes	Themes
4. Briefly, may you please take turns and describe to us an incident when you had to seek and consult a healthcare provider in Region F?	1.1 Obstacles hindering access to primary healthcare (PHC) services
	1.2 Experiences
5. When you think about your experience now, irrespective of whether your health was improved or not, is there anything that you would change?	2.1 Suggestions to improve health seeking experiences
6. What do you understand by the term social rights of citizenship?	3.1 Rights
7. How do you think the idea of social rights of citizenship plays a role in your attempts to access public healthcare services in Region F?	4.1 Social rights of citizenship are ignored
	4.2 Social rights of citizenship to promote positive primary care experiences and perceptions
8. Why did you decide not to seek healthcare services in Region F at the time?	5. Healthcare disparities
9. Recommendations for Local Government	6. Suggestions for the improvement of access to PHC services

Table 5: Focus Group Discussion Overview

FGD 1	FGD 2	FGD 3	FGD 4	Total sample
10/07/2022	16/07/2022	29/07/2022	06/08/2022	
8 participants	6 participants	7 participants	7 participants	28 participants

All FGDs were transcribed from digital recordings and translated verbatim to English by a professional transcriber. Using an inductive approach to coding, the researcher then coded the transcripts to determe and edit emerging themes.

5.1 Demographic characteristics of the unit of investigation

The sample in this study comprised of 28 participants from modest backgrounds (*table* 6 below). To protect the participants' identities, the researcher used pseudonyms for participants. Participant's places of residence were spread out across the CoJ. Additionally, participants' duration of trading years in Region F inner-city varied. Likewise, the product and service offerings were varied amongst the discussants. All women interviewed indicated that they had visited and made use of PHC services in Region F. Furthermore, some expressed that they continued to make use of PHC services administered in public health institutions.

Table 6: Research participants outline

Name of participant (pseudonym)	Place of birth	Goods/ services rendered	Number of years trading	Have accessed primary healthcare services	FGD No.
P1	Limpopo	Traditional clothing and snacks	7	Yes	1
P2	Mpumalanga	Secondhand clothing	22	Yes	1
P3	Gauteng	Traditional clothing and snacks	29	Yes	1
P4	Gauteng	Traditional clothing and snacks	12	Yes	1

P5 (Block leader)	Gauteng	General supplies	40	Yes	1
P6 (Block leader)	Eastern Cape	Clothing and snacks	29	Yes	1
P7	Gauteng	Secondhand clothing	5	Yes	1
P8	Eastern Cape	Cooked food	22	Yes	1
IT1	Gauteng	Fruit and Veg	30	Yes	2
IT2	KZN	Traditional clothing	12	Yes	2
IT3	Limpopo	Traditional clothing and fruit	31	Yes	2
IT4	Eastern Cape	Cooked food	17	Yes	2
IT5	Gauteng	Fruit, veg and fries	20	Yes	2
IT6	Gauteng	Cooked food	25	Yes	2
V1	KZN	Traditional clothing	6	Yes	3
V2	KZN	Candy	9	Yes	3
V3	Mpumalanga	Cooked food	10	Yes	3
V4	Gauteng	Hats	23	Yes	3
V5	KZN	Traditional clothing and snacks	15	Yes	3
V6	KZN	Hairdresser	19	Yes	3
V7	Limpopo	Traditional clothing and cooked food	25	Yes	3
ST1	Gauteng	Accessories	8	Yes	4
ST2	Free State	Fruit and veg	33	Yes	4
ST3	Free State	Cooked food	7	Yes	4
ST4	KZN	Secondhand clothing	12	Yes	4
ST5	Gauteng	Hairdresser	24	Yes	4
ST6	Eastern Cape	Hairdresser	17	Yes	4
ST7	Northern Cape	Fruit and veg	13	Yes	4

5.2 Themes

5.2.1 Probe 4. Briefly, may you please take turns and describe to us an incident when you had to seek and consult a healthcare provider in Region F?

Theme 1.1 Obstacles hindering access to primary healthcare services

Participants articulated various obstacles that hindered their efforts in accessing PHC services. These obstacles surfaced at an individual and system level. They included prolonged waiting time for care, being subjected to long queues coupled with the uncertainty of not knowing if actual care will be received given their many health problems. One participant reported that:

> *"…is to go for a snake queue, snake queue because you are going to rotate and rotate, move from chair to chair, from this passage to that passage, you may come back home without even seeing a doctor, without being helped, sometimes even the people that must help with the files are very few, you spend the whole day seating hoping to be helped, and you get no help" (FGD1, P6).*

Linked to the prolonged waiting times was that when they eventually got the opportunity for care their appointments where rushed, not allowing them to maximise on the care experience. One participant stated that:

> *"…it is so bad so much so that by the time you get to see the nurse or doctor the appointment is so rushed like they just want to get rid of you, sometimes you cannot even ask questions" (FGD 4, ST1).*

Another obstacle was the geographical accessibility which participants stated that their nearest PHC facility was in Hillbrow and moving from the inner-city to Hillbrow was a significant distance. Taking from the participants responses core to this finding was the issues of trader resources. This was further restricted by their informal work activities and in other circumstances existing health conditions. The following remark was made by one participant:

> "*"So, we suffer from the lack of a clinic, but it is important that we go to the clinic where they will test us the colds, and chronic diseases. The problem is that we do not have a clinic in the CBD we rely on Hillbrow clinic and moving from town to Hillbrow clinic is a huge stretch" (FGD 2, IT1).*

An added obstacle as stated by the women was limited affordability concerns (money) putting a strain on women's limited resources. This was the idea of co-payments although the services were supposedly constitutionally free. This is what one participant cited:

> *"You still must pay when going to the clinic, they want money, R75 or more, when you don't have money, you suffer a lot. Also, you must pay a taxi fare to get to the clinic which is another money and at the same time you are losing money because you are not selling" (FGD1, P3).*

Furthermore, the requirements for documentation to access healthcare services, such as the proof of residence and ID, during the registration process, was mentioned as an obstacle to women's care seeking behaviours. One participant stated:

> *"…this thing of proof of residence is really a problem because I am renting so how am I expected to have my own proof of residence if I do not have my own place, everything is a struggle for us. How I wish this can change because it is a problem that is why we do not go to the clinic sometimes (FGD2, IT 3)."*

Additionally, self-employment surfaced as an obstacle to accessing PHC services that is, work commitment (informal work) which is the essence of who the women are as survivalist entrepreneurs, and the principle is straight forward *'no work no pay'*. One participant stated:

> *"…you must think about leaving the stall, on the hand you don't have energy, you know you need money otherwise it means my kids will not eat because I will be at the clinic. We work from hand to mouth we cannot afford not be on the street selling to make money (big sigh)" (FGD2, IT 8)*

Women's perceptions of medication given was also an issue in this regard. They expressed that they sometimes felt that the medication given at care centres was not adequate. The following expression was captured from one participant:

> *"I have been to the clinic myself many times, visiting because of my eyes, you find that I do not get the help sometimes they check me manually then give the same eye drops to apply but I have not got any better, I still cannot see very clearly" (FGD 4, ST1).*

Another participants' observation was that when visiting primary care centres there was a lack of support for healthcare workers. They indicated that they also sympathised with the nurses because of the influx of patients for help. This was captured in the following expression by one participant:

> *"Oh, it gets very full at the clinics because a lot of us are sick and sometimes I also see that it gets too much for the nurses and doctors. These people are just too little, and they must help so many of us. It is just a lot (FGD4, ST6)".*

Theme 1.2 Experiences

Likewise, with the case of access to PHC services, participants revealed their different experiences in various PHC institutions during healthcare delivery. A significant number of participants mentioned that their experiences left little to be desired and were unfavourable and expressed discontentment with their experiences. This rendered the PHC system ineffective for the participants. However, some experiences where positive and these were expressed by very few participants. One of the experiences included the unavailability of healthcare professionals (human resource inadequacies). One participant supported this assertion as follows:

> *"…shortage of nurses since when you get to the clinic, you sit for a very long time until sunset, while moving from bench to bench. The nurses are not there the doctors are also not enough" (FGD3, V6).*

Poor customer service by healthcare support staff such as security and administration personnel was also reported as a negative care experience by the women. One participant had this to say:

> *"When you walk in the clinic even the security does not attend to you. The service at the clinics is very poor they are not doing things well. Sometimes when you get to the clerk at the register, the clerk just stands up and attends to his or her phone or he/ she will drink their tea/ coffee, it will be that way. You will be waiting for him/her to come register you, and will only come around at his/her own time, coming only to ask you what you want ma'am, and then you never know then since they know clearly, I am here to register because I am sick" (FGD4, ST6)*

Unavailable medication and inappropriate treatments were a huge concern for the women in their health seeking experiences. One participant said:

"I have been ill, from osteoarthritis to this day I have not been better. I have been visiting the clinic since 2011 but I am not benefiting anything since I only get Ibuprofen, and I return the next month to again get Ibuprofen there is no alternative you do not get injected you only get the ibuprofen until I stopped going. I just feel that they do not carry out proper checks at the hospital that is why I am not getting better." (FGD1, P4).

Other participants mentioned that they were subjected to having to source for themselves prescribed medication by the doctor since these were not available at the care pharmacy. Women stated being subjected to a large pill burden. One participant reported that:

"… after checking up with the doctor you will sit for a long time at the pharmacy queue and when it is your turn, they will tell you that they do not have what the Doctor prescribed. Then you must buy the medication yourself. It is so frustrating" (FGD4, ST1).

In the absence of medication from the care pharmacy participants indicated that they opted for home remedies. A participant mentioned the below with reference to home remedies:

"…it was hard to decide going to the clinic where you will take the whole day on a queue while you have a table to look after, so if you don't go to the table it means you will sleep without eating really, I ended up helping myself using home remedies like ukuchatha (enema), ukufutha (steaming) and ukugabha (throwing up)" (FGD2, IT2).

Resulting from the unavailability of medicines in primary care centres, some women indicated that they made use of alternative care processes such as, indigenous health practices and traditional medicines. One participant voiced the following:

"… sometimes I just decide to go for traditional help which is an iNyanga. The Nyanga's (traditional doctors/ healers) treat us with respect, and they are sensitive to our sicknesses. Also, they are not expensive and the treatment forms part of the consultation fee, so I do not pay more." (FGD3, V5).

Poor communication and sometimes verbal abuse by healthcare personnel was also cited as an adverse experience when visiting PHC centres making participants care

visits undesirable. This for some of women influenced their decisions to or not to seek care because according to them the attitudes of care staff was just unsatisfactory. The was a general perception among the participants that trust and good relations between themselves and care workers was non-existent, deterring some to seek much needed care services. A participant reported the following:

> *"Once I got sick. I had an infection, I went to Hillbrow clinic. When I got there, nurses made fun of me. They said all unspeakable things. I never saw the doctor I only managed to see the nurses, who were mocking me saying that I engage in sexual styles that I am not supposed to, you do this and that, that is why you get diseases of the uterus at this young age because I had an infection. I was not properly examined, no urine checked nothing. I tried to ask questions, but I was ignored. They really hurt my feelings". (FGD4, ST7).*

Another undesirable experience that affected the participants in their care visits included delayed care. Participants cited lack of knowledge to identify symptoms (misdiagnosis) questioning the care workers call on their prevailing sickness or illness. The women perceived the care workers as having very limited awareness of the effects of being an informal trader on one's health. As such, several women recounted mistrust towards care workers resulting from misdiagnosis and other delay eventualities. One participant mentioned that:

> *"Ever since I went to the clinic, I just came back without getting any assistance. Maybe they do not know what is wrong with me or they are not sure what to make of my sickness because it is difficult for us on the streets. I do not think they know what they are doing sometimes you can even see the confusion on their faces" (FGD1, P1).*

Furthermore, there were instances where participants expressed positive and acceptable treatment by healthcare personnel, these were very minimal. The few women that reported on positive quality of care recounted care workers tolerance towards the sick and the nurse's competence in dealing with comorbidities. One participant supported this and said:

> *I had another experience again in 2010. My uterus was not well and I also have high blood pressure. First, I went to the clinic. There used to be a clinic on Loveday Street. They carried out tests, and they suspected there was something,*

so I was transferred to Joburg Gen. When I got to Joburg Gen I was treated well. I never had the problem again. I can say that I was respected as a patient and the nurses did listen to me and helped me" (FGD2, IT3).

Conversely incidences of negative quality of care towards sick patients by healthcare personnel was also reported by most participants. Some were direct while others were witnessed by participants towards other patients. This was perceived as discrimination by care workers towards patients. One participant said

"Like I had a child when I was old, when I was in labour having the baby, they would ask me what I was waiting for till I got this old, why are you only having a child now, they forget that a baby is a gift from God and will only come when God decides, their talks are not alright towards us" (FGD 1, P4).

Another participant citied an incident towards another patient by a nurse that they witnessed as follows:

"…this lady was so week. She called the nurse and asked that she helps her get to the loo and the nurse was not interested and disregarded the lady's request. And it came to a point where the lady could not hold it in anymore and ended up soiling herself. It was very bad for the lady. (FGD1, P2)."

Also, the overcrowding in primary care facilities was another issue in the health seeking experiences that was reported by the women. One participant said:

"Lets us talk about Hillbrow clinic, that clinic is always full because it takes CBD, Hillbrow and many surroundings, so when you go there as a trader, you will get to the queue and wait the whole day, they do not care about who you are and where you from. Another problem we are facing when we are here at the CBD, you will go to the clinic around 5 which is late. Also, at the clinic/hospital there are not enough beds, even with the long lines there are no chairs. This was even worse during COVID." (FGD2, IT5).

5.2.2 Probe 5. When you think about your experience now, irrespective of whether your health was improved or not, is there anything that you would change?

Theme 5: Suggestions to improve health seeking experiences

Discussants suggested different ways that could assist to improve health seeking experiences at PHC centres. They reported on increasing the number of healthcare professionals and support staff as one way. One participant made the following comment:

> *"Another thing that they must do in the clinics and hospitals, they should add administrators, they have many registration counters but no people working. One counter will be working where they help patients. There at the Pharmacy where we get our medication only two counters are working but there are counters as many as thirteen but all of them are not operational since only two people are there. And you sit there until you starve while you are at the clinic and get sicker because you are seated at the clinic and not getting attended to. So, we ask they add more nurses, doctors, clerks and more pharmacy staff who will help us with the medication because we spend more time waiting there. And most of the time you get to the counter to be told that the treatment prescribed by the Doctor is not available." (FGD1, P4)*.

Advancing continuous training and development for primary care professionals was also suggested by women. One participant mentioned that:

> *"They need training real training to help people and ubuntu, which is in short supply. When you are going to be working with people especially in health services people are sick, they are suffering when they seek for help, but one will be insulted for nothing. The training should not be once off." (FGD1, P2)*.

The improvement of facility hygiene was also reported as a health response mechanism by the participants. One comment in this regard was as follows:

> *"And the clinics are very dirty more especially the toilets. The toilets at the clinic can also make a person sick they are always blocked, no tissue, no hand soap it is just bad. Sometimes you get there, and the lifts are broken. There is dirty laundry all over and sometimes the dirty laundry has blood strains and human waste" (FGD2, IT2).*

5.2.3 Probe 6. What is your understanding of the term social rights of citizenship?

Theme 6.1: Rights

Participants expressed their understanding on rights as something that every person is privy to and should be enjoyed by all. Some stated that a right is inherent, imperative and cannot be retracted. They went on to express that a right concerned freedoms and entitlements such as the right to vote, the right to healthcare in relation to the study, and some cited freedom of speech. Participants also mention that sometimes the rights are denied or ignored because they are disadvantaged when trying to make use of PHC services. One participant had this to say on their understanding of the concept of rights:

> *"When you mention the word rights immediately, I think of that small book called the constitution and I get excited, oh yes human rights. As a sick person I have the right to go to any clinic/ hospital to get help to feel better." (FGD3, V2).*

Another had this to say on their understanding of the concept of the right to health:

> *"According to my understanding, this section says that I have a right as someone sick to go to a clinic or hospital. The nurse or doctor to understand what I am telling them about my sickness and then give me the right treatment, if I do not like that treatment or maybe not satisfied with it, or they are not treating me well, it is my right to go back to the clinic to tell them that the treatment (medication) they gave me is not helping me. It is my right to go to the hospital when I feel sick to get treatment" (FGD2, IT5).*

Participants also commented on the idea of denied and/or ignored rights to health. Two participant recounted that:

> *"People are being denied those rights it is as if they went to the clinic to beg for their rights it's as if they are a problem… uh it is not right it is very wrong I can't even have words to explain it the way it is so horrible" (FGD1, P6).*

> *"At the clinic when you try to stand up for yourself because you feel they are not treating you well they will use it against you, and you will not be helped because they will say you know too much" (FGD4, ST4).*

5.2.4 Probe 7. How do you think the idea of social rights of citizenship plays a role in your attempts to access primary healthcare services in Region F?

Theme 7.1: Social rights of citizenship are ignored

Participants indicated that their SRC are sometimes ignored through instances of lack of patient care and freedom in attempts to access primary care services. Participants made the following utterances:

> *"Eish it is a serious power struggle for us at the clinic/ hospital, we are just powerless, and it is painful because when I go there it means I need care and assistance. There is a lot of name calling, we get little respect. Those people control us because they have power over us when we are at the clinic. This right means nothing to me." (FGD 3, V3).*

> *"We have so called rights, but we are abused and violated as patients ay! That is why if I can help it, I just do not go to the clinic I treat myself at home than to go there and be mistreated and disrespected" (FGD1, P1).*

Theme 7.2: Social rights of citizenship to promote positive primary care experiences and perceptions

While there was a high number of participants expressing negative views on SRC in attempts to access treatment, few women expressed contrasting positive views. One participant voiced:

> *"Truth must be told, ever since they introduced this law, I do not want to lie when I go to clinic, they treat me well maybe it is because I love laughing and talking. I was free to tell the nurse when they gave me the spray I do not like, and ask them to give me another spray, and they listened to me. If need be, they will explain how it works, and which one doesn't work, they explain to me perfectly. When you are lucky you get to be treated by nurses and other people (security) at the hospital who care for us patients" (FGD2, IT1).*

5.2.5 Probe 8. Why did you decide not to seek healthcare services in Region F at the time?

Theme 8.1: Healthcare disparities

Participants reported disparities that were associated with accessing and experiences of primary care services. These disparities in the care system and delivery according to the participants rendered the primary care system ineffective. This included lack of access to adequate treatment. One participant had this to say:

"I have been ill, from osteoarthritis to this day I have not been better. I have been visiting the clinic since 2011 but I am not benefiting anything since I only get Ibuprofen, and you return the next month I get Ibuprofen there is no alternative you do not get injected you only get the ibuprofen until I stopped" (FGD1, P4).

Livelihood security was another disparity cited by the participants in their health value chain since there was no compensation for time taken away from trading. One participated stated:

"There are a lot of times I have been sick and not go to the clinic, to be honest especially because sometimes I suffer from my feet. When I go to the Hillbrow clinic and stay there the whole day, I am working (self-employed), as people that work on the street, we are the ones that work from hand to mouth. If I did not work it means am not cooking, it means my children are not getting bread that day, so if I have a headache or suffering from sore feet, I must work like that and bear the pain, I will keep buying and tacking pills. At the end of the day, I work the whole day in pain" (FGD2, IT5).

Resulting from some of the disparities that participants experienced during care seeking some resorted to home and/or traditional medicines. One participant voiced the following sentiments:

"I was once sick with flue, and because it was during the Corona days, I didn't know what it was exactly because I was coughing while feeling the heat on the other side, a lot was happening. So it was hard to decide going to the clinic where you will take the whole day in a queue while you have a table to look after, so if you don't go to table it means you will sleep without eating really, I ended up helping myself using home remedies like enema (ukuchatha) or spade, ukufutha (steaming) and ukugabha (throwing up) which helped me. But we are really struggling without a clinic close by, you think twice about what kids will eat because me going to the clinic it means I won't have anything" (FGD2, IT2).

Other participant raised the following regarding traditional doctors:

"The Nyanga's (traditional doctors/ healers) treat us with respect, and they are sensitive to our sicknesses. Also, they are not expensive and the treatment forms part of the consultation fee, no extra costs." (FGD3, V5).

5.2.6 Probe 9. Recommendations for Local Government

Theme 9: Suggestions for the improvement of access to primary healthcare services

Participants put forward various propositions to improve and aid adequate access to PHC services to improve their health seeking behaviours and processes. They suggested the introduction of mobile clinics in the short term while the City Council considers establishing static PHC facilities in the inner-city that will be at their disposal. One participant made the following comment:

> *"What I think the government can help us as informal traders is that as the other sister has already mentioned, that the government can add mobile clinics that will be closer to the traders because you find that the one selling randomly gets sick. As it is now, we don't have a clinic nearby, so if we don't have any closer clinic, when one gets sick, it will take time to get to the hospital. Let's talk about Hillbrow clinic, that clinic is always full because it takes CBD, Hillbrow, and many surroundings, so when you go there as a trader, you will get to the queue and wait the whole day, they don't care about who you are and where you from, that is the other problem we are facing when we are here at the CBD, you will go to the clinic around 5pm which is late" (FGD1, P5)*.

Additionally, participants indicated that training of human resources would motivate them to seek the much-needed care since they believe the training will come with improved care. One participant expressed that:

> *"We are asking the government to train the workers at the clinic, they should not ask your name when it is already in the computer and then still ask for your ID, what is the computer for, people must be willing to work according to their education not that they are a relative or uncle's child and they work. They are dealing with people's lives, they should train the workers" (FGD4, ST6).*

Participants expressed a need for safe storage facilities for their wares stating that this would guarantee that their merchandise is well secured and would in turn eliminate the stresses associated with the risk of loss or damage to their trade merchandise which they directly linked to their livelihood. One participant said:

"You see the government, if they can give us an old building that they are no longer using so we can be able to put our wares in it, and collect these easily. This will reduce our stress levels and we will know that our things are stored safely because we will not be worrying about our supplies breaking or people stealing them" (FGD3, V7).

Another said:

"…you know it would really be nice if our government can help us with something at least proper storage for safety for our things… I mean there are no jobs we are really trying to make our own jobs, but they do not care for us but come election time they will want our votes mxm" (FGD2, IT2).

CHAPTER 6: EMPIRICAL DATA DISCUSSION

6. Introduction

This section delivers qualitative perspectives and discussion of the findings and contributions made by the unit of investigation. These are captured under six (6) themes for probes presented in chapter five (5) to include probes 4, 5, 6, 7,8 and 9. The meaning and implications of the research findings are discussed and deliberated on in detail, with reference to reviewed literature and the identified theoretical lens of the research based on social policy as a critical analytical enquiry.

For the participants, good health was an important element to their precarious lives as it served as a means of support and income to everyday life.

In summation of the themes from the data collected, the researcher found that the access and experiences of PHC services in the CoJ Region F inner-city by South African women informal traders was inadequate, and, had an adverse impact on the health, healthcare outcomes and quality for these groups. The challenges faced by these groups in their health seeking behaviours inclined negative effects towards their access and experiences of primary care services. Also, in the findings the researcher established that the depreciation in the quality and inadequacy of PHC service outcomes had led these groups to lose trust and dependence in the public healthcare system. Furthermore, the findings suggest that SA women informal traders attach minimal trust in SRC in meeting their healthcare needs. On the other hand, the researcher established that these social precarious groups used their SRC through taking part in economic activities, to generate much needed income to sustain a livelihood.

South Africa is known for having established a constitution that protects the human rights of citizens' and their access adequate and quality healthcare services (Constitution, 1996). The opposite is true for informal traders as observed by Skinner (2007), who cited that no parallel development in these groups' can be evidenced with their persistent increase in numbers. SA women informal traders continue to face challenging experiences when attempting to access PHC services. Furthermore, the analysis of the participants' responses suggests that South Africas PHC system is inadequate and ineffective for the urban working poor.

6.1 Discussion

6.1.1 Probe 4. Briefly, may you please take turns and describe to us an incident when you had to seek and consult a healthcare provider in Region F?

Theme 1.1: Obstacles hindering access to public primary healthcare services

Social policies by design involves activities by governments through providing money and services to constituents, and one way suggested to this research was health service delivery.

This finding used social policy as a critical analytical framework in terms of its intentions and objectives. Social policy established different types of intentions and objectives, and these include redistribution, risk management and reducing social exclusion (Titmuss, 1976). This was a suitable tool to analyse access to PHC services for social precarious groups.

Redistribution is known to be a defining feature of social policy, whereby the government states its intentions to redistribute resources amongst citizens in order to fulfil a welfare objective (Titmuss, 1976). This is true because no government considers putting forward policy interventions if there is a belief that there is satisfaction in the allocation of existing resources. Redistribution in terms of social policy takes two forms. Firstly, it is the moving of resources from those perceived to have more to those who have little to nothing. Redistribution of this nature in essence is determined through ethical and moral considerations linked to justice and fairness. The rectification of these inequalities should be through vertical distribution that is, moving resources from the rich to the poor. Secondly, government may opt to use social policy as a tool to redistribute resources as a result of existing allocations being inefficient. This is what economists refer to as market failure, and the rectification of these market failures is made possible through horizontal distribution.

The management of risk is a compelling way to understand the ideology that underpins social policy ideology. Titmuss (1976) illustrated natural risks as sickness/ illness, childhood, and old age. There are also man-made risks resulting from civilization and general human evolution for example, work injury and unemployment. Titmuss went on to refer to those subjected to those risks as being *'in need'* (the precariat) and South

African women informal traders exemplify this assertion. In the management of risk both natural and man-made involves access to healthcare services, social policy exists and is justified to meet social needs such as healthcare.

Social exclusion arises when income levels are greatly unequal (Townsend, 1979) and such is the case with informal traders (Pick et al., 2002). These groups are excluded since they are unable to meet some societal standards, such as, paying for medical insurance. Social exclusion is unproductive that is, inefficient. This finding demonstrates in-adequate redistribution of healthcare resources to those who cannot engage in work due to illness. To rectify this varience, it requires horizontal redistribution. Moreover , social exclusion mirrors government's failure to adequately deal with risks confronting people in very complex situations and thus creating new risks if those excluded are alienated from the wider society. Social policy is needed to deal with the risks that lead to exclusion related to illness. It also has to avert the advancement of new social problems making adequate access to healthcare services an important imperative.

Healthcare access in the public sector is key for SA women informal traders, since they do not have the luxury of occupational health services and medical insurance. This finding determined and explored obstacles hindering access to PHC services as articulated by these women.

Prolonged waiting time.

The most common obstacle to access PHC services as indicated by the women was the prolonged waiting time for care at healthcare centres. One may argue that this obstacle is not just synonymous with South African women informal traders but to most people seeking care from public health institutions (Harris et. al, 2011). The participants recounted long queues, over and above the general ineffectiveness of care workers led to these long queues by showing no interest. This was also linked to rushed care once they had made it to the consultation room. The participants expressed that they experienced rushed consultation sessions at care centres limiting their opportunity for comprehensive care. Also, because of the rushed care they were unable to have full discussions with care workers on their multiple health problems which were sometimes outside the purview of the existing ailment at the time. This was equivalent to skewed

care services as expressed by the women. This finding resonates in studies conducted in other countries where informal workers were present, mentioning that prolonged waiting time for care was a deterring factor in seeking healthcare (WIEGO, 2014). This may also be attributed to the direct implication of time taken off from trading, resulting in loss of earnings. In the sentiments of the women, they would have rather made use of the time spent in long queues to be productive at their trading spaces. For the women, this was a great deterring factor to visit a health institution for healthcare services even when urguently needing care.

Work commitment(s)

Informal trading by its nature is set up in such a manner that daily, income generation is imperative. This can be said to be a loss of income for being absent from trading. A defining feature to this is that income generation is unpredictable. Most strikingly is that, different and gendered effects characterize employment informality. In this case the women lived through the double-burden of family care, which is unpaid and income earning, and arguably informal employment surfaced negative health consequences for the women (Alfers and Rogan, 2015). This obstacle was the second most common with the women. Taking time off from trading was not feasible, a finding synonymous with those reached by WIEGO (2018) on health access by informal workers in India.

Unlike working in a formal economy, women informal traders are not protected by legislation such as, occupational frameworks which make provision for income protection during time taken off to seek healthcare. This idea is consistent with studies that have been carried out before, citing that vulnerable and precarious groups have limited access to healthcare services due to poverty (Ekipira, 2008). Most of the participants were engaged in trading activities that did not yield much income, so they were unable to set aside some savings for their healthcare needs. Based on this view, the participants expressed little consideration for their health in comparison to their informal work commitments.

Geographical accessibility

Difficulties in accessing healthcare facilities due to geographical location was the third most common obstacle identified by the women in utilization of primary care services in the CoJ Region F. This was closely linked with the issue of transportation. The women

cited that transport services were costly and health facilities were situated far from where they worked and lived. This was contrary to the formal labour force where occupational healthcare facilities were often found at the workplace. Furthermore, this gave rise to the assertion that, if informal traders were given the opportunity to access occupational health services onsite, or at least nearer to their trading spaces, they would-be improvement in the utilization of health services by these groups. This would help in avoiding obstacles associated with access of healthcare services and consequently improve the healthcare outcomes of these groups, thus resulting in early diagnosis of diseases. Few participants expressed that they used health facilities that were close to their place of residence. Only few women had this privilege since for other women, there were no facilitities available near their place of work in the inner-city. Some also indicated that they had no choice but to make use of far-flung facilities because of desperation and need for care. This emphasized the need for clinics in and around the vicinities where people live, or where they work since that is where they spend most of their time. This finding is consistent with studies highlighting the importance and need for making available healthcare services nearer to where people work and reside (Harris et. al, 2011). Judging from the women's responses, they are highly likely to make use of health facilities that are easily accessible highly likely them. Introduction of easily accessible facilities, could improve the health seeking behaviours of these social precarious groups.

Limited affordability concerns

The inability of social precarious groups to register with health insurance schemes or make upfront payment for medical services at private healthcare centres due to limited resources was another obstacle associated with access to healthcare services. The women cited instances where they had to pay in primary health facilities for care that is, a co-payment. The participants were aggrieved by this since they were under the impression that public primary care services were supposed to be free, and because of this they sometimes took the decision not to seek care. The participants associated this to low earnings and poverty linked with their informal work activities. This assertion is consistent with findings from prior studies arguing that informal traders have minimal access prospects to affordable, sufficient and correct healthcare outcomes for themselves, especially when considering potential costs associated with seeking healthcare (Woodward et. al, 2011).

Requirement for documentation (when presenting at a PHC facility)

Several participants indicated that there were strict requirements that included the need to produce documentation such as ID, proof of residence during registration. This shows the lack of a '*fixed abode'* in care seeking processes. Some also mentioned that getting proof of residence when renting was difficult, and some lived in informal settlements that did not have a residential address. In most instances these documents were not readily available. This obstacle is not unique to this research work and is in line with other studies conducted in this field, with data on various challenges encountered by informal traders in attempts to access healthcare services (Mkandawire, 2005). Gunner et al., (2019) study on access to PHC by the homeless revealed how patient registration processes were a barrier to seeking care services by the homeless. Ramirez (2014), cited how informal workers were constrained in seeking healthcare services because of personal identification concerns related to providing permanent physical address, an ID document and providing upfront payment in some instances. Some women indicated that it proved to be very challenging for them to get the much-needed assistance at primary care facilities without producing valid documentation. Consequently, this placed the women at a disadvantage compared to those in the formal labour force. Furthermore, the women expressed the view that requirements to provide a fixed abode status address should be eliminated, as it was a sensitive constant reminder of their precarious conditions.

On the other hand, the requirement of valid documentation helps PHC providers with relevant information during the registration process , for the patient's history recording. This may also assist in requesting for additional resources from authorities during service delivery allocations in the form of equitable grant allocation for the City of Johannesburg from National Treasury. Conversely, this may potentially be interpreted as an infringement on the optimal right to healthcare, that is non-discriminatory, resulting in the deprivation of people's right to affordable and free healthcare services (NHA, 2003). Vearey (2010), suggested that in some cases healthcare facilities formulate self-serving guidelines that contravene national legislation.

Women's perceptions of medication given at healthcare facilities

Medication is the medical management of a disease or illness. The participants reported that there is poor quality of medicines being distributed at care centres. . This negatively affected the continuity of healthcare as well as health outcomes. At times, the participants indicated that they opted for alternative self-medication such as, the use of indigenous medicines, thai is herbs, and over the counter self-medication from pharmacies. Asampong et.al, (2015) in their qualitative study referred to this act as '*bad'* health seeking behaviour among informal workers to include drug stores, self-treatment, and traditional medicines. Significant to the study was that these obstacles did not totally prevent some of the women from visiting healthcare facilities, in most instances the women reported delayed care seeking behaviours. This had to do with the lack of trust on the type of medication given and the perception that the treatment would not be helpful. This finding is in line with several studies conducted in this field, with information on the various challenges encountered by informal workers in the utilization of healthcare services (Ramirez, 2014).

Conclusion

This finding shows that the participants just did not have money to spare. As witnessed and captured, the women worked relentlessly to secure much needed income and in most cases, they could not make time for health consultations. Transport costs to healthcare facilities , sometimes it was a challeng in getting there. When considering what the participants had to comprehend and overcome, the logic applied by the decisions taken to stay away and not seek healthcare services for medical treatment became clear. The obstacles explored on accessing primary care services were contributing elements that worsened the health issues experienced by the participants.

Theme 1.2: Experiences

The findings examines social policy as a critical analytical enquiry in terms of administrative and financial arrangements. This implies to how government organize its services and related institutions in order to achieve its objectives. In this sense social policy as an administrative and financial arrangement makes local development a useful and helpful tool of social reform (Baldock, 2007). This being a key directive for local government in SA as enshrined in the constitution. In addition, policy and administrative practice in social services includes health services, among others.

Social policy as social administration

The successful delivery of the intentions that inform social policies in predictable and orderly ways, is the fiduciary duty of government. Therelated institutions has to see these policies through, with healthcare being key, deliverable for all three spheres of government in SA. To this effort, a part of the Beveridge report (1942), was not to deliberate on the overall goals and objectives but instead about a plan of action explaining the administrative arrangements needed to realize them. This means that even if the best systems are put in place ,they will be of no use if there are no people to administer those well-developed systems. Post democracy has seen SA constitute a significant excerpt of government bureaucracies, attached with the employment of considerable amount of labour force, with the provisions of various policies to include health policies.

When Titmuss first coined the concept of social policy, he referred to it as social administration. It insinuated that the idea that what is of interest to some degree is social policy in terms of its intentions, but to a noticeable extent the administrative arrangements, that would be most ideal to accomplish them (Baldock, 2007).

In general, there are three main administrative procedures set out to achieve social policy goals that is, regulation, cash benefits and of relevance to this research work is *'services in kind'* (Baldock, 2007). This ideology is also supported by Marshall (1950). Services in kind implies the administrative methods set out by government to accomplish social goals providing services directly to the people, to include healthcare among others (Baldock, 2007). The government sets up state institutions to carry out the job. These are public bureaucracies such as the department of health (NDoH), or the envisaged National Health Insurance (NHI). It may even assign the delivery of health services to private companies or voluntary institutions (NPOs). It is evident that informal workers depend on the public healthcare system.. This demonstrates how organizational arrangements greatly influence the success or failure of social health policy. It would assist if current debates on social health policies considered less of the main goals, which are clear cut and more of appropriateness and adequacy of the administrative and financial systems set out to deliver them (Lewis, 2003). On the other hand, there may be some issues with the administrative processes. This can be evidenced by many lawsuits levelled at the SA public health sector for various reasons..

Social policy as public finance

Global governments are confronted with the predicament of having to service unlimited wants of constituents with very limited resources. This should be not an excuse to compromise on health issues. Government social policy tasks include substantive properties of economic outputs of nations (Baldock, 2007). Both occasions of securing the money and management of how it is spent, are significant conditions of social policy. In recent times, perceptions have transformed regarding the costs of social benefits. Of relevance to this research is the question that must be asked; *'are health delivery programs built on financial arrangements that are equitable and conducive to social precarious groups (informal traders)?'*, and this study disagrees judging from the responses given by the participants.

The financing of social policy unfolds in two ways that is, through taxation (direct or indirect) as well as social insurance contributions (Baldock, 2007). An associated argument is that these taxes influence the wellbeing of people, and these may be adverse sometimes (Baldock, 2007). The major argument in this regard posed by the paper is that, the informal sector is said to not be paying tax or it is evading tax. One may argue that in most cases informal workers trade goods or services that are taxable before reselling. Furthermore, taxation policies are in essence social policies. Key to this is that, public management finance is fundamental to social policy (Titmuss 1951). This was largely magnified in SA during the peak of the COVID-19 pandemic, where public finances were wasted through corrupt activities. It was also during this time where the social precarious nature of informal traders was worsened. The women expressed that no support was demonstrated by the South African government.

Health service delivery calls for the investment on people and building long-term, knowledge of financial projections, and expenditure(Baldock, 2007). The experiences are discussed below.

Unavailability of healthcare professionals

Unavailable healthcare professionals to give care and attend to patients at primary care centre's was reported by most of the participants. Majority of the women indicated that the unavailability of care workers affected their experiences of primary care services. Arguably, this is the major shortcoming in most public health systems in the sub-Saharan African Region including SA (Maphumulo and Bhengu, 2019). This speaks

directly to labour force issues of staff shortages, to some extent the general effectiveness of existing personnel and inherently this will have an adverse implication on the quality of care. This may translate to the poor services offered to patients. Barron and Padarath (2017), state that SAs health problems are exacerbated by an uneven distribution of healthcare proffessionals between the two health sectors, that isprivate and public, sector among provinces. This finding corroborates with that of a study by Tana (2013), where participants expressed that there was an inadequate supply of health professionals in public health institutions. This led to worsening health conditions as well as mental and physical fatigue for both the patients and existing health workers.

Another important dimension is the issue of inadequate number of health professionals. In turn, this then leads to staff shortage due to only a few workers being recruited, poor staff retention, and this is a global problem (Veld and Van De Voorder, 2014). Apartheid South Africa produced a strong capacity of health professionals through the establishment and maintenance of health training centres predominantly nursing colleges. Currently there are serious human capacity constraints being experienced in the South African health system (Van Rensburg, 2014). Furthermore, there is an uneven distribution of healthcare personnel between private care which is well resourced and servicing a minority, as compared to public care which is poorly resourced and offering services to the majority. The women indicated that the staff shortages were evidenced mainly with the nurses and administrative personnel. Coovodia et al. (2009), stated that, the health staffing shortages find expression mostly with the nurses, and it is the nurses that are supposedly the frontline personnel of healthcare service delivery. Moreover, the uneven distribution of health human resources may also be attributed to SAs rapid urbanization, and this characterises Region F inner-city. Additionally, the closure of several nursing colleges in the 1990s, as well as some health professionals choosing to apply their trade in private sector or overseas, contributed to staff shortages. This information is not documented in the study.

Unavailable medication and equipment (material shortages)

The participants reported on the unavailability of medication and equipment at care centres. Majority of the participants expressed that the scarceness of medication at primary care centres had an effect on their health seeking experiences and access to medication . They stated that after spending the entire day in long queues at care

centres, patients were then given medical prescriptions to source the medication at pharmacies at their own cost, as they were not readily available at the facility pharmacy. This was perceived as a pill burden by the women. They deemed it preferable to visit the pharmacy when not feeling well and purchase medication instead of going to a PHC, where they will be given a prescription they must still source themselves. This was the idea of selfcare at home. While other participants opted for traditional remedies like enema and steaming to mention a few. Akazili et al., (2018) cited that the unavailability of medicines at care centres led to poor healthcare services and practices for informal workers.

As a result of the inadequacy of primary care services, the participants embraced the idea of making use of indigenous practices to healthcare. Some of the women indicated that sometimes they opted for the traditional route to healthcare that is, consulting a traditional healer for indigenous or herbal treatment medicines. This action translated to the idea of *'traditional healthcare services'* for the women. The emergence of traditional healthcare services has found prominence in sub-Saharan Africa as patients were subjected to various challenges in their western health seeking experiences and processes (Ekipira et al., 2008). The women indicated that these services were readily available in the inner-city and they did not have to travel long distances and deal with prolonged waiting to access the traditional care services. Traditional healthcare services forms part of informal work as there is very little regulation to these practices. Some also sell their merchandise on street pavements. The reality is that traditional and modern medicines co-exist in many African settings (Ekipira et al., 2008).

The participants that opted for indigenous/ herbal treatment medicines believes that it worked for them. Moreover, the women took responsibility for their actions of seeking alternative medicines, as theystated that the tradional healers were not to blame. This finding is consistent with a study by Ekipira et al. (2008), that reported cultural practices and beliefs led to seeking health treatment through consultation with traditional doctors. This then discouraged some women from visiting PHC centres to seek care and treatment. Also, the participants cited that the traveling distance, cost, and prolonged waiting times were not the only matter of interest. From the participants responses I observed that the traditional healers were portrayed by the participants to be more respectful and easily approachable than the health practitioners at PHC. Furthermore,

data on the adequacy of traditional healthcare services was not collected in this research.

An article by the TimeLIVE (June 14, 2018), raised a concern by members of the public on the issue of medical equipment shortages in public health facilities. At times this issue led to fatalities due to delays in urgent and critical surgery. Another important factor to this matter was the issue of work backlog as a result of extended delays for critically ill patients in need for treatment such as, cancer patients. Their treatment was adversely affected by the lack of specialist oncology doctors and equipment, as well as prolonged waiting lists for diagnosis due to inadequate equipment. The report also stated that the prolonged waiting times for treatment was likely to expose patients to further health complications and sometimes loss of life, as reported in the article that public health facilities have turned into “a death trap for the poor” (TimesLIVE 2018: 5). Mokoena (2017), argued that the lack of supplies and equipment also contributed to prolonged waiting times and stay in public health facilities for the sick.

Poor patient service by healthcare support staff

Most of the participants reported poor patient service from clerks, and security personnel at a care facility. The women expressed discontent with the treatment by hospital personnel at health facilities. They went on to state that their first point of contact was with the security followed by administrative clerks, and this was a very critical part of health service delivery because, that is where patients information was disclosed and must be articulated and captured correctly as this had implications on health service delivery and outcomes. Kama (2017) asserts that substandard data capturing and record keeping resulted in needless delays for patients. In some cases, patient files went missing or even lost and instead of explaining this to the patient, healthcare workers decided to not say anything (Kama 2017). In extreme cases, patients’ medical history was lost, which at times led to incorrect diagnosis and even worse lose of life (Kama 2017). Manyisa and Van Aswegen (2017), reported that inadequate admin equipment and unskilled professionals had an adverse effect on the quality of care and outcomes. This further implied the importance of health support services in the delivery of care while also acknowledging the clinical care.

Inevitably poor and compromised patient service potentially impacted negatively on health service delivery for the participants. The effects of a poor patient service could

be detrimental to social precarious groups such as informal traders. A patient must be prioritised in health service delivery. One may also argue that health service delivery is a service driven industry. In such services kind gestures are a necessity. In the health delivery process, the actual experience sets the tone for the quality of care and outcome.

Mistakes in data capturing can lead to critical medical mistakes and sometimes even fatalities. Arguably, healthcare delivery is relient on accurate and timeous patient information, for healthcare workers to device a proper diagnosis and treatment plan for patients. Accurate information is key to health service delivery Another important feature to patient service was that health issues tend to be stressful and bring a lot of worry to patients. Most important element is the care that patients look out for when they visit a health facility more than the treatment itself. Howerver, patient service is not part of the clinical treatment plan but rather gives hope in times of distress, confusion, and fear to the patients.

Poor communication and verbal abuse by healthcare professionals

A significant number of participants reported that the treatment offered by the nurses towards them was unsatisfactory. They attributed this tonegative attitudes which they then interpreted as discrimination because of their status. Moreover, the women indicated that among the malicious conduct and attitudes, they suffered a lot of insults and abuse at the hands of nurses. This finding is in line with prior studies reporting on verbal abuse, malicious conduct and poor communication experienced by women in pursuit of medical care and treatment (Vearey 2010). Data on physical abuse was not documented in this research.

The participants gave the impression that it was the nurses that showed negative conduct towards them and not the doctors. In essence, the nurses displayed no respect and very little empathy towards some of the women during care seeking. Instances of verbal abuse were experienced directly or indirectly by witnessing others being victimized. According to the participants, Instead of being empathetic, the nurses displayed contempt . This claim is also supported by Harris et al. (2011), arguing that patients seeking care at public healthcare facilities are seldom treated with dignity and respect.

A close exploration of the women's responses was that verbal abuse and poor communication appeared to be a norm in public healthcare institutions. This further demonstrated the gender imbalances in SA societies. These abuse tendencies should be attended to as these may potentially have an implication on human rights. These tendencies may lead to even bigger problems caused by going against the supreme law of the right to health. Communication between healthcare workers and patientswas arguably an important clinical requirement. This was not witnessed by the participants during their care seeking experiences. Healthcare workers' success is largely attributed on effective communication ability with patients in an ideal world (Vearey 2010). A healthcare worker is expected to be able to communicate effectively (Kama 2017).

Delayed care

Delayed care in this regard referred to delays in the health seeking experiences and process for the participants. The participants indicated that the primary care institutions they visited did not have acceptable treatment for patients. Some went on to express that the inacceptable treatment led to healthcare workers to look incompetent, and this led participants to lose faith in their competency levels. The women alluded to various observations regarding the health workers' low competence levels. Some mentioned that there seemed to be lack of knowledge in identifying symptoms, resulting in misdiagnosis. In addition, the participants did not trust the care services provided by care workers. They also mentioned that the health workers provided treatment that was insufficient and they had to continue their pursuit for care, as the symptoms worsened putting a further strain on already limited resources. There was also an indication by the women that healthcare centres lacked proper diagnostic tools and this resulted in further delays for diagnosis and subsequent treatment (Mokoena 2017). Another contributing factor as indicated by the women was the unavailability of doctors in health centres, and this has been deliberated earlier in the finding's discussion. Kistan et al. (2020), reported that the delays in the health seeking process ultimately led to poor health outcomes resulting from delays in diagnosis as well as the treatment. The participants had a perception that care workers had very limited awareness of the adverse effects of being a women informal trader on one's health, hence the inability to treat properly. Additionally, close exploration of the participants responses in this finding suggests a major case of exclusion from care services by the women.

Pack and Gallo (1938), explained the delays in health seeking as, the time it takes from the initial detection of a sickness, leading to the first consultation at a healthcare facility, with a health worker for the presenting symptoms. This may then be followed by a professional delay that is, the initial consultation with a health worker, on a presenting symptom that may lead to a patient receiving a diagnosis that is definitive (Pack and Gallo 1938).

The delays in the health seeking process varied among the participants. The findings insinuates that the impact of delayed care in the public healthcare sector is most likely to be widespread and continues to evolve.

Positive/ acceptable treatment by healthcare personnel

Not all participants had a negative review of PHC service delivery. There were reports by the participants of positive health seeking experiences with health personnel. These were at a small scale as they were articulated by only few participants. The fair treatment was attributed to cases where nurses were attentive and quick to respond to the needs of women. Moreover, nurses were listening and considering certain requests by the participants. Overally, those that experienced positive encounters with health workers expressed gratitude with the treatment they received. Thefact that even if a few women reported on their fair treatment encounters with some health workers, demonstrates that not all health workers in primary care services behaviours are inappropriate towards patients, more so to those that are said to be vulnerable. Furthermore, another observation on the positive care experiences, was how the nurses where able to display their clinical expertise in instances where patients suffered comorbidities such as high blood pressure. The participants were pleased with the nurses. Vearey (2010) and a qualitative study by Gunner et al., (2019) detailed how the homeless recounted on the competence of care workers, in managing their comorbidities and displayed high tolerance levels to their medical conditions.

The few participants expressed that the positive treatment they received from care workers, wasdisplayed through kind gestures, respect, and caution to their individual concerns. These were handled with empathy, and they were pleased.

Quality of care that is negative towards sick patients

Many participants reported on negative care experiences as unprofessionalism displayed by some care workers. For the participants, another factor that had a negative

impact on their health seeking experiences was the verbal and emotional abuse displayed by care workers, and they found it to be unpleasant. Some participants revealed details of how they tried to ask questions regarding their health conditions and how they were ignored by health personnel. This suggested poor nurse-patient relations. A significant number of participants stated that they were only examined on the initial visit, but no follow-up examinations were carried out. They observed that the clinical care received was not satisfactory. Some of the women expressed that, most of the health personnel that examined them were not supportive and were uncouth. The participants exhibited general displeasure with the care given. It can be argued that because of the precarious work activities of informal traders, they may be vulnerable to discrimination and disrespect. Most women were of the view that they were ill-treated at healthcare centres (Harris et al. 2011). This finding corroborates with qualitative studies carried out with informal workers reporting on the negative experiences of care by health workers towards patients (Akazili et al. 2018). Generally, in cases where patients were ill-treated by health personnel, it could potentially prohibit them from seeking much needed healthcare services (Harris et al. 2011).

The negative quality of care by health personnel towards the participants had an adverse effect on their health seeking experiences. However, this was not unique to South African women informal traders but rather women making use of the public healthcare system (Gatsinzi & Maharaj, 2008). These negative behavioural tendencies by health personnel were in contrast with international regulations (WHO, 2008) and SA health policy prescripts (NHA, 2003). In retrospect this may be considered as a manufactured construct of power, where health personnel would want to display control over patients (Makandwa, 2014). . As such, some women indicated that if funds were readily available, they would prefer to receive care through private healthcare centres, where health seeking experiences were perceived to be satisfactory and pleasant. However, as articulated by the participants, they continued to seek medical care and treatment in PHC facilities due to financial constraints.

Overcrowding in PHC facilities

The participants reported that they experienced patient overcrowding when visiting healthcare centres. They identified long queues, limited sitting space, limited bed space, as well as staff shortages as causes of overcrowding. This was experienced in both outpatient care inPHC services and in hospitals. Some of the participants also

mentioned that another contributing factor to overcrowding, was people coming to health centres to visit patients. This finding is in line with literature reporting that the public healthcare service in SA serves most of SAs populace, including those with no medical insurance as well as migrants (Harrison, 2009).

The overcrowding was also attributed to the increased influx of people in the CoJ as indicated earlier in the study, and this also impacted the functioning capacity of primary care centres. The overcrowding leads to inadequate resources and put more strain on an already strained primary care system. The SA constitution states that noone should be denied access to healthcare services including non-citizens (Mokoelo, 2012). Further, implication on the influx of people to cities such as the CoJ Region F inner-city exposes the staffing shortfalls, which result in compromised quality healthcare delivery and outcomes in urban health institutions (Kamdaya et al. 2014).

Overcrowding is a leading challenge in the public healthcare system due to lot of people making use of public healthcare facilities. This can be summed up either as inadequate provision of care or the continuous increase in the demand for healthcare services. This challenge is not a problem limited to SA but it spreads globally. There is high patient demand and limited resources for care and treatment, which then negatively impacts patients' experiences of care and outcomes.

Conclusion

Consistant with the preceding theme, it emerged that South African women informal traders encountered several negative experiences in their healthcare seeking behaviours. The finding revealed that the women's experiences were diverse in various primary care institutions. Even though there were indications of positive experiences, a significant number of participants reported on negative care experiences. Recognition and acknowledgement of these negative experiences of care is necessary in attempts to improve the health seeking experiences of social precarious groups in their health seeking behaviours and processes.

In general, human resources are inadequate in healthcare facilities and also material shortages, such as medication and equipment. There is lack of appropriate medical equipment including laboratories to carry out blood testing and other associated necessary medical tests. This challenge is clear, and its remedy will be found through the increase of resources that are lacking.

6.1.2 Probe 5. When you think about your experience now, irrespective of whether your health was improved or not, is there anything that you would change?

Theme 2: Suggestions to improve health seeking experiences

This finding examines social policy in terms of the second objective as set out by Titmuss (1974: 29). That the effects of social policy properly apprciated include “economic as well as non-economic objectives” as an underpinning dimention. The measurement of social policy effects have a lot to do with inequality and discrimination, disadvantaged and powerlessness, and these measurement criteria characterise South African women informal traders.

The exploration of the participants responses in the broader sense point to the issue of financial access to PHC services that is, the overall cost of health interventions must include both human and material resources for an adequate and effective PHC system. Furthermore, the non-economic objectives that tend to be poorly appreciated as they are not tangible nor visible but have a significant impact in the lives of patients. For example, when a person has trust in the primary care facility they visited for medical treatment, this act does not demonstrate an immediate financial gain, but it locates itself in the value chain of an economic objective. Furthermore, subjecting PHC service delivery to evaluations is crucial. This finding suggests that there is a linkbetween social interventions and health outcomes, that social policy may improve health and healthcare. As such, the use of social policy in its evaluative nature will be a remedial method or approach to social problems such as health and healthcare.

Evaluations in this regard relate to social policy decisions. Since healthcare is a form of welfare state expenditure, it is important to maximize the available limited resources. The evidence gathered through evaluations may then be used to influence future health policy making, and how local government can monitor economic resources within the PHC system.case.

The participants suggested various strategies that could assist in improving their care experiences of primary care services.

Increase the number of healthcare professionals and labour force

The participants stated that recruiting more primary care personnel, that is for clinical, administration, and cleaners, as well as ensuring the effectiveness and efficiency of human resources could be a contributing factor in the improvement of the current primary care challenges. The participants believed that adequately provided human resources, would encourage them to visit primary care centres with no hesitation and make use of the much-needed care services. They observed that the current primary care workforce is inadequate, whilst health is a significant asset in their precarious lives. The participants further advised that the increase in labour force must also be attached with improved quality of care. This finding is in accordance with a study by Saks (2021), suggesting that the increase and regulations of healthcare resources are inclusive of support staff, that isadministration and cleaners.

The labour force in healthcare differs in size, in relation to population and differs in composition, across and within the non-metropolitan and metropolitan regions (Maphumulo and Bhengu, 2019). The public healthcare system is in short supply of healthcare professionals and the responses from the study participants also suggest constraints in support personnel As such, fundamental reforms must be put in place in order to increase the number of primary care practitioners, as well as adequate administrators since support services take up an important role in healthcare service delivery (WHO, 2011). These reforms must also address the distribution and subsequent retention of practitioners, this is of utmost importance (WHO, 2011). Also, the labour force supply and distribution must assimilate a geographical element.

This finding also points to the idea that, patient health data is important and takes up a vital role in primary care which talks to a point that has been deliberated on earlier in the research. Health reforms must be designed to advance the geographical distribution of primary care professionals through recruitment, distribution, and retention campaigns. They should place a particular focus on program evaluations, and these resources must meet the health needs of constituents (WHO, 2011). In adition, health reforms must be geared towards the promotion of quality clinical care. To this, there must be a coordinated methodology of collecting labour force data, program designs, and the setting up of national, provincial, and local statistics, targets and goals for an effective primary care system (Maphumulo and Bhengu, 2019).

Improving the overall health labour force will require a collaborative effort among various institutions both public and private. WHO (2011) suggests that area-based health education institutions must be utilized in the training, recruitment, distribution and retention of health practitioners and administrators, so as to apply trade in the public healthcare sector. Research demonstrates that the public healthcare sector is not preferred by health workers in many countries globally. The negative connotations of the public health service working environment could be addressed through partnerships with nursing, medical and affiliated schools of health in attempts to mitigate local primary care needs (WHO 2011). Moreover, the introduction and implementation of incentive programs, monetary and non-monetary for primary care services in retention efforts, could be an important feature in this regard. Furthermore, policies need to be developed in ways that talk to re-imbursement and quality measurement mechanisms for primary care practitioners. This is much needed in metropolitan regions like the CoJ because of the nature of healthcare service demand, due to the constant influx of people to cities for various reasons.

Training and development of primary care professionals

The participants suggested continuous training and development for primary care practitioners. This idea supports the strengthening of the primary care frontline to include the clinical training and interpersonal skills. They claimed that mitigating this challenge could contribute towards the improvement of the current primary care system challenges, including their access and health seeking experiences. The women sated that continuous training and development of primary care practitioners could empower them in the effective delivery of health services. Participants identified a need for supervision at facility level to guarantee that the prescriptions by doctors to patients at the primary care pharmacy included medication that was available at the facility pharmacy, to avoid waiting in long queues for unavailable medication. This finding is in line with qualitative studies carried out with informal workers reporting on the negative experiences of care by health workers towards patients (Akazili et al. 2018).

PHC services should advance more the idea of accessing the skills of trained care practitioners, which must be supported by medical services, treatment medication, equipment for medical tests and diagnosis, and other necessary specialized resources

(WHO 2011). Linked to this is that once the practitioners have been recruited, they will need to be trained, accredited professionally, supervised and regulated, through the respective health regulatory bodies, irrespective whether they are clinical practitioners or cleaners (WHO 2011). The training of practitioners should be coupled with appropriate compensation, support, and incentives for best performance.

This finding in essence talks to the idea of strengthening the primary care frontline. This idea is essential in improving the access and health seeking experiences of social precarious groups of primary care services. In addition, a strong and adequately trained primary care workforce can assist in mitigating pressure on the overall public healthcare system, by relieving the burden on public hospitals.. Moreover, a satisfactory primary workforce can contribute to the improvement of health outcomes for social precarious groups and reduce the use of expensive private care services that these groups cannot afford (OECD 2020) i. Positive health outcomes may be achieved when a well capacitated primary care practitioner is able to provide appropriate services to patients at the first point of contact, can give advice to patients on how to align healthcare with various other needed care services (OECD 2020). This is seen as a holistic approach to healthcare service delivery.

Improvement of facility hygiene

The participants reported on poor hygiene, dirty care facilities and that a number of these institutions needed to improve overall facility hygiene. Most of the participants reported that poor hygiene practices characterized most PHC centres. They indicated that it had negative effects on their health seeking experiences and processes. This finding is consistent with a study by Dunjwa (2016), stating that most public healthcare services exemplify very poor hygiene practices such as, lack of cleanliness, poor waste management, and poor servicing of equipment and grounds. However, this is not an exclusive issue to SA healthcare facilities. WHO and UNICEF in their Joint Monitoring Programme (JMP) report of 2022 reported that half of the healthcare facilities across the globe are characterized by poor hygiene practices and dirty facilities.

It is argued that proper hygiene practices and clean facilities are an input to PHC service delivery. A lack of these may compromise the delivery of quality care. Also, proper sanitation services must be part of primary care services with linkages to improved

health, delivery of adequate primary care, welfare and the mere dignity of practitioners and patients. In essence, sanitation services are a basic human right (WHO 2020). The COVID-19 pandemic demonstrated the importance of proper hygiene practices, with washing and sanitizing of hands as one of the key preventive mechanisms of the virus.

Another argument to the effect was the persistent electricity outages being experienced in South Africa impacting on water supply. These outages, contributed to the poor hygiene practices in primary care centres as a result of water disruptions. A water supply that is safe and adequate is important for healthcare facilities in advancing an effective health system (WHO 2020). The research in preceding chapters pointed out that informal traders were subjected to limited infrastructuralservices which includes clean water, purification facilities to mention a few, in their work activities on the streets. With the addition of poor hygiene practices in health facilities, they were then confronted with double implications of poor hygiene practices, further worsening their health.

Conclusion

Reform and expansion of health personnel is key for an effective PHC system in pursuit of acceptable care experiences. These reforms and expansion strategies must also include other support personnel, such as clerks, securities and cleaners. What should be noted and acknowledged is that the healthcare labour force is in crises globally (WHO 2011). Health practitioners are arguably the heroes of humanity, and it is through them that health and healthcare is delivered to the people. As such, the evaluation of primary care services is crucial, and this can be attained through mechanisms such as financial access to healthcare in order to achieve an effective healthcare system overally. Furthermore, it would be worthwhile for local governments to evaluate healthcare outcomes using validated health measures, focusing specifically on women broadly across the socio-economic spectrum and consider extensively family caregiving duties, as ignoring these can present unintended health effects.

6.1.3 Probe 6. What is your understanding of the term social rights of citizenship?

Theme 3: Rights

A right is a phenomenon that is inherent and imperative to all humans irrespective of status (Constitution 1996). Human rights include a set of standards that give recognition to protect and provide dignity for everyone in the world for their entire existence .

Upon exploration of the participants responses this theme uses the social policy enquiry to ask, does social policy influence health? Health policies by design have a direct influence on health, for example through instances of healthcare service. On the other hand, social policy may exert an indirect influence on health through the impact on socio-economic factors that are also referred to as determinants of health. These outcomes are located outside the prescripts of healthcare delivery systems (Osypuk et al. 2014). Since these socio-economic factors are causes of health, conversely, they can affect health (Kawachi and Berkman 2000).

Right to healthcare

The right to health implies “the right to a system of health protection which provides equality of opportunity to enjoy the highest attainable level of care” (CESCR 2000). The right to health is closely linked to other human rights,) and is arguably a fundamental human right indispensable for the exercise of other rights. Moreover, fundamental principles of right to healthcare are non-discriminatory. Also, the right to health contributes to the principle of health equity that is, redistributive justice (Kawachi and Berkman 2000).

Most of the participants reported that the right to healthcare was a basic human right enshrined in the SA constitution that they must enjoy. Some mentioned that it came with certain freedoms such as, freedom of expression, that they could exercise when seeking care at a health facility. The right to be heard, as well as associated entitlements such as, accessing any public healthcare centre in times of need. This finding is consistent with a qualitative study conducted by Sassen et al. (2018) on women’s experiences of informal trading and wellbeing in Cape Town.

Human’s health is arguably a matter that is of daily concern. Regardless of other considerations, health is considered as the most crucial and basic asset to sustaining livelihoods and wellbeing. The study has demonstrated thus far that health is a significant asset for SA women informal traders. Sickness and ill health have implications on everyone,for the participants, mainly it would be that it kept them from engaging in their survivalactivities, and thus having an impact on their livelihoods. In essence, the concept of wellbeing was closely linked to the health of the participants

South African women Informal traders demonstrates inequalities pervasive in the South African society, whereby the quality and services that people obtain are mainly

influenced by their socio-economic position and ability to access and experience services such as healthcare irrespective of the degree or magnitude of healthcare needs. Lalloo et al. (2004) also argues that influences contributing to the ability to access of quality care services is mainly the socio-economic status of a person, instead of a need for care. Research demonstrates that a significant number of people in SA such as informal traders, are dependent on public healthcare institutions as their right to healthcare services, . The right to healthcare is an inclusive right and contributes to the principle of health equity (Osypuk et al. 2014). With the appreciation that it must link both the right of a person to gain a specific standard in relation to healthcare and an obligation by the state to provide an acceptable level of PHC for the general constituency (WHO 2011). The current precarious status quo of South African women informal traders suggests the opposite and as such, they cannot fully enjoy the right to healthcare as determined through the exploration of the participants responses

Denied and/ or ignored rights to health

The participants noted and reported that incidence of denied rights to healthcare was a constant occurrence in many PHC centres. Some expressed that the denial of the right to care was just too prevalent in the process of health seeking. It could have been directly or indirectly, that is witnessing others being denied their right to care. Several participants were very emotional when giving responses to this study. They were even questioning if these rights existed, as the current situation in their access and health seeking experiences was undesirable. Furthermore, they mentioned that this was the case even in other government services such as home affairs. Others reported that when trying to defend their right to care it was even more detrimental and sometimes even resulted to not getting any care. The situation was just dire. As such, the implications of health violations were not just clinical and medical but also impacted on other aspects of life such as social, psychological, and biological elements of health. This finding corroborates a qualitative study by Maphumulo and Bhengu (2019), on challenges of quality improvement in SAs healthcare.

The women demonstrated considerable knowledge and understanding of their rights, specifically the right to care. On the other hand, there was limited understanding on reporting to relevant authorities on mistreatment by care practitioners. Some expressed that even the complaints boxes at care centres were of no use and did not yield any tangible outcomes in terms of healthcare malpractice.. Coovodia et al. (2009), argues

that health complaints processes generally are dysfunctional and ineffective with very poor oversight for abuse by health practitioners or health system failures.

The active ignoring of any human right including the right to health, surface regardless of any law or constitution and this was also evidenced in this research upon exploration of the participants responses. Literature demonstrates that women bear the burden of chronic illness and poor experiences of access to care (Oyefara, 2005). Ill-treatment and denied rights to healthcare prompt undeserved pain, suffering and result in poor health outcomes. Maphumulo and Bhengu (2019) cite that this potentially discourages women from making use of health services and worsens maternal mortality.

Satisfactory and respectable primary care services are vital in attempts to prevent patients being mistreated and even untimely deaths, maternal deaths for women, regardless of their socio-economic position. Moreover, the rights stipulated in the constitution, gives provision for everyone in SA irrespective of any demographics that is, legal status, socio-economic status, and nationality (Constitution 1996). As such denial of the right to care is seen as a misconduct and even more a crime against humanity . It is time for the enshrined vision, and for the rights to become a reality for social precarious groups such as South African women informal traders, to be able to access and experience an inclusive and effective healthcare system that is free of any bias.

Denial of the right to care also implies a gross violation of the National Health Act (NHA), which assigns the state to provide primary care that is free. It is also unconstitutional as it is discriminatory and an unfair practice to social precarious groups, as it further worsens their vulnerability (Coovodia et al. 2009). As a result, the SA public healthcare system continues to be entangled in litigation wars, further putting a strain on already limited resources, because of pay-outs resulting mostly from clinical malpractices (Maphumulo and Bhengu 2019).

Conclusion

Research demonstrates that social determinants reflect a lack of health equity (Lalloo et al. 2004). Moreover, social determinants may shape health and health equity. Health equity can make a substantial contribution to the right to health through equitable distribution of health resources as there is a linkage between social determinants and health equity (Osypuk et al. 2014), and thus enabling South African women informal

traders to “share in a common life” (Sandel 2012: 202). It is argued that there is a link between human rights and health equity.

Social policy may have an influence on health and healthcare outcomes, whether unintended or indirectly. The importance of examining and understanding why social policies influence health may be a mechanism that social and health policy makers may adopt to design effective health programs. To also inform significant pathways on how socio-economic factors influence health and healthcare (Osypuk et al. 2014). In addition, social policy may be a useful tool to monitor compliance to the right to health.

6.1.4 Probe 7. How do you think the idea of social rights of citizenship plays a role in your attempts to access primary healthcare services?

This finding explores social policy as a critical analytical enquiry in terms of a welfare state. In essence, this finding talks to the enforcement of SRC. In this regard, social policy refers to all policies developed to ensure that the welfare of the state and citizens as well as the dynamic and changing processes. Accounts of welfare and welfare change is the essence for social policy. Generally, where a considerable portion of welfare production is funded and provided by the government are referred to as *‘welfare states’* (Baldock, 2007). The development of a welfare state is a continuum. Marshall (1965) asserts that SRC constitutes the core idea of the welfare state. It is also in this analysis where we try to understand how the welfare state influences the relationship between informal employment and healthcare.

A welfare state in the context of this research is a public health response to access primary care services. As described by Marshall (1965) a welfare state represents a natural expansion of citizenship rights supported by mutual agreement among societal members. Esping Anderson (1979) suggests that a welfare state encompasses every citizen as a client at some point in life, contextually to this research is the idea of health service user. For the less priviledged, the welfare state offers a minimum level of healthcare. In addition, health and healthcare benefits are directed to these groups based on their low standard of living, higher prevalence of illness, or the inability to source and purchase medical care (Kitagowa and Hauser, 1973).

The academic discourse of social policy debates continues to determine the requirements for qualification as a welfare. Is SA a welfare state? Evidence in literature

shows that as compared to other developing nations, SA is a country that showcases extensive social welfare systems (Goldblatt 2005). Moreover, SAs long history of various regimes is characterized by social welfare programs, but not much evidence in literature suggests that SA is a welfare state (Goldblatt 2005). This may be attributed to the prevalent inequalities that continue to persist at a rapid and alarming rate in SA ,with a Gini Coefficient of 0.63 and thus, rendering SA as the most unequal country in the world. . In retrospect literature suggests that the SA government post-apartheid has intervened in the healthcare sector, but this finding demonstrates that adequate impact has not been felt by South African women informal traders.

Considering the precarious work activities of SA women informal traders, health is a key asset to their economic endeavours and as such, adequate access and experiences of primary care services are of importance to these groups.

Misconceived state welfare poses a big threat to freedom and civility particularly for disadvantaged groups such as South African women informal traders. Advocates of welfare reforms are of the view that, these reforms must incorporate more self-reliance, and this is the case with South African women informal traders through their survivalist economic activities. What is lacking is government support to proper healthcare service delivery and meaning to this right that is, SRC. This necessitates SA in all government spheres to witness wide-ranging debates on the scale and nature of health and health welfare reforms essential to ensure progress and prosperity in the country more especially where social precarious groups are concerned.

By design the welfare state has a fiduciary duty to make certain provisions to people that is, equality, equal opportunity, freedom, and rights (Deacon, 2007). Contextually to this finding, SRC is inferring social welfare and social security and the right to healthcare which has already been deliberated on earlier in the research to social precarious groups. What we know is that all the rights referred to are provided for by the welfare state. Individuals including South African women informal traders, living in a society are guaranteed to the state through citizenship. It is from this view that the concept of SRC takes up a significant role in deciding the obligations of the state and individual rights as part of a social policy) in the access and health seeking experiences of primary care services (Deacon, 2007. Additionally, in social policy the welfare state takes up an active role.

Theme 4.1: Social rights of citizenship are ignored

Lack of patient care

Several participants reported that the concept of SRC as patients in their access and health seeking experiences of primary care services was non-existent. It held no significant meaning, as it was not upheld and protected in their health seeking behaviours and processes. The women stated that they experienced a serious lack of patient care which implied discrimination against them. Health practitioners were reported to be intimidating, used offensive language, and to the participants this was t disrespect and it made them feel uneasy at their lowest point where compassion and empathy was needed. This finding is in line with a qualitative study by Akazil et al. (2018) on informal workers access to healthcare services. Furthermore, the participants indicated that they found no pleasure in these encounters which they interpreted as violating their SRC as rightful users of primary care services.

Patient care is a distinct and significant characteristic on the right to healthcare deserving conscious curiosity and needs to be subjected to serious scrutiny as an issue of human rights in terms of SRC (WHO 2011). A serious array of human rights violations are evident in the context setting of patient care in care facilities violating rights, over and above the right to health care. This finding placed emphasis on the social policy framework for the idea of human rights in patient care closely related to SRC and how these rights were blatantly ignored in the access and health seeking experiences of primary care services by social precarious groups.

Instead of appropriate and satisfactory expectations in primary care, participants were confronted with abuse, rights violations that went against mere human dignity and as such threatened the women's health service delivery and outcomes. These abuses were vast to include but not limited to discrimination, patients' rights to confidentiality, torture, degrading and inhumane treatment by practitioners (Coovodia et al. 2009). Also, there are arguments suggesting that health practitioners are subjected to abuse during the cause of care delivery.

SRC highlight patient care with regards to the patient as the key user and ultimately the beneficiary of health outcomes. On the other hand, even though the users that is women had legal status as citizens, their responses suggests that they continued to experience many violation of their rights and responsibilities in their access and health

seeking experiences of primary care services. Concerns about primary care service users' trustworthiness and doubts their socio-economic position and level of insight has an influence on their status as full citizens (Marshall 1965). For rectification, this will require health practitioners' understanding of the conditions placed on the SRC, and responsibilities of users will in turn ensure inclusive and less restrictive care and treatment (Marshall 1965). SRC in view of patient care, identifies health practitioners as an important input actor in care users' access and health seeking experiences.

The finding also referred to the issue of social exclusion that has been identified and discussed earlier in the study, and in this regard underlies the abuse against patients which are women informal traders. This is of significance, since abuse against vulnerable groups such as women informal traders are widespread in public health settings (Amon and Plus 2008). These may be attributed to structural inequalities, such as the power dynamics between patients and health practitioners that is, the social construct of power (Mendez 2013). As a result, SRC in patient care plays a particular role on the socially marginalized groups, to address violation and abuse in healthcare service delivery, directly impacting health outcomes.

Lack of freedom

Participants reported a serious lack of freedom in the access, health seeking experiences and processes which then affected their decision to utilize primary care services. Some participants indicated that they were afraid and hesitant to make use of primary care services due to lack of respect and freedom regarding treatment by health practitioners and support staff.In turn, this contributed to late initiation of care and sometimes the decision to not seek care services.

Reason for this was mainly attributed to the lack of freedom and dignity associated with access to and experiences of healthcare services. Emphasis was also placed on the lack of freedom of expression when seeking care, which was a disempowering experience as reported by the participants. The women's concerns included not being able to express themselves and to receive results on their illness and subsequent care. Participants indicated that they were not free to probe practitioners on their conditions and treatment. They felt personally attacked when attempting to engage, which translated into a power struggle between them and practitioners. As such, they felt their SRC were violated in their access and health seeking experiences of care. This finding

is in line with a study by Kuenburg et al. (2016), citing that when a person in a precarious condition is not able to use their SRC in their health seeking experiences and processes, it translates as a disadvantage that implies a lack of freedom when choosing to make use of care services. Furthermore, every informal trader as a patient has freedom such as of religion, opinion, information, expression, and others, that must be respected by health practitioners.

In addition, people exercise freedom to choose a health provider because they want one that they can trust and one that is able to attend to them promptly, in a proper environment and with respect, humility and confidentiality (Maroon, 2010). As such, when there is difficulty,South African woman informal trader finds it difficult to access primary care services, and encounter problems in their health seeking experiences. The use of their SRC in this regard was a disproportionate disadvantage that suggested a lack of freedom when choosing to access services (Kuenburg et al.,2016).

This finding also placed emphasis on the issue of power and its related struggle which was also reported by the participants. Lack of freedom represented a diminished autonomy and influenced the woman's decision not to access care services. This is because the concept of freedom in this regard was that "freedom requires access to the means of a decision" (Mills 1958: 31).Health inequalities will be lessened only when individuals are empowered with complete and adequate access to primary care services (US Department of Health and Human Services, 2000). It can never be accepted that a diminished autonomy be a prerequisite for access and experience of primary care in the new SA dispensation, but the women's responses indicated that this was the norm for them in the SA health system. Therefore they found no meaning to SRC in meeting their health needs.

This research is of the view that failing to recognize healthcare as a human right and a prerequisite to freedom greatly undermines SRC in health and healthcare. We should guard against the commercialization of healthcare as it hinders on the freedom of South African women informal traders at their most vulnerable state. Access to healthcare is central to one's ability to exercise freedom either as an individual or in a society. For Snyder (2022), the idea of universal care is a humane and empathetic recognition placed on the value of the health of others, as well as a means to protect their freedom in access and subsequent care seeking experiences of health services.

Conclusion

What did freedom to health mean for the participants? The constitution outlines the meaning very clearly that is, freedom to primary care is a constitutional right, but how did these impact women? The study shows that it is of importance for the fundamentals of freedom of health to be intensely deliberated on, as the evident deepening social divisions/ chasms canot be condoned in attempts to uphold and protect the SRC of South African women informal traders in their healthcare endeavours. Suggested here is the idea of 'health freedom' needs to be advocated for. Related to this was the issue of dignity that the women cited as lacking in their access to and health seeking experiences of care services. The idea of human dignity is the basis for equality and freedom from discrimination in the implementation of human rights (Constitution 1996). The participants indicated that their dignity was not considered in their health seeking experiences and processes.

Theme 4.2: Social rights of citizenship to promote positive primary care experiences and perceptions

Only a minority of participants reported on positive care experiences at primary care centres. They mentioned how practitioners and support staff displayed dignity, care, and respect towards them, also paying attention, listening and responding to them. The positive care experiences listed also included medical treatment given, details on their illness, aftercare and physical checks. One woman went on to detail how a security officer assisted her with a wheelchair when she was too weak to walk. As such, few participants admitted to democracy in action, the true exercise of SRC in their access and health seeking experiences of care services. This to the women, signified positive quality of care and treatment in their health seeking behaviours and processes. The acknowledgement of positive treatment and care received by the participants in accessing primary care services was in line with research study recommendations by Glanz et al., (2008); who reported on the improvement of health, proper health practices, and women's positive health seeking experiences consequent of a positive engagement with the health services.

It is prudent and recommended to acknowledge from the positive experiences faced by South African women informal traders in the exercise of SRC of accessing and experiences of primary care services as this demonstrates an effective health system

even if experienced by the few (Glanz et al., 2008). These positive experiences by the participants showed that it was not only negative reviews in South Africas PHC centres. Also, the positive quality care and experiences such as, respect and attention by care workers may be utilized by the government and policy makers to explore guidelines on how to improve healthcare service delivery in primary care centres. Further, the responses may also be used in health evaluation programs to determine factors such as cultural norms and values, and behaviours affecting these women together with the behaviour of health practitioners,in order to establish South African women informal traders positive care experiences and perceptions in accessing public primary care centres and services.

Similarly, the idea of training and development of health practitioners also featured in this finding, as it was through healthcare personnel where quality care and positive experiences was realised. Health practitioners in the primary health service must be trained, developed and monitored continuously to understand, respect and value the rights of patients irrespective of their socio-economic status, in order to instil and maintain positive quality of care and attitudes (OECD 2020). The significance of this is that, many of the participants' care experiences and perceptions of primary care centres was poor and unfavourable service. Mitigating these must include relevant activities such as workshops and trainings, engagements with care practitioners on the rights of patients and courses of interpersonal skills, stress management to health and elimination of tensions directed at patients in their access and health seeking experiences of care. Furthermore, the continuous development of practitioners must also include elements that will assist them to dismiss ideas and challenges related to any form of stigma and judgement associated with these groups.

Conclusion

This finding suggested that South African women informal traders as primary care service users experienced conditional SRC in the access, use and experiences of primacy care services. This was despite SAs free 'health for all' policy. Social inclusion for these groups through acts of citizenship is still limited in its reach and effect.

6.1.5 Probe 8. Why did you decide not to seek healthcare services in Region F at the time?

Theme 5: Healthcare disparities

This finding explores social policy as a critical area of analysis drawing on insights of Titmuss (1947) on the Institutional Redistributive Model based on the universal provision of public services in this case primary healthcare.

The institutional redistributive model is classified as a normative approach to social policy, as it considers how the welfare of constituents can be optimally improved by applying values and beliefs as supported by Titmuss arguing that welfare can never be 'value free'. Also, this model uses social policy as an assimilated component of public policies which provides services such as healthcare based on needs and not market forces (Titmuss 1974). Also, the model places emphasis on universalism as a mechanism to overcome the stigmatisation associated with means tested forms of provision. Further, the model is rooted in the ideology that citizens of a particular country inherently are in possession of the basic right to welfare (Marshall 1965).

Eliminating health disparities should be an important goal for the SA government. The study is of the view that the general objective of the SA government should be improving population health for precarious groups such as South African women informal traders, for whom health is an important asset for their productivity in a precarious environment. Further, the idea of social justice is also advanced in the process. Enhancing access to primary care services to social precarious groups may be an important pathway in the improvement of overall population health and wellbeing. Furthermore, the study is also of the idea that social policy can be an important mechanism used to bring about change and minimize health disparities while also improving the health services for social precarious groups like South African women informal traders.

These health disparities signify inequalities pervasive in SA, resulting in negative health consequences for the poor such as, South African women informal traders (Kawachi et al., 1999). Key to this is that, health disparities are undesirable, unfair and should be eliminated. The idea of addressing health and healthcare disparities translates to improving overall population health and economic prosperity while also advancing social justice and equity for social precarious groups.

<u>Lack of access to adequate treatment</u>

There were numerous similarities between probe 4 and probe 8. A significant portion of information reported and processed during the course of data analysis described under probe 4 was very much identical to the data in probe 8. This was in relation to

issues of theme 4.2 Experiences: unavailable medication and theme 8.1 Healthcare Disparities; lack of access to adequate treatment. Just as in theme 4.2 (experiences) several participants reported on their misfortunes to access adequate treatment at primary care centres. . The women indicated that in most instances they had to wait in long queues in pharmacies, only to be told that the prescribed medicines was unavailable. In a 2011 report by the Human Rights Watch (HRW), it was reported that most women in SA were subjected to delays in care for various reasons such as lack of access to adequate treatment in their health seeking process at public care centres whether outpatient or admission. Moreover, the participants responses demonstrated clear discrepancies in accessing adequate treatment at primary care centres. This finding resonates with that of Akazili et al., (2018) on informal workers access to care services citing that the unavailability of medicines at public care centres led to poor care services. The women questioned how could the doctors prescribe medication that the facilities did not have. They also questioned why the doctors would give them false hope of getting better in their care experiences. This in turn rendered the primary care service delivery unfavourable for the participants.

Livelihood security

Information collected in probe 8 shared significant similarities with that of probe 4 that is, identical information as evidenced in the process of analysis. This was in relation to issues of theme 4.1 Factors hindering access to public PHC services: work commitment(s) and theme 8.1 Healthcare Disparities: livelihood security. Participants disclosed that they were confronted with a predicament when considering seeking care services as this had a direct impact on their livelihood. Such that, there was a huge opportunity cost for seeking care services generally for the participants. This meant that, not being present at their trading spaces, meant no income generated. Taking cognizance of the fact that already their income generation was unpredictable. The women also highlighted their experiences and perceptions of the opportunity cost for seeking primary care services. The findings are in line with that of the WIEGO (2018) report on health access for informal workers in India, as well as Akazili et al., (2018).

Most of the participants were aware of and had experienced the direct consequences on their livelihood security of seeking care services rather than trading. Also, they agreed that seeking medical care and treatment was important for them when not feeling well, but the price was just too high owing to their precarious lives and work

activities. Some also mentioned how they had been accustomed to working through pain for the sole reason of sustaining their livelihoods. This in essence, demonstrated a classic case of desperate decisions and outcomes. However, these responses did not undermine South African women informal traders concerns of their challenges in accessing primary care services as well as their perceptions of their adverse health seeking experiences.

Home and/ or traditional medicines

There were numerous similarities between probe 4 and probe 8. This was in relation to issues of theme 4.2 Experiences: unavailable medication and theme 8.1 Healthcare Disparities; home and traditional medicines. Just as in probe 4, most of the participants indicated that in the absence of adequate medicines at primary care centres, they resorted to home remedies or traditional medicines. Some participants opted for home remedies sourced from pharmacies and then stayed home to heal. Other home remedies included use of enema and steaming with traditional herbs rather than visiting a care centre where they were subjected to several challenges. Akazili et al., (2018) cited that, the unavailability of medicines at care centres leads to poor healthcare services and practices for informal workers access to care.

As a result of primary care service inadequacies, the participants also embraced the idea of indigenous practices to care. The women mentioned that they sometimes opted to consult traditional healers in their health seeking processes. They cited the convenience of using these services worked to their advantage in terms of ease of access and plausible treatment by traditional doctors. Ekipira et al. (2008), reported cultural practices and beliefs led to seeking health treatment through consultation with traditional doctors. This then discouraged some women from visiting primary care centres to seek care and treatment.

The participants' experiences and perceptions of traditional healthcare services were mostly positive as in probe 4, theme 4.2 Experiences: unavailable medication. However, of the researcher demonstrates that the perceptions and experiences displayed by the participants were not unique to them. These may also affect the general African community who rely on traditional healthcare services in their health seeking behaviours and processes. Furthermore, participants were adamant that

patient care in traditional healthcare services was much more satisfactory than that received in primary care services (Ekipira et al., 2008).

Conclusion

Social policy conceptual framing provides a potentially substantive response to issues of social inequality and in this regard should be more meaningfully deployed to effect change to the health and healthcare of South African women informal traders. Moreover, the change required should be the idea of planned change to address the health inequalities confronting these groups. In addition, social policy can realize this as it is viewed as a positive instrument of change (Titmuss 1974).

6.1.6 Probe 9. Recommendations for Local Government.

Theme 6: Suggestions to improve access to primary healthcare services

Social policy analysts and commentators believes that intentions underpinning policy are secondary to what they really and precisely achieve (Baldock, 2007). That is, the idea of intended or unintended consequences of social policy as set out by Titmuss (1968: 22). This means that focus should be directed on the actual evidence of policy intervention results, in order to detect and mitigate adverse outcomes. Titmuss also observed that sometimes governments implemented interventions that displayed consequences but were not recognized. Inevitably, considering the extensive proportions of countries redistribution of resources from social policies, is of utmost importance that outcomesare carefully monitored.

If outputs are what governments produce, outcomes are the grand design that citizens see behind those outputs" (Levy et al., 1971: 1). As such, the management and measure of outcomes in the public sector, put emphasis on effectiveness and efficiency. Furthermore, Smith asserts that "the assessment of effectiveness is impossible without satisfactory measures of outcome" (1996:2). To realize this government authorities must effectively and cautiously make use of public procurement to realize and achieve social outcomes. More so, because expenditure on health has direct linkages to health outcomes for South African women informal traders.

Poverty is a matter of deprivation, contextually to this research is the idea of lack or inadequate access and health seeking experiences of PHC services. Also, these may

include the consequences of disease, squalor, ignorance, and idleness as determined by Beveridge (1948). Consideration of redistributive social policy draws attention to the redistribution of resources coupled with the reduction of inequalities, so that eventually more people can share in the fruits of economic growth and inclusive development. However, research demonstrates that inequality as observed in poor households, social policy has been stubbornly resistant. In the same breath, I am of the view that income inequality can never be an ideal measure of key social policy outcomes as these tend to vary significantly from person to person and from household to household. The social policy outcomes referred to include equity redistribution, poverty reduction and social cohesion that is, coverage (Beveridge 1948), directed by an objective to maximise return within an appropriate variety of outcomes.

As a people we all deserve an equitable chance in life. To this, expenditure of public funds by governments is vital in attempts to provide citizens with what they will need to survive and thrive in their lives. Relative to this, is that social services in most instances are underfunded, governments must fulfil unlimited citizens needs with very limited resources and this assertion resonates with most governments including SA. Further, contextually to this research, the SA local government is tasked with providing social services like PHC (constitution 1996), and at times they are inadequately capacitated to collect data, engage citizens, and determine why and where women remain cut off from government needs. Consequently, poverty and inequality compel those with limited means (South African women informal traders) to bear great burdens for example, disease burdens.

This research calls for governments to recognize precarious women's health and healthcare needs as a national policy agenda and priority and try to possibly guard them against effects of devastation for example, events of deprivation that go well beyond income and address these through social policies, adequate budgets and appropriate programs in order to fulfil the correct coverage (social policy outcomes). Further, the research supports and encourages local government to mobilize accordingly, adequately assign and improve the deployment of public finance resources to enable the fulfilment of the government bottom line that is, deliver more equitable and sustainable social services to constituents with emphasis on social precarious groups like South African women informal traders. Doing this will aid capacity building of local

government in the urban context (Region F inner-city), where the urban poor (woman informal traders) find expression, to collect local data, urban planning services, be better prepared for emergencies, importantly budget equitably, measure performance of human resources, monitor and evaluate the impact of social and health interventions for social precarious groups (South African women informal traders). Key to this is that for local authorities to acquire the desired outcomes on interventions of any form implementation over output must dominate to bring about welfare to citizens. In essence, do not measure outputs but rather outcomes. Further, contextually to the research link informality with social policy and dispel the notion of social policy only advantaging those that are in the formal sector, the idea of planned change.

Several countries like SA confront issues of rising healthcare costs with limited evidence in the improvement of health outcomes for constituents (WHO 2011). As such, focusing attention on broader domains of social policy that is, outcomes may be useful for government authorities in attempts to accomplish improvements in health and healthcare imagined by advocates of healthcare reforms for constituents equitably. As well as enhanced political will and support.

Introduction of mobile clinics

Reforms of any kind in healthcare (primary) by all intents and purpose signify an opportunity in the improvement and advancement of the lives of constituents as well as the general performance of the healthcare system (WHO 2011). One such reform is the idea of mobile health clinics.

Most of the participants reported that their health seeking behaviours may be extensively enhanced through the introduction of mobile clinics to deal with the issue of lack of healthcare options. The perception among the participants on the mobile clinics was that it would enhance health seeking processes of access and experiences for the urban poor to include themselves. They also indicated that the mobile clinics must be evenly distributed across the Region F and in proximity to where informal traders are present. According to them this action by authorities could make PHC service and delivery a reality. Consequently, the distribution of the mobile clinics would be a form of much needed support that has always been missing for a long time from authorities to the urban working poor as an underserved constituency. Also, this would strengthen

social support for these women. This finding is in alignment with existing literature mentioning that mobile clinics facilitate and enable access to healthcare for the underserved (Nuttbrock et al., 2003).

Exploration of the participants responses gives one the sense that they really do want a workable pathway to adequate access and experience of primary health care services. I am of the view that that mobile clinics in the region can realize this for the participants for several reasons. For instance, the women have expressed that traveling long distances to places of care was expensive and time consuming and also, they could not afford to be away from their trading spaces for long periods as this implicated on their livelihood directly. The participants were of the perception that mobile clinics could potentially reduce the challenges and obstacles to PHC service access and experience. This view is also supported by Guillot-Write et al. (2022) reporting that providing mobile clinics in the inner-city may increase access to primary care services for traders.

The participants reported few visitations to clinics as a result of perceived discrimination by health practitioners and support staff, this view has been alluded to in the research which they described to causing depression and stress over and above existing sicknesses, so they just stayed away. Carmack (2010) argues that the success of many mobile clinics is mainly attributed to their capability to forge good and trusting relationships with beneficiaries/ patients. Also, more qualitative research reporting on mobile clinics have discovered that users attached value to the informal, somewhat familiar setting in a convenient location creating an enabling environment for patients to divulge personal information about themselves to health workers (Guruge et al., 2010). Symbolic to this finding is that the inability to access primary care services in essence, implied a lack of medical attention to the participants. To this, mobile clinics would be a novel gesture directed at precarious occupational settings with under supported populations such as South African women informal traders (Nuttbrock et al., 2003).

In the main, the mobile clinics intent and purpose would serve to provide access to healthcare services for South African women informal traders who found it challenging to visit static primary care facilities. This would also talk directly to the socio-economic needs and prevention or control of future medical conditions of traders (Guillot-Write et al., 2022).

Training of human resources

There were several similarities between probe 5 and probe 9, that is identical information as evidenced in the process of analysis. This was in relation to issues of theme 5, Suggestions to improve health seeking experiences: Training and development of primary care professionals and theme 9, Suggestions to improve access to PHC services: Training of human resources. Just as in theme 5 most of the participants reported that care workers and support staff needed extensive training on the execution of their duties to establish desirable primary care service delivery and health outcomes. They also indicated and understood that human resources were important in the facilitation of adequate access and health seeking experiences of primary care services. Meaning that even though government may put in place the most impressive systems and processes, these can only be mobilized and operationalized through an adequately trained human resources. This finding is in line with a qualitative study by Akazili et al., (2018) on informal workers reporting on the negative experiences of care by health workers towards patients. In addition, the quality of teaching needs social mixing (Marshall, 1950) to put together an overall effective health system.

The participants also cited the lack of co-ordination in primary care service delivery processes among clinicians and support staff. According to the women there was a clear disconnect and lack of coordination and/ or facilitation in their access and care seeking experiences. As a result, from the perspective of the participants the primary care system was just not effective (Maphumulo and Bhengu, 2019).

Storage facilities

The lack of sufficient storage space for wares was identified as a constraint. The lack of adequate storage space is generally a serious constraint for traders in Region F inner-city, this is even after the city has attempted to address challenges of infrastructure through linear markets across the city (Willemse 2011). This can be directly linked to the fluid nature of the informal trading occupation, because of the inconsistent and sometimes negative growth of the SA economy and not yielding any jobs forcing the unemployed into informal occupations. As such, the city has resorted to allocating traders on street pavements that have no shelter and stalls to anchor traders in their informal activities. Noteworthy, most participants in this study were trading on city

pavements and very few had stalls at the nearby linear market. Additionally, storage space was a big predicament for traders since in most instances they lived far from their trading spaces. Some moved their wares around in taxis and others used storage facilities provided by the private sector at a fee for their goods (Skinner 2008b).

Based on the finding, the participants indicated that they endured serious anxiety where storage for their wares was concerned. Even more worrying for the women was that while they had put storage measures in place, these were very inferior as it still led to stock losses and damage. On the other hand, the women reported that there were private providers available offering adequate storage facilities coupled with proper security, but these services came at costs that they could not afford. Also, some participants reported that the lack of storage space had an adverse impact on their health as this caused serious worry and anxiety for them leading to stress related illnesses. This finding corroborates Willemse (2011) on constraints facing informal traders observing that most participants complained of storage space inefficiencies.

Informal trade input costs that did not lead to desired output because of stock loss and damage due to lack of storage space was an ongoing challenge for the participants (Skinner 2008b). Exploration of the participants responses suggested that provision of adequate storage space would be a way of supporting trading conditions by authorities. An obvious observation was that storage was an important feature in informal trading activities. This could be a progressive partnership and cooperation between traders and the city. Also, in support of this idea is Emmanuel'O et al., (2012) suggesting that quality output may have a significant impact on women's much needed income and potentially prolong their stay in employment which has moved to being informal and the norm in recent times.

Maximising public spaces and infrastructure is important for the city, either through meeting the citizens needs and experiences of public spaces or alternatively set up dignified spaces of work for informal traders as they featured prominently in the city. Disregarding them would not be ideal. This is the idea of a public good as asserted by Moore (1995). To achieve this the research suggests linkages between efficient CoJ informal trading management, direct and enabling policy and access to government provisions such as access to adequate PHC services as the relevant authority in this

regard. Also, this should be an inclusive and participatory process between the city and traders.

Conclusion

Mobile clinics may be a promising tool to help deliver much needed healthcare services to this underserved constituency and may also help control health procurement expenditure (costs) and possibly decrease health disparities (Hill et al., 2012). Essentially, mobile clinics are set up to mitigate obstacles and challenges to health care (Hill et al., 2012). Also, an intervention of this nature would be a step in the right direction since it would be meeting people where they are at, more especially the socially excluded groups (South African women informal traders) which is the idea of social policy. Also, capacity is a central issue to effective primary care service delivery. And linked to this is the idea of coordination and/ or facilitation. Coordination and/ or facilitation is an important feature to any process and the absence of it has surfaced a lot of discrepancies in the health seeking behaviours and processes of the participants. Further, lack of sufficient storage space for wares was identified as a constraint by the participants. The significance of storage facilities for traders cannot be overstated as it has a direct implication on their livelihood as loss of or damage to wares means loss of profit. Consequently, the finding determined that the lack of storage facilities for wares was a serious operational impediment for the traders.

CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

7. Introduction

This chapter presents conclusions that are based on the findings of this empirical study. The study focused on explored access and PHC services seeking experiences for South African women informal traders in the CoJ Region F inner-city. The study was conducted in the context of Section 27's constitutional provision on the right to healthcare. This chapter will also offer recommendations that were constructed on the research conclusions and the purpose of the study.

7.1 Conclusions

This study has detailed South African informal trader women's experiences when accessing PHC services in the CoJ Region F inner-city. The study demonstrated how the interaction of various factors such as precarity, informal work, the right to health, and SRC affected South African women informal traders' ability to access PHC services in an urban setting. The study found that South African women informal traders perceived major inequalities in access and confronted negative experiences in their pursuit and use of PHC services.

Additionally, participants perceived conditional citizenship as users of PHC services. This suggested that their employment in the informal sector was associated with SRC in meeting their healthcare needs which was largely adverse. Thus, women's informal employment status influenced their health seeking behaviours, they attached no meaning to SRC in their health seeking processes. This rendered their PHC services access inadequate and the primary care system in the CoJ Region F ineffective. This necessitates significant and imperative changes in the facilitation and coordination of access and improvement of South African informal traders' on PHC services. This should be done to deliver the true meaning of the RSA's constitution Sec 27 on the right to healthcare and other related health prescripts in attempts to preserve SRC in healthcare provision.

Key obstacles hindering access to and use of PHC services in the CoJ Region F inner-city were identified in the findings. These were related to prolonged waiting time, work commitments, geographical accessibility, limited affordability concerns, requirements for documentation and women's perceptions of medication. Additionally, there were

many negative care experiences that were reported by participants in relation to the use of primary care services. These were in relation to unavailable healthcare professionals, unavailable medication and equipment, poor patient services by healthcare support staff, poor communication and verbal abuse by healthcare professional, delayed care, positive/acceptable treatment by healthcare personnel, quality of care that was negative towards sick patients, and overcrowding in PHC centres.

Therefore, no filter should be applied in the recognition and acknowledgement of these obstacles and challenges to access and experiences in PHC services by South African women informal traders because this is necessary for improved provision of care by local government. Furthermore, participants' perceptions of the service delivery model of PHC were not best practice. Mitigating these obstacles and challenges should be advanced in attempts to bring about positive change to South African women informal traders' health seeking behaviours and outcomes. These challenges and obstacles to access and adverse care experiences to primary care services reported in this study can potentially widen and worsen existing systemic inequalities, which is against the prescripts of the RSA constitution. Urgency is necessitated for all stakeholders to mitigate these because participants continued to value the provision of care to service their precarious health.

Concerning the right to healthcare as posited in the RSA constitution's Sec 27, it emerged that participants did not fully enjoy the right to healthcare. Participants reported were several recounts of denied and/or ignored rights during their health seeking processes. This showed the continued marginalisation of the South African women informal traders in many respects reletive to PHC services access. This study is of the view that it is long overdue for the enshrined vision and PHC rights become realised for South African women informal traders. Noteworthy, the denial of this right to PHC implies gross violation of the NHA which assigns the state to provide free primary care, this compromises the welfare state.

This study reported extensively on the use of SRC by the participants when seeking PHC, to ascertain the meaningfulness if any. Considering the informality of the participants, health emerged as a key asset to their economic endeavours. As such, adequate PHC services access experience was of importance to the participants at individual levels. Overall, women did not attach any meaning to SRC because they were unable to apply it in their PHC services access and experiences in the CoJ Region F

inner-city. The study posits that it is time that fundamentals of freedom of health are intensely deliberated on because there are deep social chasms that can no longer be ignored in attempts to uphold and protect South African women informal traders' PHC seeking behaviours. Additionally, restoring the dignity of South African women informal traders' PHC services access and experiences is imminent. This is because the idea of human dignity forms the basis for equality and freedom from discrimination in the implementation of human rights through SRC.

Nonetheless, there were noticeable, although minimal traces of positive PHC services seeking experiences in this study. Most participants perceived and maintained the value and importance of seeking care in PHC centres. This may be attributed to the resilience of the participants in the hope for a better tomorrow. The exceptional positive cases demonstrated that with all inefficiencies and shortcomings, the SA PHC system was still held in high regard by many who rely on it for care. Arguably the use of PHC services is shaped by various factors that are often intricately interwoven, and include individual and broader factors that are structural and supposed to be systematic. Therefore, the study puts forward the idea that informal trading is a social determinant of health.

Health disparities were also identified in the study, and these were largely driven by the economic and social inequalities that characterise the South Africa women informal traders. Health disparities are an undesirable outcome and should be eliminated. This will aid advancing inclusion, social justice, social cohesion, and equity for South African women informal traders. The disparities were seen in the study through participants' lack of access to adequate treatment, livelihood security and the use of home or traditional medicines.

It should be stated that SA's PHC system remains riddled by many challenges, because it was viewed as inadequate by the participnats. It is against this assertion that all stakeholders such as, government, health practitioners, patients, and non-state sectors should collaborate for a greater good in efforts to advance adequate healthcare provision and an effective PHC system for all. Essentially, for the betterment of all in SA since public PHC is a social demand and provided for by the government. Careful exploration and consideration of the participants' responses gives the impression that they would appreciate a workable pathway to access and experience of PHC services. The study is of the view that adequate access and health seeking experiences may be

a form of positive reform and pathway for the inclusion of South African women informal traders into the wider society.

7.2 Implication of the study

The study has outlined the intricate interaction of obstacles and challenges to access and experiences of PHC services by South African women informal traders in the CoJ Region F inner-city. Participants did not enjoy adequate PHC services access and had poor experiences. According to South African women informal traders, the PHC system was inadequate and ineffective. They also coupled with the zero meaning they attached to SRC in their health seeking behaviours. Also, the lack of healthcare facilities in the inner-city for their use further worsened their in-access to PHC services. Furthermore, the study's findings assume that adequate PHC services should be adopted such that they are inclusive of South African women informal traders in the realisation of and conforming to the true meaning and vision of all policies and frameworks governing health and healthcare in SA as guided by the supreme law of the land.

7.3 Recommendations

The recommendations are rooted in the study's findings as informed by the participants. The study also puts forward recommendations anchoring those of the participants. These short- and long-term recommendations seek to address key points of weakness in the healthcare system in attempts to advance adequate access and experiences of PHC service by South African women informal traders in the CoJ Region F inner-city.

7.3.1 Short term recommendations

Firstly, participants recommended the introduction of mobile clinics which is a type of health reform. They were of the view that these should be evenly distributed across the region, and this will signify some form of support by the government that continues to be in short supply for the underserved groups. Also, this gesture will signify social support for women.

Secondly, participants recommended the training of human resources both clinicians and support staff at primary care centres to restate and enforce the healthcare governance guidelines and to find innovative ways to intervene in health support for South African women informal traders. Among other interventions should be a rethinking on the requirements for documentation and the fixed-abode idea because

these cannot be an obstacle in accessing PHC, considering the socio-economic status of many using these services.

Thirdly, there was a recommendation on the provision of storage facilities for wares. The issue and importance of adequate storage for traders cannot be overstated because storage is an input to informal trading activities. Therefore, the lack of storage facilities has an adverse effect on informal traders' health in relation to stress and anxiety because of current storage inadequacies and loss of their earnings.

The fourth recommendation that was put forward by the study is that of compliance with and enforcing all health-related legislations in PHC service delivery, guided by the constitution obligating the state to deliver comprehensive healthcare for all irrespective of any other variable for example, labour force in the informal sector.

7.3.2 Long term recommendations

These are put forward by the study. Firstly, the government needs to establish direct policy framework/legislation to govern the informal sector. This will allow local authorities to intervene correctly with intent for all sub-sectors of the informal sector inclusive of informal trading. Secondly, practitioners must be trained on on the integration needs into PHC services for women informal traders. Additionally, there is a need to improve care quality and eliminate the perceived discrimination in care processes towards socially excluded groups.

Lastly, intensive training of specialised health professionals who will be equipped to execute specialised care in PHC centres with a high density of women informal workers is required. This will also facilitate access to a variety of care services in the same premises and mitigate costs that are involved in the care seeking processes of the South African women informal traders such as transportation and advance care accessibility to sophisticated treatments.

7.4 Further research

There is a need to carry out further research on South African women informal traders in greater depth because they will not be extinct, considering the economic trajectories of many nations including SA. This is also because these groups are at a great disadvantage compared to their male counterparts in the same domain. Research may include:

a) A geographical context on access and health seeking experiences of public healthcare services by South African women informal traders with other healthcare systems (regional, district) not included in this research.
b) The perceptions and ideologies of healthcare providers to obtain a wider viewpoint and insight into the obstacles and challenges to access and experiences of primary care services by South African women informal traders in the CoJ.
c) Interventions combining the supply side and demand side on improving access and health seeking experiences to primary care services by South African women informal traders in the CoJ.

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APPENDICES

APPENDIX A

Focus Group Discussion (FGD) Guide

1. Opening remarks

Good day all. My name is Duduzile Dube (a research student) and my role in today's session is to facilitate the Focus Group Discussion. Also, party to the session is my colleague Marcia Siaga and she will be assisting me as well as taking down notes on the day's proceedings. Let me take this opportunity to thank you for taking time out of your busy trading schedules to be present today.

The purpose of today's discussion is to understand what happens to you upon becoming sick or in need of medical treatment in the City of Johannesburg, Region F. Also, to ascertain if there is any meaning of Section 27 of the Constitution on the social rights of citizenship in meeting your health needs. All the information gathered today will be treated with anonymity as well as confidentiality. If at all at any point during the session you do not wish to continue taking part in the discussion, please note that you will be at liberty to leave the session and no questions will be posed to yourself then on. Further, the information gathered today will contribute towards the fulfilment of the requirements for the degree Master of Management in Governance (Public and Development Sector Monitoring and Evaluation) that I am currently pursuing with the WITS Graduate School of Governance.

We will greatly appreciate it if you could please allow the session to be recorded in order for us to have an accurate record of the discussion. This will augment the manual notes taken, because, it will not be possible to capture every word manually and this will also allow us to make reference to any information that we may have missed. Be assured that all the recordings and notes taken will be safely and securely stored. May I ask, is everybody comfortable with the tape recording of the discussion? (It is important to confirm consent with the group participants).

There are no right or wrong responses, just differing viewpoints and opinions and feel free to express these, also our interest is on both positive and negative comments/ encounters. May we kindly request that you allow each other the opportunity and turns to speak and not disrupt each other. We are interested in what you all have to say, and we ask that you please respect each other's views/ opinions. The duration of the discussion will be 60 to 90 minutes long. Note that my role is to guide the discussion and encourage you to engage each other. Before we start, are there any questions you would like to ask us?

Note that name tags have been placed on the table in front of you to assist all of us in remembering each other's names.

2. Introductions

As we start. Let's get to know each other by going around the table for a round of introductions. Tell us your name, where you come from, where you live, how long you have been trading in Region F, where about you are trading in Region F, and what service(s) you are offering.

3. Question(s)

Opening questions

- What is the first thing that comes to mind when you think or hear of the term primary healthcare services?
- What are some of the health diseases/ problems that affect you as women informal/ street traders in Region F?
- How are you protected from being affected by these health diseases/ problems?

Main question(s): Experiences

- Briefly, may you please take turns and describe to us an incident when you had to seek and consult a healthcare provider in Region F?

Follow-up question(s)

You have all shared very interesting and intriguing experiences. At this point in time I would like us to go into detail and further focus on few of the shared stories?

- Starting with story Y. Y may you please describe in more detail your experience?

- While Y is providing a detailed description of their experience(s), may I also request that the rest of the group takes time to think and consider what Y went through and how you would have felt in the same situation described by Y?
- (Once Y has given a detailed encounter of their story). Please allow me to ask clarity seeking questions?
- Following Y's encounter I am opening up the discussion for the entire group to pose questions and voice out comments on reactions to Y's experience.

Probing question(s)

These will be asked only if not yet covered by the participant sharing their experience.

- Please reveal to us the place where you visited the healthcare service? Example, was it a public or private healthcare service?
- Is this the place where you normally go when you need medical/ healthcare services?
- Please share with us when did the experience you are describing to us happen?
- How was the treatment that you received from the healthcare workers/ givers (nurses, doctors)?
- What were your thoughts on the facility where you received the healthcare service?
- When you think about your experience now, irrespective of whether your health was improved or not, is there anything that you would change?

Follow-up question(s)

- With all what has been shared with us, would the group like to put forward their reaction to Y's story/ experience?
- Further, I would like us to follow-up four more other stories that have been shared in a similar manner.

(Once Y's story/ experience has been exhausted then we will move on to the next story until all the stories have been discussed).

One perspective of Social Rights of Citizenship is the idea of access to public benefits and specific to this proposed research study is access to public healthcare services. The Constitution of South Africa prescribes basic human rights access to

healthcare and posits every person in South Africa the right of access to healthcare, and the application of the right is to everybody, that is citizens and non-citizens alike.

Main question(s): Social Rights of Citizenship (SRC)

- What do you understand by the term social rights of citizenship?
- How do you think the idea of social rights of citizenship plays a role in your attempts to access public healthcare services in Region F?

Closing question(s)

- All of you have shared stories on your experiences with the healthcare services in Region F. I am wondering if anybody in the group has been sick/ ill and decided not to seek healthcare service(s) in Region F. Is there anybody who has gone through such an experience? Would you please take some bit of time to reflect and tell the group about it?

Follow-up question(s)

- Why did you decide not to seek healthcare services in Region F at the time?
- Are there any other additional views/ opinions that anybody else would like to share with the sitting at this point in time?
- Anything else to add?

Your experiences have been very insightful and interesting. Let me take this time to thank you all for taking part in this Focus Group Discussion, thank you very much for your participation it is much appreciated.

APPENDIX B

Participant/ Research Information Sheet

Dear Madam

My name is Duduzile Ellen Dube a Masters student in the field of Governance at the Wits School of Governance in Johannesburg. I have to undertake a research report towards the fulfilment of the requirements for a master's degree, and I am exploring primary healthcare services for informal workers: a case of women informal/ street traders in the City of Johannesburg Region F. The aim of this research project is to capture, describe in detail and understand what happens to South African women informal/ street traders upon becoming sick or in need of medical treatment in the City of Johannesburg Region F. Secondly, to understand if there is any meaning of Section 27 of the constitution on the social rights of citizenship of these groups in meeting their health needs.

As part of this project, I would like to invite you to take part in a focus group discussion at the Johannesburg CBD, President Street (outdoor). This activity will involve answering questions, a single session and will last about 60 to 90 minutes. With your permission, I would also like to record the focus group discussion using an audio tape recorder and these recordings will be stored on the researchers' personal computer and in cloud-based storage facilities such as google drive to which the researcher has sole access.

You will not receive any direct benefits from participating in this study, and there are no disadvantages or penalties for participating. You may withdraw at any time or not answer any questions if you do not wish to do so. The focus group discussion will be completely confidential and anonymous as I will not be asking for your name or any identifying information, and the information you give to me will be held and kept securely and not disclosed to anyone else. I will be using pseudonyms i.e. false names to represent your participation, in my final research report. If you experience any distress or discomfort, we will stop the focus group discussion and/ or resume another time.

If you have any questions afterwards about this research, feel free to contact me on the details listed below. If you have any queries, concerns or complaints regarding the ethical procedures of the study, you are welcome to contact the University Human Research Ethics Committee (non-medical), telephone +27(0)11 717 1408, email Shaun.Schoeman@wits.ac.za .

Yours sincerely,
Duduzile Ellen Dube

Duduzile Ellen Dube (Research Student)
1774938@students.wits.ac.za
072 576 6020

Prof. Robert Van Niekerk (Supervisor)
Robert.vanniekerk@wits.ac.za
071 938 1124

APPENDIX C

Consent Form

Exploring primary healthcare services for informal workers: a case of South African women informal/ street traders in the City of Johannesburg Region F.

Duduzile Ellen Dube (1774938)

I_____ agree to participate in this research study. The research has been explained to me and I understand what my participation will involve. I agree to the following:

(Please circle/ underline the relevant options below)

I agree that my participation will remain anonymous. **YES** **NO**

I agree that the researcher may use anonymous quotes in her research report. **YES** **NO**

I agree that the interview may be audio recorded. **YES** **NO**

_____ Signature

_____ Name of participant

_____Date

_____Signature

_____Name of researcher

_____Date

APPENDIX D

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

WITS SCHOOL OF GOVERNANCE
UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Research Office:
Ayanda Molefe
Tel: 011 717 3968
Email: ayanda.molefe@wits.ac.za

Research Ethics Chair:
Rekgotsofetse Chikane
Tel: 0117173869
Email: rekgotsofetse.chikane@wits.ac.za

03 May 2022

Dear **Duduzile Dube**,

Title: Exploring primary healthcare services for informal workers: a case of women informal/ street traders in the City of Johannesburg Region F.
Student Number: 1774938
Degree: Master in Management in the field of Governance
Ethics Clearance Number: *WSG-2022-18*

All candidates must satisfy the University's ethical standards for research. Your ethics application has been received and reviewed by the Wits School of Governance Human Research Ethics Committee.

Your ethical clearance has been approved subject to you getting permission to conduct research from all sites where research is conducted. The letter(s) of permission to undertake research must be submitted to the WSG Research Office and kept on file with your final proposal and other ethics documents.

You may commence your data collection under the guidance of your supervisor. In the event that the scope, methodology or nature of the research changes, you are required to submit another ethics application reflecting the changes.

The onus is on you as the candidate, with support from your supervisor, to ensure your research complies with university human research ethics policies and protocols at all stages of the research process.

It is recommended that you keep this letter in a safe place as you are responsible for ensuring you have proof of ethics clearance and have lodged the ethics clearance / protocol number with Faculty before final submission of your research report. If you do not have an ethics clearance number, you are not permitted to graduate.

Please do not hesitate to contact me if you have any queries.

Yours sincerely,

Rekgotsofetse Chikane

Rekgotsofetse Chikane
Research Ethics Chair