



**Use and perceptions of public sexual and reproductive
health services:**

**A quantitative situational analysis in OR Tambo and Gert
Sibande districts**

Submitted to

The AIDS Foundation of South Africa (AFSA)

By

Human and Social Development Programme

Human Sciences Research Council (HSRC)

2016

*This report was commissioned by the AIDS Foundation of South Africa.
It was prepared by the Human and Social Development unit at the Human Sciences Research Council,
Pretoria, South Africa.*

COMPILED BY

Dr Tracy Morison – Project leader
MA (Research Psychology), PhD | Senior Research Specialist

Dr Ingrid Lynch – Co-principle investigator
MA (Research Psychology), PhD | Research Specialist

CONTRIBUTORS

Ms Ntombizonke Gumede – Field research
B.SocSci Hons (Sociology) | Junior Researcher

Ms Roshin Essop – Research assistance
B.SocSci Hons (Psychology) | Junior Researcher

Ms Amanda Mtshengu – Fieldwork coordination & research assistance
B.SocSci Hons (Sociology) | Junior Researcher

Prof Monde Makiwane – Statistical support
M.SocSci (Sociology); PhD | Chief Research Specialist

ACKNOWLEDGEMENTS

We gratefully acknowledge assistance received from implementation partners, *Treatment Action Campaign* and *SECTION27*; without them this study would not have been possible. Thanks also to Amanda Mtshengu for excellent fieldwork co-ordination.

SUGGESTED CITATION

Morison, T., & Lynch, I. (2016). *Use and perceptions of public sexual and reproductive health services: A quantitative situational analysis in OR Tambo and Gert Sibande districts*. Durban, South Africa: Aids Foundation of South Africa.

Contents

INTRODUCTION	3
STUDY AIMS AND RESEARCH QUESTIONS	4
BACKGROUND	4
<i>Conceptual framing of the study</i>	4
<i>National Health Insurance (NHI)</i>	4
<i>Use and the perceptions of the quality of public health services</i>	7
CONTEXT OF THE STUDY	9
<i>High pregnancy-related mortality</i>	10
<i>High rates of teenage pregnancy</i>	10
METHODOLOGY	11
<i>Pilot study</i>	11
<i>Main study</i>	11
<i>Site descriptions</i>	11
<i>Sampling</i>	12
<i>Data capturing and analysis</i>	13
<i>Domains in healthcare user questionnaire</i>	13
<i>Strengths and limitations</i>	14
ETHICS	14
RESULTS	14
<i>Demographic characteristics of healthcare users</i>	14
<i>Socio-economic characteristics</i>	15
<i>Domain A: Access to general care</i>	16
1. Main service required	16
3. Waiting time	19
4. Experience at facility and satisfaction with care	20
5. Reasons for negative responses (open-ended responses)	22
<i>Domain B: Knowledge, perceptions, and utilisation of SRHS</i>	22
1. Knowledge and awareness of availability of SRHS and types of services	22
2. Use of SRHS	24
3. Experiences of SRHS and care	25
4. Awareness of discrimination on basis of social characteristics	29
DISCUSSION – IDENTIFYING ‘LEVERS FOR CHANGE’	30
(i) <i>Overall positive use perceptions and high satisfaction levels</i>	30
Low utilisation of SRH services	30
(ii) <i>Expression of dissatisfaction and possible problem areas</i>	32
Youth and young women	32
Men’s uptake of SRHS	32
(iii) <i>Alignment with NHI objectives with respect to SRHS</i>	33
Spatial inequity in the provision of health care	34
RECOMMENDATIONS	34
REFERENCES	36
APPENDIX I	I

EXECUTIVE SUMMARY

Background: This report presents the findings of a quantitative situational analysis of the use and perceptions of the quality of health care services among healthcare users in two districts, using survey methodology. The report was commissioned by the *AIDS Foundation of South Africa* (AFSA) as part of their three-year Sexual and Reproductive Health and Rights (SRHR) programme. The study is framed within a Sexual and Reproductive Justice framework. This conceptual approach expands the rights-based perspective to consider wider contextual factors like socio-economic status, gender, disability, race, and sexuality as potential barriers to Sexual and Reproductive Health and Rights (SRHR).

Aim: The primary aim of the study was to identify the key advocacy strategies and levers for change with respect to access to SRHR, identified from a situational analysis of selected facilities. These will inform the work of AFSA's implementing partners.

Method: Survey methodology was used to ascertain people's own perceptions and experiences of services in terms of access, quality, and satisfaction with general as well as SRH-specific services in the public health system. A Healthcare User questionnaire was administered with people exiting three public health facilities in OR Tambo district in the Eastern Cape and three in Gert Sibande district in Mpumalanga. Both districts are part of the South African NHI (National Health Insurance) pilot. The data from the six facilities were analysed using SPSS and disaggregated according to gender, sexuality, and geographic location, where possible.

Summary of main findings:

- i. Supporting previous research, the findings indicate that healthcare users in the selected districts are predominantly "black Africans, poor, uninsured, and rural" (Harris et al., 2011, p. S102).
- ii. In terms of utilisation patterns:
 - a. Overall, more women than men are accessing healthcare services, and this finding also holds for SRH-specific services.
 - b. Persons seeking SRH-specific services are generally of reproductive age, but with a low proportion of persons under 20 years old, pointing to under-representation of adolescents.
- iii. In terms of user satisfaction:
 - a. The findings indicate generally high levels of satisfaction with care received, but global assessments of satisfaction may mask negative perceptions and dissatisfaction with specific aspects of healthcare (Chimbindi et al., 2014). It is important, therefore, to interpret this finding in relation to existing data and to pay attention to negative responses or expressions of dissatisfaction (Williams, Coyle, & Healy, 1998).
 - b. There is higher dissatisfaction with care received for older persons, and those in the Eastern Cape, pointing to age impacts, as well as spatial inequity in the provision of healthcare services.
 - c. In general, communication with healthcare staff was reported as a key barrier in receiving optimal healthcare service.

When considering SRH-specific services specifically:

- ❖ A large proportion of respondents reported that their social characteristics (gender, sexual identity/orientation, or age) influenced the SRH-specific services they received.
 - i. For sexual and gender minorities, and for very young (teenage) and older (<40 years) participants, age was also regarded as influencing the quality of care received, similar to findings reported for accessing general healthcare.
 - ii. Young respondents were particularly concerned about privacy and confidentiality in receiving SRH-specific services.
 - iii. Sexual and gender minorities reported more frequent perceptions of health workers being unable or unwilling to assist them, than their heterosexual counterparts.

- ❖ Across participant characteristics, when reporting on future access to SRH-specific services, respondents highlighted the importance of proximity of services in their likelihood of accessing SRH services.

INTRODUCTION

As South Africa continues its quest for universal health coverage through National Health Insurance (NHI), it is of utmost importance that data are collected to assess the current status of health services provision and also for comparison with the future service provision under NHI. Important data for these purposes include health care utilisation and perceptions of health care services, including those targeted at Sexual and Reproductive Health (SRH) (Shisana et al., 2012). This report presents the findings of a quantitative situational analysis of the use and perception of the quality of health care services. The survey is framed by a Sexual and Reproductive Justice perspective. It was commissioned by the *AIDS Foundation of South Africa* (AFSA) as part of their three-year Sexual and Reproductive Health and Rights (SRHR) programme. AFSA's programme is intended to strengthen SRHR and community-based HIV/AIDS interventions in South Africa, and to build the evidence base for effective regional responses. The findings of the report are intended to support these aims.

Sexual and reproductive health rights refer to “the extent to which people feel comfortable about their sexuality and gender identity and are able to make decisions about their sexual and reproductive lives, including if, when, and how to engage in sexual relationships, and if, when, and how to have children, in a social, cultural, and interpersonal context free of coercion, discrimination, and violence” (Klugman, Treger, Conco, & Moorman, 2011, p. x). Sexual and reproductive health rights are legally protected in South African law and policies. However, in order for them to be meaningful they must be enabled through adequate budgets and “affordable, available and acceptable services [that are] responsive to patients' needs and expectations” (Harris, Eyles, Penn-Kekana, Thomas, & Goudge, 2014, p. 1). Instead, in South Africa a large body of research documents a range of poor quality services in the public sector and barriers to access.

Despite generally progressive health policies, the health system has been compromised by “failures in leadership and stewardship and weak management” (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009, p. 817). In general, these failings are fundamentally linked to poor governance and management (Coovadia et al., 2009). Systemic failures therefore compromise people's ability to obtain Sexual and Reproductive Health Services (SRHS). This results in unmet need, the inability to exercise fertility preferences and desires, and a range of negative—often preventable—health outcomes. The ability to realise one's SRHR is severely constrained and often undermined by the malfunctioning health system. Thus, it is essential to address systemic failures in order to ensure sexual and reproductive justice for all.

In order to inform the work of civil society partners working to improve the public health system, a Healthcare User survey was conducted. Respondents were asked about their use and perceptions of both general services and SRHS. The survey was administered at six health facilities located in OR Tambo district in the Eastern Cape, and Gert Sibande district in Mpumalanga. These districts were selected for two main reasons. The first reason is that both areas are experiencing severe problems in relation to health service delivery and systems failures. Civil society organisations associated with AFSA's SRHR programme, notably *SECTION 27* and the *Treatment Action Campaign* (TAC), are actively working in these areas to address the issues. The second reason is that both districts are designated National Health Insurance (NHI) pilot sites. This allows for valuable information to be collected regarding the impact that NHI activities have in the area, as well as potential problems with future roll out, identified in the NHI pilot.

STUDY AIMS AND RESEARCH QUESTIONS

The primary aim of the study was to identify the key advocacy strategies and levers for change with respect to SRHR that can be identified from a situational analysis of the selected facilities. The study was guided by the following research questions:

1. What systemic issues are identified as currently problematic at specific public healthcare facilities?
2. What are users' perceptions of selected healthcare facilities in terms of accessibility and quality of care?
3. What barriers do users identify as obstacles to service delivery, in terms of both access and quality?
4. What opportunities do users identify in relation to service delivery, in terms of both access and quality?

BACKGROUND

Conceptual framing of the study

When dealing with SRHR issues, it is important to consider “the dimensions of sexuality and reproduction that are inscribed into the broader organisation of social and economic life” (Klugman, 2007, p. 88), particularly access to services. A Sexual and Reproductive Justice frame allows such a view. This conceptual approach expands the rights-based perspective—which is usually focussed on individual rights and choice—to consider wider contextual factors (e.g. socio-economic status, gender, disability, race, sexuality). Importantly, “this framework [positions] reproductive rights in a political context of intersecting race, gender, and class oppressions” (Roberts, 2015, p. 79) in particular. It allows us to see how interlocking inequities shape people's SRH experiences and needs, as well as the obstacles and challenges that they face in exercising their SRHR (Gilliam, Neustadt, & Gordon, 2009; Morison, 2013). These rights include *both* the right to refrain from having children (usually emphasised in a rights-based approach) *and* “the right to have children and to raise them with dignity in safe, healthy, and supportive environments” (Roberts, 2015, p. 79). Framing the study in this manner illuminates the ways in which systemic failures and barriers to SRHR are fundamentally linked to social inequities. The National Health Insurance (NHI) scheme, which is currently being piloted, is seen as one necessary solution to accessing adequate care, including SRH services (Benetar, 2013; Shisana et al., 2013), as discussed below.

National Health Insurance (NHI)

Access to healthcare in South Africa is shaped by a range of social inequities. “There are substantial inequities across the country in both the availability and the quality of services” (Klugman et al., 2011, p. 11). Private health services are extremely costly and out of reach of the majority of citizens who cannot obtain medical insurance to pay for private care (Coovadia et al., 2009; L. Rispel & Hunter, 2015). Research shows that the greatest access barriers are encountered by those who are “black Africans, poor, uninsured, and rural” (Harris et al., 2011, p. S102). Thus, the current task of health care reform is in “achieving equitable universal health coverage [which] requires the provision of accessible, necessary services for the entire population without imposing an unaffordable burden on individuals or households” (Harris et al., 2011, p. S102).

The move toward universal health coverage mirrors shifts made in other low- and lower-middle-income countries in Africa that have launched national health insurance initiatives in the last decade. For instance, Ghana and Rwanda are in intermediate stages of reform, while Kenya, Mali, and Nigeria are in the earlier stages. In Southern Africa, most countries have begun planning for the implementation of universal health coverage, but face significant obstacles, not least of which are high levels of income inequality [see McIntyre (2012) for a more detailed discussion on this]. It is, however, difficult to compare the progress, outputs, and outcomes of universal-coverage reforms in developing countries, due to a lack of common comparable standards. Countries differ in how they package and roll out insurance coverage, primarily in terms of who is covered, what illnesses are covered, and what proportion of costs is covered (Lagomarsino, Garabrant, Atikah, Richard, & Otoo, 2012). Of course, this is not the only way to try to attain universal health coverage, and is not without its challenges (Benetar, 2015; Lagomarsino et al., 2012).

NHI AIMS

1. Improve access to quality health services for all, irrespective of employment
2. Pool risks and funds to achieve equity and social solidarity through the creation of a single fund
3. Procure services on behalf of the population and efficiently mobilise and control key financial resources
4. Strengthen the under-resourced and strained public sector so as to improve health systems performance

In South Africa NHI was launched in 2012 and is intended to transform the delivery of health care (especially primary health care). The main objective is to create a single, publicly owned and administered fund to purchase health services on behalf of the total population from suitably accredited and contracted providers (Hongoro, 2014). Underlying this objective is the aim of eliminating income and financial barriers to health access (Department of Health, n.d.). The emphasis is on both *access* and *quality* (Hongoro, 2014). The specific objectives of NHI, as laid out in policy (Matsoso & Fryatt, 2013), are summarised above.

The NHI policy is expressly geared to healthcare reform and underpinned by the central principal of social solidarity, which aligns with other social justice principles of the constitutional right to healthcare and equity (Naidoo, 2012). This is expressed by the Department of Health as follows:

National Health Insurance is a way of providing good healthcare for all by sharing the money available for healthcare among all our people. The health benefits that you receive will depend on how sick you are, not on how wealthy you are. Hospitals, clinics, doctors, specialists, dentists, nurses and all other health workers will also be available much more equally. It all depends on our willingness to SHARE as ONE NATION. [...] NHI will **create fairness in the sharing of healthcare finance and other resources**, including skilled health professionals. [...] [This] **means you will receive healthcare for free at the time you require it** (Department of Health, n.d., p. 2)

It is envisaged that primary healthcare services will be delivered through (1) district-based clinical specialist support teams; (2) school health services; and (3) ward-based primary health care agents overseen by health professionals (Naidoo, 2012). The initiative thus focuses on both prevention and treatment (Department of Health, n.d.).

Piloting and progress to date: The government has committed to a phased approach over 14 years. NHI is to be implemented in three phases, as outlined in table 1 below (Hongoro, 2014; Marten et al., 2014).

Table 1. NHI pilot phases

<p>Phase I (2012/2013 to 2015/2016)</p>	<ul style="list-style-type: none"> • quality improvement strategies in public sector, including problems with infrastructure and availability of essential medicines • piloting key elements of the National Health Insurance reforms in selected ten districts
<p>Phase II (2016/2017 to 2019/2020)</p>	<ul style="list-style-type: none"> • continuation of activities initiated in Phase I • mobilising additional revenue streams and generating additional revenue through taxation <ul style="list-style-type: none"> ○ Establish an NHI fund ○ Creation of a purchaser-provider split
<p>Phase III (2020/2021 to 2024/2025)</p>	<ul style="list-style-type: none"> • Continuing existing activities • Implementation of mandatory contributions • Initiation of contracting-out activities with identified accredited private providers

The proposal for NHI was introduced in 2011 in a Green Paper and Phase One began in 2012 with the announcement of pilot sites (shown below, fig. 1), covering 20% of the total population. The NHI pilots are focused on improving health outcomes for the most vulnerable in South Africa, including among others, to reduce maternal mortality and the burden of disease borne by women.

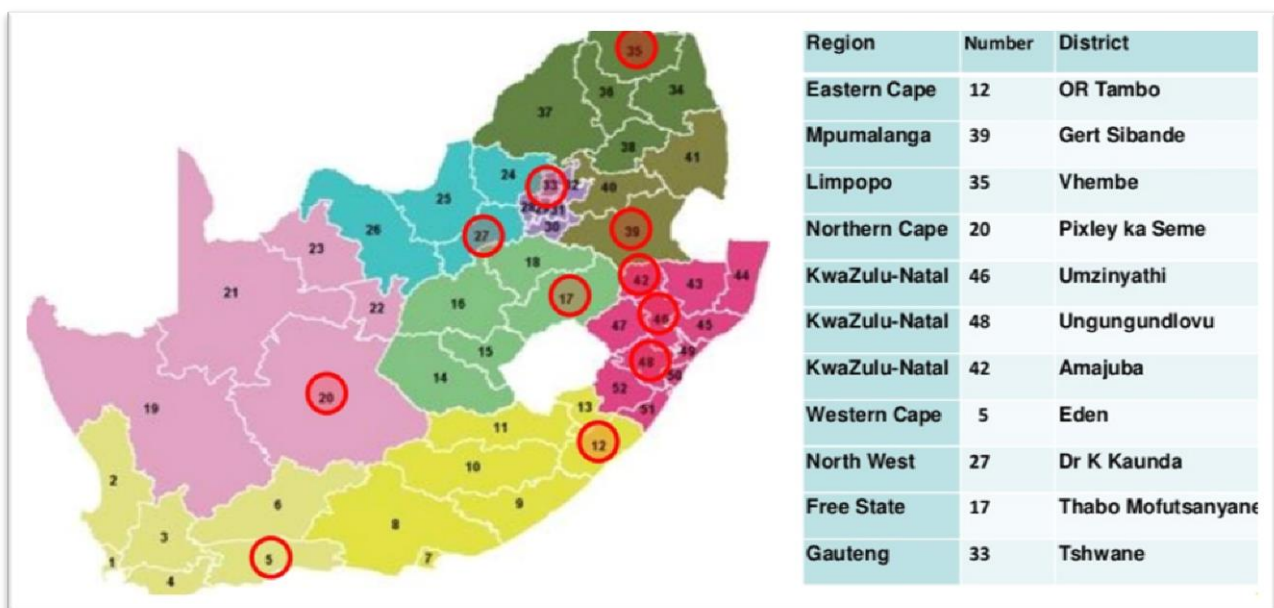


Figure 1. NHI pilot districtsⁱ

The pilot sites were selected based on performance on a number of indicators, including Health Service Performance Indicators of:

- HIV prevalence;
- antenatal coverage;
- delivery in facility; and
- couple year protection rate.

Maternal and reproductive health services are prioritised as part of a number of ‘non-negotiable’ components of a successful health system and are accordingly to be protected from under-funding (Motsoaledi, 2012).

The pilot phase was intended to provide an evidence base, demonstrate benefits of reform, and build capacity. After the launch, several reviews were conducted to monitor implementation. A review of the NHI pilot districts conducted in 2013 focused predominantly on human resource capacity, infrastructure, management and mechanisms for quality assurance; there was therefore no specific assessment of SRH indicators in relation to the NHI pilot (SARRAH, 2013). While the NHI pilot has as one of its key objectives the improvement of access to quality health services, with a particular focus on rural and previously disadvantaged areas, the activities in support of this objective are however limited to harnessing private sector resources, such as general practitioners and specialists, improving referral systems and strengthening specialist capacity, such as District Clinical Specialist Teams with the required dedicated senior obstetrician, gynaecologist, and midwife, as per the NHI White Paper. For example, Gert Sibande indicated only partial achievement in staffing District Clinical Specialist Teams; only the nursing specialists have been recruited to the Teams and the district has a generally poor ability to attract and retain specialists and skilled professionals (Eastern Cape Department of Health, n.d.; SARRAH, 2013). This highlights the importance of monitoring the establishment, functioning and impact of the District Clinical Specialist Teams in the pilot areas as part of any initiative aimed at evaluating the impact of the NHI pilot programmes on SRHR of marginalised groups.

At the end of 2015 the NHI policy was passed into White Paper but, at the time of writing this report, overall progress remains well behind schedule (Daygan Eagar, personal communication). To date, efforts have been focused on the public sector (Cullinan et al., 2015). In mid-2015 *Health-e*, a health news service, reported that “most of the 10 NHI pilot districts – with the exception of OR Tambo in the Eastern Cape – are making reasonable progress to improve the public health” (Cullinan, Nkosi, Lopez Gonzalez, & Mkhwanazi, 2015). The reasons for OR Tambo’s poorer performance were not made clear. In the Health Minister’s report to Parliament in 2015, the parliamentary committee was also generally positive and commended the Health Department’s efforts and its focus on primary healthcare (Health-e, 2015). The Minister reported that the NHI programme has focused on infrastructure development of primary healthcare systems and the recruitment of doctors and specialists for clinics. Based on the Department’s plan for “the ideal clinic”ⁱⁱ, 106 structures have been built in the ten pilot districts. A total of 253 private doctors have been contracted to work part-time in pilot districts, mainly in government clinics (Health-e, 2015). Reported successes appear to be focused on preventative care, including school health teams (screening learners for eye, ear, dental, and nutritional problems); and ward-based outreach teams (providing preventative care, antenatal care, infant care and antiretroviral treatment for HIV-positive infants). Another success is the piloting of a scheme to de-congest clinics by allowing stable patients to collect chronic medicine (including antiretroviral drugs) from schools and private pharmacies.

Use and the perceptions of the quality of public health services

Increased patient representation and participation are important for improving service delivery, particularly as more emphasis is given to patient-centred approaches in healthcare and public participation in policy-making (Andaleeb, 2001; Mpinga & Chastonay, 2011). Studying utilisation patterns and user perceptions of health services can help to gain an understanding of the quality and effectiveness of the public health system (Andaleeb, 2001; Mahomed, Wallis, & Motara, 2008).

It is important to note that user reports of experiences of health services can form part of evaluations of health services, but do not form the entire picture (Williams et al., 1998). Patient reports of their

experiences are by nature subjective and influenced by a number of other factors, such as recall, public discourse, social desirability and so forth (Shisana et al., 2012). (See the study limitations section further below for a discussion of how these challenges were addressed in this study.) Nevertheless, patient perspectives provide useful information for increasing responsiveness to patients—one of the goals of the NHI scheme, as mentioned above. They can also assist with health policy development (Mpinga & Chastonay, 2011; Shisana et al., 2012; Williams et al., 1998). Importantly, these data can help to pinpoint problem areas and avenues for follow-up, especially using qualitative methodologies that help to provide further nuance and explain results (Williams et al., 1998).

Utilisation patterns and patient perceptions are inter-related, since user perceptions of public health services impacts on the use of these services. Positive perceptions can contribute to increased use of services, while the opposite is true of negative perceptions. The effectiveness of healthcare is also linked to patient's positive perceptions of services. Satisfied patients adhere to practitioner recommendations and to treatment plans, and have better health seeking behaviour, which translates to improved clinical outcomes (Bernhart, Wiadnyana, Wihardjo, & Pohan, 1999; Muhondwa, Leshabari, Mwangu, Mbembati, & Ezekiel, 2008; Nunu, 2015). It is therefore necessary to consider how and why people access health care, as well as their perceptions of the quality of the care that they receive (Shisana et al., 2013).

There is a limited number of studies in 'developing' countries, including South Africa, on user perceptions of care (Bernhart et al., 1999; Hardon et al., 2007; Mashego & Peltzer, 2005; Muhondwa et al., 2008; Myburgh, Solanki, Smith, & Lalloo, 2005; Nunu, 2015; Wouters, Heunis, van Rensburg, & Meulemans, 2008). Most of this research has focused broadly on primary health care services, not necessarily on SRHS, with the exception of studies that consider HIV-related services (Chimbindi, Bärnighausen, & Newell, 2014; Nunu, 2015). The current study is therefore useful in that it provides data specifically related to SRHS.

The existing studies point to a range of issues hampering healthcare service delivery in the public health system, related to the lack of adequate resources and human resource capacity (Coovadia et al., 2009; Stevens, 2008). Patients commonly report long waiting times, unavailability of medications, and poor treatment from staff as problems with public health services. These may deter patients from going to these facilities and thus delay help-seeking or result in defaulting on medication (Hasumi & Jacobsen, 2014). Furthermore, reviews of national surveys indicate a number of common barriers to access. These include rural-urban location and distance to facilities; socio-economic status, insurance status, and racial categorisation (Gilson & McIntyre, 2007; Harris et al., 2014; Kon & Lackan, 2008). In particular, rurality and deprivation have been pin-pointed as significant in determining access to health care. Deprivation is not confined to rural areas, but there are particular aspects of rural living, that aggravate deprivation. These include distances to services, poor infrastructure, lack of transport, and urbanisation (Harris et al., 2011). Therefore, "access barriers continue to inequitably affect many who experienced the dispossession and structural violence of apartheid - poor, black, rural and informal-urban communities - as well as newer marginalised groups, including refugees and migrants" (Harris et al., 2014, p. 2).

As mentioned, the accessibility, affordability, and acceptability of services play a role in the degree to which people actually use services. This also has implications for adherence to medications and delayed health-seeking, which might mean, for example, that conditions become worse or antenatal care is not received. Most recently, Harris and colleagues (2014) concluded that health workers' treatment of

patients also plays an important role and can help counteract access barriers. The researchers analysed patient and provider accounts of seeking and delivering care, and concluded that “Although many providers were sympathetic to patient barriers of poverty and difficult life circumstances, for patients, suffering was more than adverse socio-economic conditions. It was exacerbated by uncaring, hostile or dismissive providers and certain health system arrangements, which were often intended to curb defaulting, yet added to the risk of patients dropping out of the system (p. 47). For example in rural health care facilities patients receiving ART have different patient folders to patients with other health related problems, contributing to stigma experiences for patients with a positive HIV status (Mathibe, Hendricks & Bergh, 2015) Conversely, Harris et al., (2014) propose that “caring, respectful communication, individual acts of kindness, and institutional flexibility and leadership may mitigate key access barriers” (p. 35).

In the case of SRH services, health care users are not always able to access the treatments, contraceptives, and services that they desire (Klugman et al., 2011). A number of socio-cultural barriers affect access to SRH but given the primacy of gender and sexual identity in relation to sex and reproduction, inequities in these areas are key obstacles to realising SRHR (Klugman et al., 2011). Further contributing to poor uptake of SRH services is the stigma associated with HIV/AIDS (Bogart et al., 2013) and termination of pregnancy (Mbali & Mthembu, 2012; Trueman & Magwentshu, 2013), as well as negative attitudes to young people’s sexuality or early pregnancy (Macleod & Tracey, 2009 & 2010; Wood & Jewkes, 2006).

CONTEXT OF THE STUDY

The study was conducted in two of the NHI pilot districts: Gert Sibande in Mpumalanga and OR Tambo in the Eastern Cape. Both provinces are rural and relatively underdeveloped. Both also show low rates of economic activity and high rates of deprivation. The Eastern Cape, for example, has ten of the country’s ‘most deprived’ districts, all rural. Gert Sibande compares somewhat more favourably to OR Tambo, with a ranking of 28 out of the 52 districts in terms of deprivation. Nevertheless, resources still do not meet the population need (Massyn et al., 2014). A key concern in both districts, in relation to health systems, is underspending on health budgets. Of all the NHI pilot sites, the two districts have the lowest primary healthcare expenditure per capita with Gert Sibande at R709, followed by OR Tambo at R647 (Massyn et al., 2014). Being rural provinces, both the Eastern Cape and Mpumalanga struggle with staff shortages and availability of medicines and supplies. This poses significant problems for health outcomes as both provinces are heavily affected by HIV/AIDS (DoH, 2012).

The two districts fare poorly in terms of SRH when compared to the rest of the country. Barriers to exercising SRH rights are reflected in the following problems (Morison & Janse van Vuuren, 2015):

- i. increased rates of pregnancy-related mortality;
- ii. low attendance at antenatal care services;
- iii. lack of functional Termination of Pregnancy services;
- iv. high teenage pregnancy rates;
- v. poor access to, and use of contraception; and
- vi. high HIV prevalence among vulnerable groups (e.g. sex workers; men who have sex with men; young women).

These interlinked challenges are particularly expressed in high pregnancy-related mortality and high rates of teenage pregnancy, further examined below.

High pregnancy-related mortality

While both districts report high pregnancy-related maternal mortality, OR Tambo is ranked as the third worst district in the country. One reason for these high mortality rates is low attendance at antenatal care services. Research has indicated persistent problems relating to the availability and costs of transport to access services, which is a particular challenge for rural areas (Human Rights Watch, 2011). This is compounded by a dysfunctional Emergency Medical Service, which has insufficient ambulances and cannot access some remote areas (Harris et al. 2011).

Some women are turned away at facilities due to overcrowding and given alternative booking dates. Another factor that dissuades antenatal care attendance is poor and abusive treatment at facilities (Amnesty International, 2014; Massyn et al., 2014; Human Rights Watch, 2011). Many women, especially migrants and refugees, delay or avoid seeking care. Another reason for the high number of pregnancy-related deaths is barriers to termination of pregnancy services, linked to a lack of state facilities. Recent statistics on ToP are not available but in 2003 the Eastern Cape the percentage of facilities functioning was 10% below the already low national rate (Massyn et al., 2014). Available statistics for Mpumalanga indicate that the province has the second lowest percentage of functioning designated TOP sites (Macleod & Tracey, 2009).

High rates of teenage pregnancy

High rates of teenage pregnancy of course intersect with the poor maternal health outcomes discussed above. The percentage of teenage pregnancies based on births at public health facilities in the Eastern Cape is at 14.5% and in Mpumalanga at 15%, which is above the national average of 12% and also higher than several other rural provinces (see Morison & Janse van Vuuren, 2015 for more information).

Unwanted and unintended pregnancies suggest unprotected sex, which also carries the risk of sexually transmitted diseases. The Eastern Cape is one of the provinces with the highest unmet need for contraception, with the province lagging behind the rest of the country (Macleod & Tracey, 2009). The increase in usage of modern contraception among (heterosexual) women living in the Eastern Cape and Mpumalanga

Table 3: Contextual summaries of the two selected NHI districts

Gert Sibande District is the largest of three districts in Mpumalanga with a predominantly rural population of approximately 1,056,178. There is high youth unemployment and most households depend on social grants. Health problems and challenges experienced in the district are influenced by high levels of HIV/AIDS, unemployment, alcohol abuse, and unsafe sexual practices such as intergenerational and transactional sexual partnerships. Because of the demographic spatial arrangement of the province, there is a high number of trucking communities passing through the province and, along with the mining community, contribute to an active sex work industry.

OR Tambo is one of six districts in the Eastern Cape Province with a population of approximately 1,358,917. It includes former homeland Transkei and is formed by five local municipalities. The district is classified as one of the worst-off districts in terms of socio-economic standing; it experiences great deprivation even though it is the fourth largest economy within the province. *TAC* and *Section27* are members of the Eastern Cape Health Crisis Action Coalition and active in this district, with the *TAC* provincial offices based in this district. Similar to the rest of the province, in the OR Tambo district the economic burden is exacerbated by high rates of HIV/AIDS, which necessitates expenditure for treatment and grants, as well as further inhibiting economic participation.

mirrors the steady national increase since 2011,ⁱⁱⁱ meeting the national target (Macleod & Tracey, 2009). This does not consider access to and uptake of contraceptive methods by vulnerable or marginalised groups, such as girls and young women, including lesbian women, or men who have sex with men (WHO, 2010).

METHODOLOGY

Pilot study

Before commencing with the main study, a pilot was conducted at Driefontein Community Health Centre (Mkhondo) in Mpumalanga and a total of 57 patients were surveyed. This facility was selected based on convenience. The purpose of the pilot was to test the instrument and procedures. Based on the pilot the questionnaire was revised to make some questions clearer. In addition, it was decided that it was not possible to conduct surveys with the health workers as was initially hoped. The reason was that most workers declined due to time constraints as they are working in incredibly busy facilities. Further research will be required to access this population and ways of doing so will need to be carefully thought through.

Main study

The six sites for the main study were selected using purposive sampling. These sites were identified with assistance from the AFSA Programme implementing partners based on their relevance to the study and accessibility (i.e., whether partner organisations already have access and networks at the sites). They are sites where implementing partners' work has been focussed. They comprise one rural district clinic, one urban district clinic and one hospital in each district (OR Tambo and Gert Sibande). This was done in order to ensure that a number of different types of facilities were included in the study, possibly allowing for comparisons to be made.

Table 4. Study sites

District	Facility	Type
OR Tambo	<i>Lusikisiki Village Clinic</i>	Rural
	<i>Mthatha Gateway Clinic</i>	Urban
	<i>Zithulele Hospital</i>	District
Gert Sibande	<i>Amsterdam Clinic</i>	Rural
	<i>Ermelo Municipal Clinic</i>	Urban
	<i>Ermelo Hospital</i>	Provincial

Site descriptions

The four selected clinics provide primary health care and HIV/AIDS and TB-related treatment, care and support services, and medical male circumcisions. SRH care identified by field researchers includes outpatient maternal health and antenatal care, provision of contraception, and family planning information. The clinics also have community focused primary healthcare programmes that monitor the health and well-being of families in the surrounding areas. One of the clinics houses an NGO, Mother2Mothers, in a temporary structure. This NGO trains and employs HIV-positive mothers to work alongside doctors and nurses in understaffed health centres as members of the healthcare team. The

two selected hospitals—a district and provincial hospital—offer comprehensive health care services, including in-patient maternity care (antenatal, delivery and postpartum), HIV/AIDS and TB-related treatment, care and support services, and medical male circumcisions.

All of the clinics and hospitals are accredited antiretroviral treatment initiation and on-going treatment sites. There are also resident social workers across the six facilities, who assist patients in applying for social grants, identity documents and birth certificates. They also provide assessments and referrals for people with mental health concerns.

During fieldwork many of the challenges experienced by public healthcare facilities reported in existing literature were observed. For instance, it was noted that facilities were generally overcrowded, compromising confidentiality when consultations with health workers were overheard by others in the clinic. In some clinics dispensing of medication took place in queues or buildings based on the patient's diagnosis (e.g. HIV or TB), again compromising patient confidentiality. Hospitals were generally less crowded than clinics. Several facilities reported medication shortages, particularly of contraceptive injections at clinics. Most clinics also experienced staff shortages, affecting patient waiting periods. Patients frequently complained of hunger and fatigue while waiting. At rural facilities patient transport was noted as a challenge, with patients travelling long distances to reach the facilities.

Sampling

Sampling strategy

We used exit interview methodology to probe healthcare users' perceptions; this reduces limitations of survey research where poor recall affects the accuracy of responses. In order to improve validity by reducing bias, we planned to use simple random sampling, approaching every fifth person leaving the clinic to complete the survey. While we attempted to adhere to this principle it was not always possible for three main reasons: people refusing to participate, many people leaving at the same time, or people leaving while researchers were busy administering the survey. Nevertheless, field researchers attempted to ensure that they allowed for heterogeneity in terms of social characteristics of the sample as much as possible.

Sample size

The sample sizes were determined according to the size of each facility. For clinics, this was done using the reported number of people in its catchment area and a headcount of the patients visiting the facility (bearing in mind that these could be multiple visits). For hospitals, the out-patient headcount was used, including the number of visits to the hospital for both admissions and day patients. This was done in order to ensure that the intended sample size was reasonable *vis-à-vis* the size of the facility. The researchers then sampled 5% of the average number of monthly visits. This set us a target of 1,168 responses for the main study, which was exceeded. Approximate equal numbers were interviewed in the Gert Sibande district in Mpumalanga (48.2%) and OR Tambo in the Eastern Cape (51.6%). The target and actual sample sizes by facility are reported in the table below.

Table 5. Target sample size by facility

Facility	Catchment	Headcount (monthly)	Target Sample size	Actual sample size
Lusikisiki Village Clinic	25,293	4,917	246	245
Mthatha Gateway Clinic	35,782	3,857	193	197
Zithulele Hospital	--	3,203	160	245
Amsterdam Clinic	28,035	3,964	198	231
Ermelo Municipal Clinic	19,492	2,904	145	166
Ermelo Hospital	--	4,511	226	206
Total			1,168	1,290

Note that the 'other' category comprised 57 cases where field researchers did not enter the facility name; however, it is still possible to see that the targets were reached.

Data capturing and analysis

A Healthcare User questionnaire was designed based on similar instruments and adapted to the local context, specifically: the Comprehensive Sexual and Reproductive Health Survey for Adolescents (Centre for Disease Control); the Reproductive Health Baseline Survey (Pearson & Cockcroft, 1999); and the Access to Healthcare Questionnaire (Giachello et al., 2003). The domains included on the scale, with various response formats, are listed below. Some open-ended questions were included to allow for greater depth of information. The questionnaire was written in English. The field researchers who administered the questionnaire were all conversant in the local language and able to translate the survey questions into the vernacular if needed. The survey responses were captured using a mobile phone interface.

Domains in healthcare user questionnaire

The survey was designed to find out about both general services and SRHS. In addition to the domains listed below, demographic details were also captured (see APPENDIX I for a copy of the questionnaire).

Table 7. Survey domains

A. Access to general care	B. Knowledge, perceptions, and utilisation of SRHS
1. Main service required	1. Knowledge and awareness of availability of SRHS and types offered
2. Accessibility (Transport; Travel time; Challenges in receiving healthcare)	2. Use of SRHS
3. Waiting time	3. Experiences of SRHS and care
4. Experience at facility	4. Accessibility
5. Level of satisfaction with care	5. Satisfaction with services
6. Reasons if care not received	6. Awareness of discrimination on basis of identity markers

The data were analysed using scientific software (*IBM SPSS Statistics 24*). The analysis comprises primarily descriptive statistics, with some inferential and multivariate analyses. Tables and charts drawn from the data analysis are presented in the following section. Where possible, data were disaggregated by the following variables: (1) gender, (2) age, (3) research site, (4) geographical location, (5) urban/rural location, and (6) sexual 'orientation' (if possible). After presenting the main findings the discussion that follows synthesises the results, with literature and theoretical perspectives.

Strengths and limitations

“A benefit of a patient perception study is that it is simple to perform and easily reproducible” (Mahomed, Wallis, & Motara, 2008, p. 429). Such studies can therefore be used to track progress and to continually ensure that the system remains responsive to its users. A potential weakness of this kind of research design, however, is that by necessity it relies on people’s subjective reports. While this is not a problem in and of itself as the use of self-report data allows respondents to describe their own experiences, such data are sometimes limited by participants’ ability to recall their experiences. As mentioned, we attempted to mitigate this by conducting an exit interview at the facility so that participants’ experiences would be fresh in their minds. When asking about SRHS at other facilities we asked participants to refer to their most recent visit, and also to say when this was in order for us to contextualise their responses. As noted in the findings, the majority of people who responded to questions about SRHS had used these services in the last three month, thus ensuring better recall.

Other factors to consider when conducting research on sensitive topics such as SRH are embarrassment or social desirability bias, which might mean that participants decline from answering or are vague in their responses, as noted in the analysis. We attempted to control for this by emphasising confidentiality and anonymity, and providing reminders of this during the survey, as well as ensuring that field researchers interviewed participants away from other people to allow them to answer more freely. Using local field researchers, particularly in smaller communities meant that on the one hand respondents might feel more comfortable and be willing to participate, while on the other they might be less inclined to reveal certain details if the person was known to them. This is taken into account when analysing the findings.

ETHICS

The study adhered to the ethical standards set out by the Research Ethics Committee of the HSRC, including informed consent and confidentiality, which comprised part of the formal procedure in the form of a verbal briefing, information, and consent forms. To this end, fieldworkers were trained to explain the purpose of the study to potential respondents, obtain informed consent, and inform respondents about their rights and benefits in a factual and neutral way without coercing people to participate. Respondents were given a gift voucher after the administration of the survey as a token of appreciation for their time. Those who participated did so freely, were fully informed of potential risks and rewards of participation, any limits to confidentiality, and how the information they provided would be used. No minors were allowed to participate in the study.

RESULTS

Demographic characteristics of healthcare users

Most of the users of the public facilities identified themselves as Black African (98.7%), which is in line with existing public health research. An exceedingly small number of other racial categorisations were represented, including Coloured (0.4%); White (0.6%); and Indian (0.1%). (Only 0.2% of respondents declined to answer this question and the same proportion identified as ‘other’.) These proportions are clearly not representative of the general population. More than three quarters of the sample consisted of women (77%) and less than a quarter were men (22.4%). This suggests that most clinic users are

women. This is also noted in other studies (e.g. Nunu, 2015). In terms of age, participants ranged from 18 to 90 years with a mean age of 36.3 years. As the table below indicates, the majority of the participants were young adults. Almost two thirds (62.59%) of respondents were aged between 20 and 40 years.

Table 8. Age groups across sample

Age group	Percent
>20	3.94
20 - 30	35.28
30 - 40	27.31
40 - 50	15
50 - 60	9.39
60 - 70	6.08
70 - 80	2.13
80 - 90	0.87
Total	100

Respondents were also asked how they identified in terms of their sexuality. In order to avoid imposing identity categories that were not locally relevant, we asked people to describe their sexuality in terms of who they were attracted to romantically or sexually. Most of the responses to this question can be interpreted as implying heterosexuality (91.8%), that is, women reported being attracted to men and vice versa. Less than a tenth of the responses (8.2%) were of a non-normative sexual/romantic attraction. This included being attracted to persons in the same gender category (i.e., lesbian or gay) or to persons of the same gender as well other genders (i.e., bisexual).

The relationship status of the respondents mirrors that of the general population of South Africa, which is characterised by a low formal marriage rates. Less than a third (28.3%) of people reported being married (through conventional or customary marriage, or civil partnership). In contrast, a third (33.7%) reported being single. Those who reported being in non-marital relationships comprised just over a third of respondents (37.2%); this group included those who reported that they were ‘dating’ (32.2%) and either in a domestic (1.2%) or cohabiting (3.8) partnership.

Table 9: Relationship status of participants

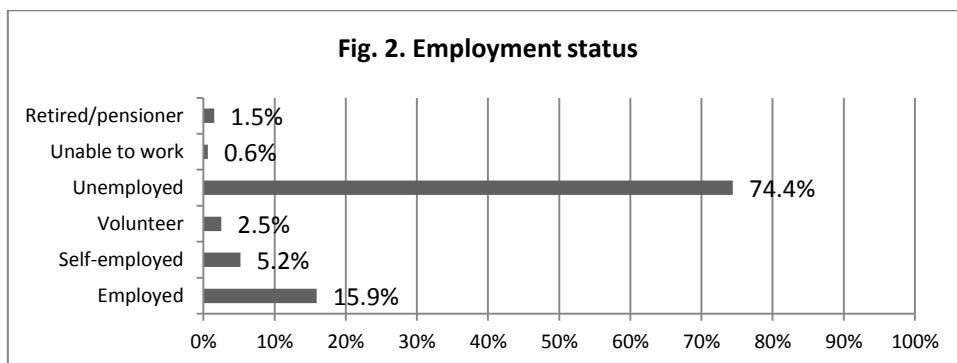
Relationship type	Count	%*
Single/No relationship	424	33.7
Dating	411	32.6
Married	362	28.7
Domestic partners	15	1.2
Co-habiting partners	48	3.8
Total	1260	100.0

*Responses as percentage of total

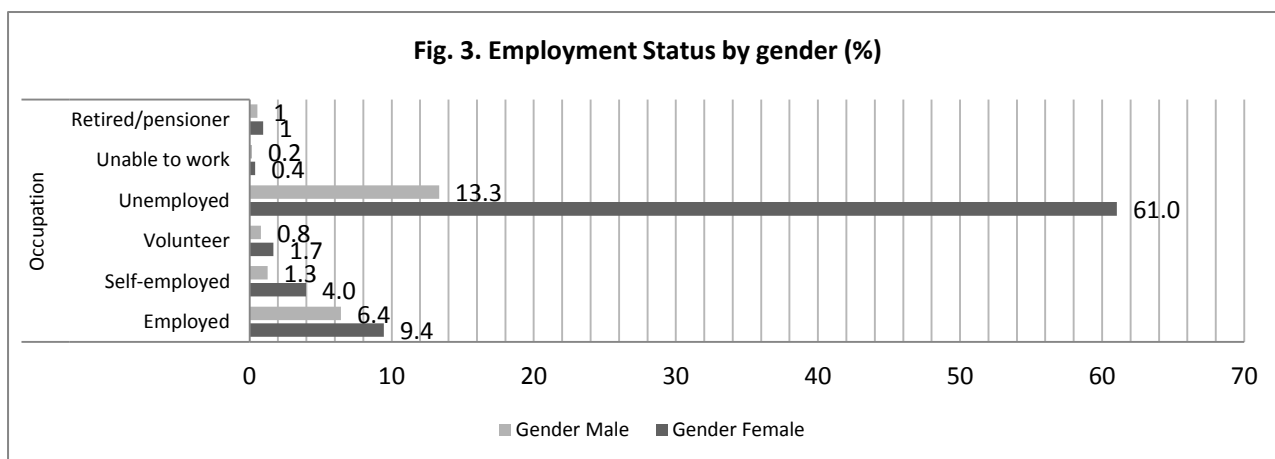
Socio-economic characteristics

The data suggest that the majority of people who attend the public health facilities studied are from a relatively low socio-economic stratum. As Figure 2 below shows, almost three quarters of the sample was unemployed and only around a fifth was employed, either working for someone (15.9%) or for themselves (5.2%). Most participants reported only one source of income, with almost half indicating that their source of income was social grants. This is not surprising given that the majority of the

sample were women, the major recipients of grants in the country [see Lund (2006) on gender and social security in South Africa]. In addition, less than a tenth of the sample (7.4%) reported that they had medical aid. This is about half of the national average.



When disaggregating the sample by gender it is possible to observe that while women and men fared more or less comparably in other categories, far more women were unemployed than men (61% versus 13.3% respectively), with a 47.7 percentage point difference. This is illustrated in the figure below. This pattern is in line with national employment rates by gender.



In addition to being more likely to report receiving a grant as a means of economic support, a greater proportion of women than men also reported being supported by a partner. A larger proportion of women (70%) than men (30%) said that they had access to medical aid. A cross-tabulation of access to medical aid and partner as a source of support suggests that the medical aid was their own and not their partner's.

Domain A: Access to general care

1. Main service required

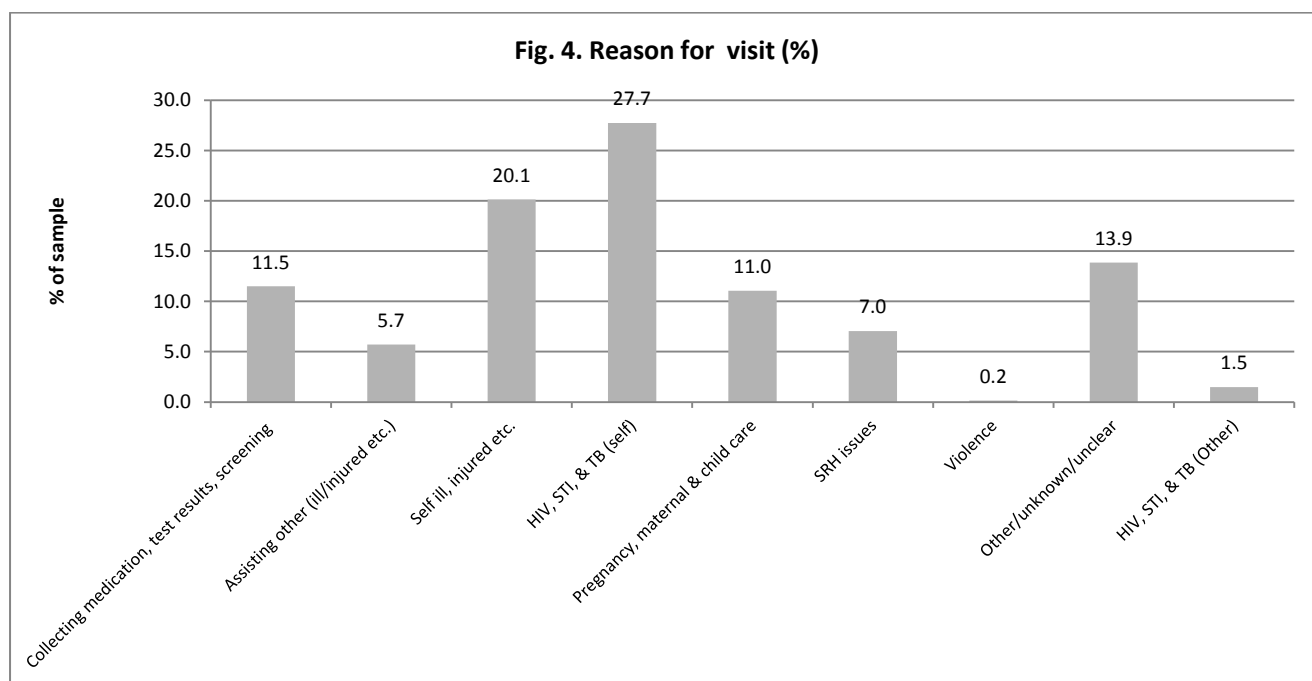
There were 1,177 open-ended responses to the question 'what was the main service that you came for today?' These were subsequently coded according to common responses, producing the following nine common reasons for attending health facilities:

- (ii) Collecting medication, test results, screening
- (iii) Self ill, injured etc.
- (iv) Assisting other (ill/injured etc.)

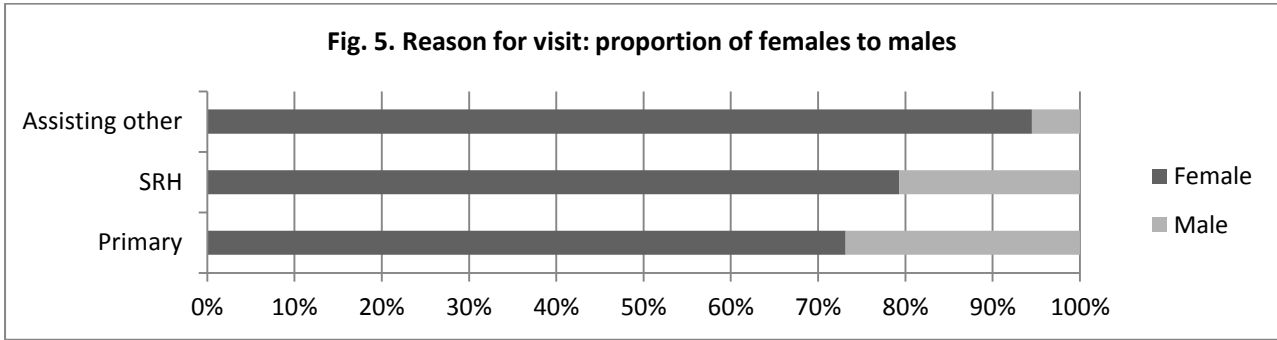
- (v) Violence
- (vi) HIV, STI, & TB (Self)
- (vii) HIV, STI, & TB (Other)
- (viii) Pregnancy, maternal & child care
- (ix) SRH issues
- (x) Other/unknown/unclear

The responses to these are provided in the figure below. It is possible to see that a small share of respondents (13.9%) either declined to say why they were attending the facility or gave an unclear answer. These were captured accordingly. In addition, in line with the exit interview method utilised, questionnaires at hospitals were administered at the dispensaries; thus quite a number of respondents reported that the reason for their visit was 'to collect medication'. It is unclear whether they had received treatment prior to this or what the treatment was for.

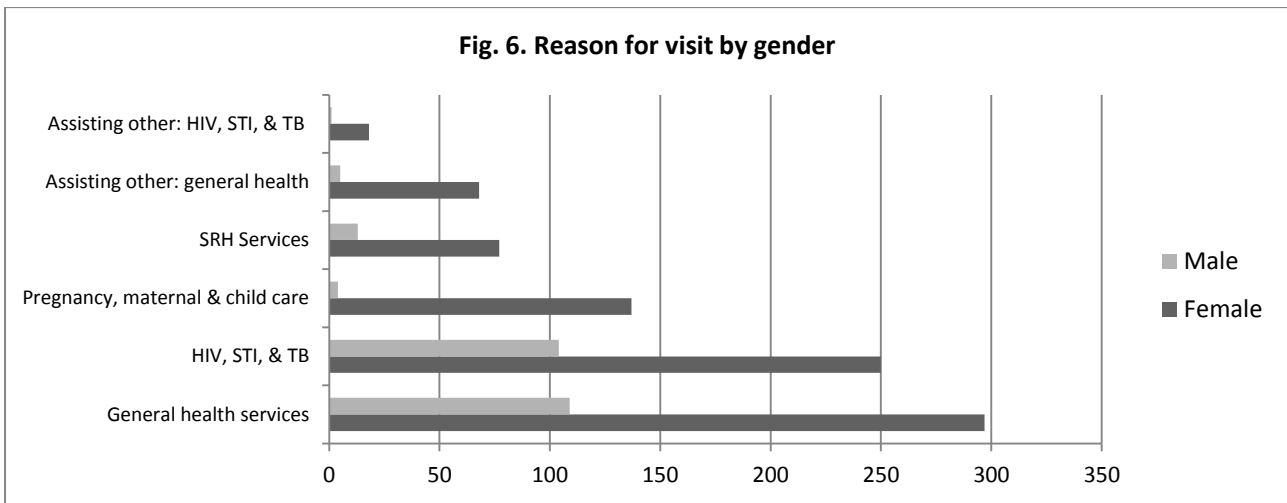
Other than general health issues, about half (~48%) of those who disclosed the reason for their visit were seeking care related to SRH. The majority of respondents (27%) reported that the main service they were seeking was in relation to HIV/AIDS, sexually transmitted infections, and Tuberculosis (TB). They reported that they were coming for voluntary counselling and testing, psychosocial support, to collect anti-retroviral (ARV) treatments, for check-ups and monitoring. This proportion can be combined with those persons (1.5%) who were there assisting other persons (usually children or family members) to obtain these services. A smaller proportion was visiting due to pregnancy or maternal and child care (11%) (e.g., antenatal care, immunisation, delivery etc.), or general SRH issues (7%) (e.g., to collect contraception, or to receive family planning advice).



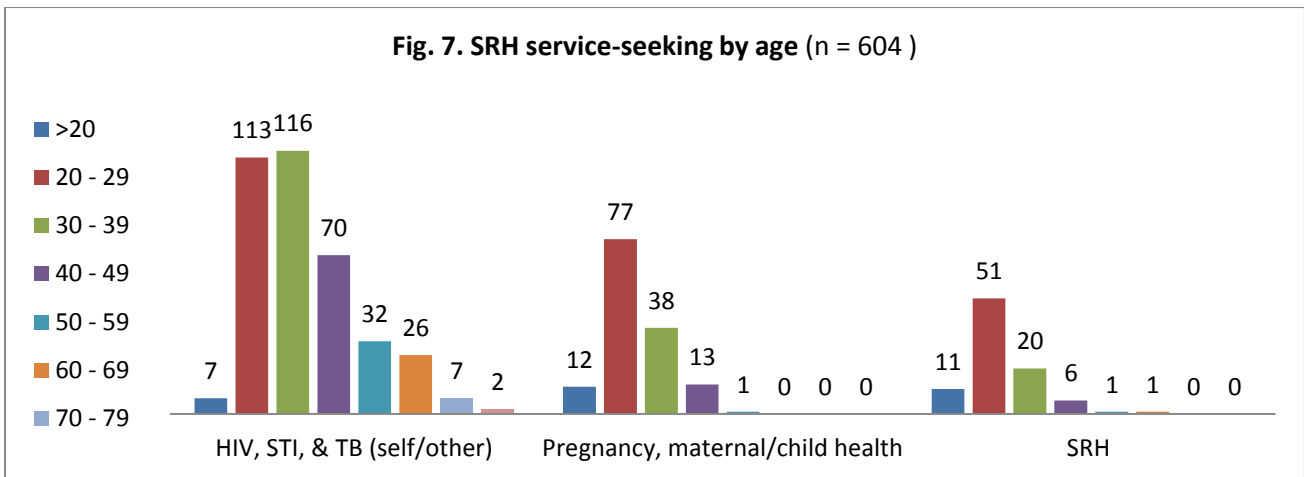
When further disaggregating the data to ascertain which people were seeking which services, we noted that, in general, more women were seeking SRH related services than men. The figure below illustrates this well. It shows the proportion of women versus men who reported that they were seeking SRH-related services; primary health services; or assisting another.



Women more often than men reported that they were assisting another person or bringing an infant or child for care. This gendered utilisation pattern of SRHS has also been reported by other researchers, who note that SRHS tend to have a woman-focus (Rottach, Schuler, & Hardee, 2009) and that rates of male partner attendance for services such as antenatal care or couples HIV testing remain low (Kunene, Beksinska, Zondi, Mthembu, & Mullick, 2004; Mullick, Kunene, & Wanjiru, 2005; van den Berg, et al., 2015). Indeed, only four men reported accessing maternal and child services in this study. Men have also been found to be less likely than women to use voluntary testing and counselling services for HIV (Snow, Madalane, & Poulsen, 2010), which findings of this study support. The figure below shows a more detailed breakdown of the types of services by gender that respondents reported seeking.



Not surprisingly, most people seeking services related to pregnancy or maternal and child health were in their reproductive years, as the figure below illustrates. This also tended to be true of those seeking general services, where the 20 to 29 age group comprised the highest number of responses. HIV, STIs, and TB services were also generally sought by those of reproductive age, but a number of users from other age groups also sought out these services. Nevertheless, the highest number of people seeking HIV, STI and TB services were under 30 years old.



It is possible to see from the figure above that the proportion of people under 20 years old who reported seeking SRH services was low. People from this age group amounted to only 30 users in total, which is less than 1% of those who reported seeking SRH services. This under-representation could be related to stigma associated with sexual activity and pregnancy at a younger age. This is supported by the open-ended responses provided as well as existing qualitative research (Amnesty International, 2014).

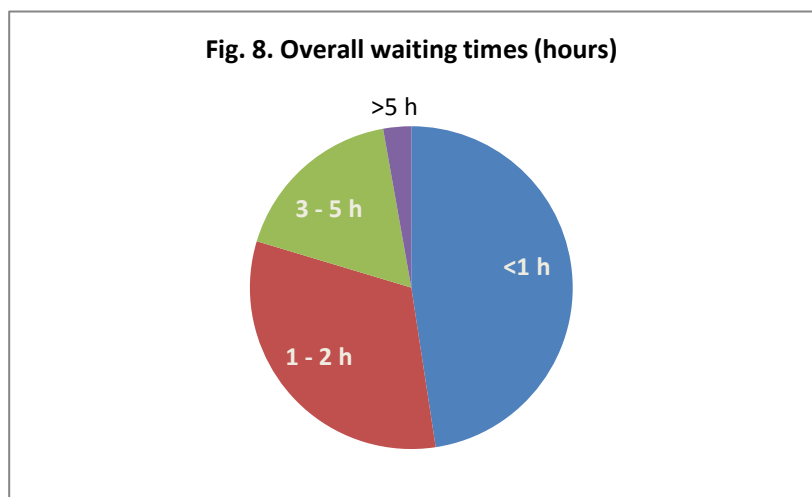
2. Accessibility

Almost two thirds (62.4%) of people reported that they had used public transport to get to the facility, while just over a quarter (26.7%) had walked there. A large proportion said that it had either taken them under an hour to make the trip (71%) or under 2 hours (24.8%), hence the majority of people (95.8%) attend the facility closest to where they live. Most people (93.6%) also reported having received the care they needed at that facility.

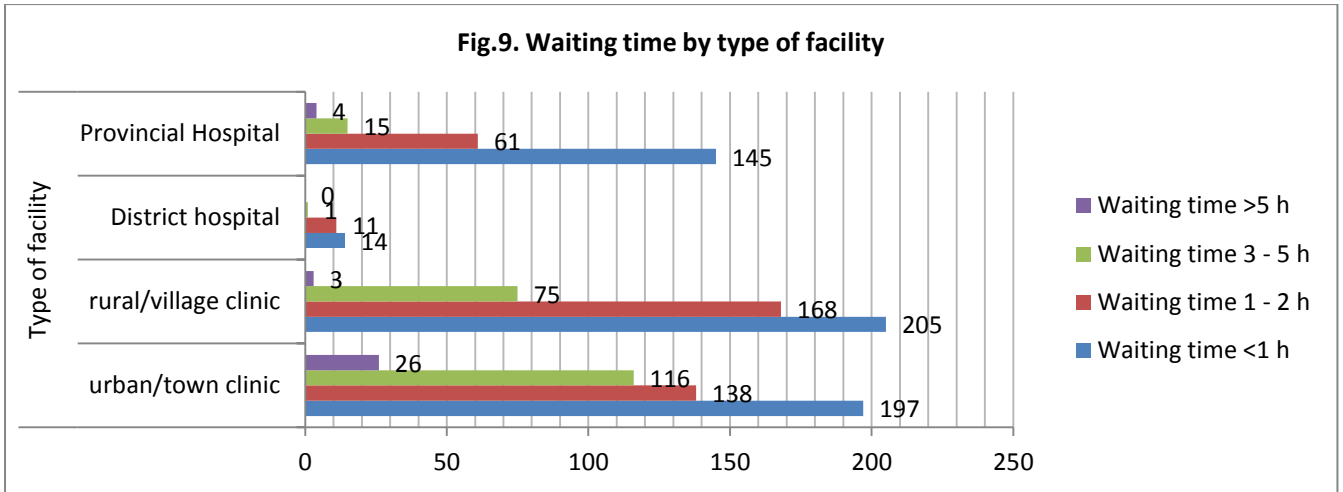
3. Waiting time

People generally reported reasonable waiting times, with the majority served in one to two hours. Most people were assisted within an hour (47.6%), with just less than a third (32.1%) helped within two hours. A relatively small share (17.6%) waited between three to five hours and a fraction (2.8) waiting longer than that.

These times did not appear to be related to the type of service sought,



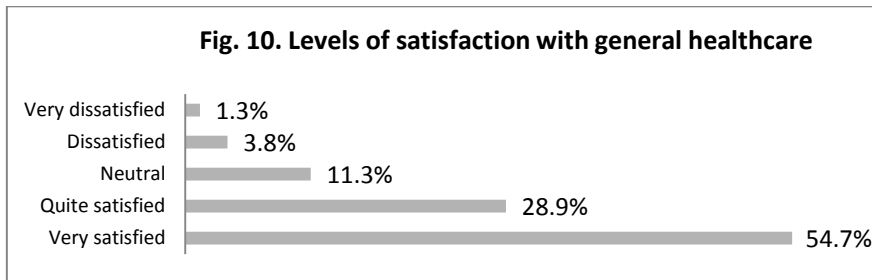
but rather to the type of facility. As the figure below shows, urban and then rural clinics had longer waiting times. This is likely because such facilities provide primary health care, while hospitals, where waiting times are shorter, provide predominantly specialised and in-patient care and/or refer patients to clinics.



4. Experience at facility and satisfaction with care

The standard of care received appears to be more or less consistent, with most people who had attended the facility before reporting that the care they had received was similar to previous experiences. A small proportion said that the care had deteriorated and even fewer said that it had improved. Most people said that they had always been able to obtain the medical care (88%) or medication (89.6%) that they had sought. Most people (87.2%) reported that there were no communication problems with staff.

In line with other studies (Nunu, 2015; Shisana et al., 2013; Wouters et al., 2008), the levels of overall satisfaction were high. Most people reported that they were very satisfied (54.7%) or quite satisfied (28.9%) with general healthcare (28.9%) that they received. Only slightly more than five percent reported being dissatisfied.



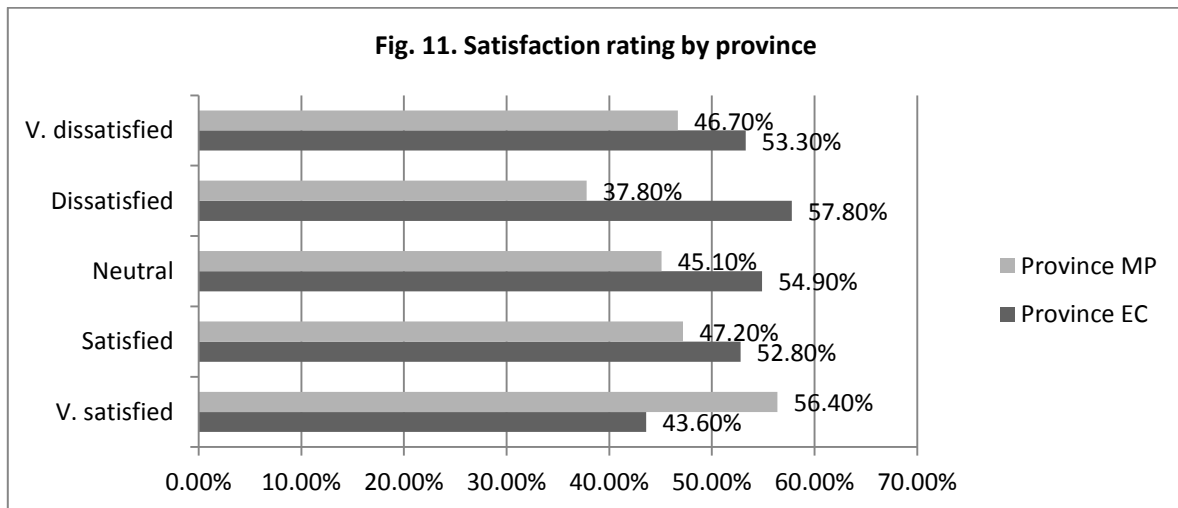
Respondents were asked to rank the level of care received (1 = very satisfied to 5 = very dissatisfied). The mean score attained was 1.68, showing that overall attendees are satisfied with the general services rendered in these facilities. Nevertheless, it was observed that the level of satisfaction differs according to certain sub-groups. A regression analysis was used to assess the relationship between selected variables (viz., type of facility, gender, sexuality, age and province) with the level of satisfaction with the level of care. The results are presented below.

Table 8. Factors influencing satisfaction level

	Standardised Coefficient
Type of facility	-0.41
Gender	0.014
Sexuality	0.042
Age	-0.075*
Province	-0.122*

*Significant at 95% confidence index

Two factors that were found to be significantly related to the level of satisfaction with the care received: (1) the age of respondent and (2) the province where the health facility is situated, with the latter showing a stronger relationship. The older generation was more dissatisfied with the level of care received^{iv} and being in the Eastern Cape compared to being in Mpumalanga was associated with higher levels of dissatisfaction with care. As suggested, being in the Eastern Cape has a greater influence on satisfaction than being old. It was possible to see a pattern in terms of satisfaction with services and location. As the figure below illustrates, people from the Eastern Cape were more likely to feel very dissatisfied or dissatisfied than those in Mpumalanga. They were also less likely to say that they are very satisfied with care received.



The difference in satisfaction in the different regions is clearly reflected in the satisfaction levels according to the facility, as shown below. The figure illustrates the level of satisfaction as expressed by people who attended each of the six health centres surveyed.



The three centres where interviewees expressed greater dissatisfaction with the level of care were in the Eastern Cape, namely Mthatha Gateway Clinic, Lusikisiki Village Clinic and Zithulele Hospital. On the other hand, attendees of the three centres in Mpumalanga showed a lower level of dissatisfaction with the level of care.

5. Reasons for negative responses (open-ended responses)

People were asked to explain why they gave negative responses to particular questions. When asked the reasons that they had not received care (8.6% of the sample), people commonly said that they were not able to obtain the treatment they needed or they were turned away. The following common reasons were provided: (a) Staff shortages and/or overcrowded facilities ('long queue'); (b) 'Slow' or inattentive staff; (c) Equipment or medications unavailable ('no stock'); (d) Asked to come back (because presented on 'wrong' day, failed to make an appointment, day's 'quota' reached); (d) Refused help or turned away. In cases where people said they had been turned away (a very small number), the reasons were not always clear. For example, one person stated 'they won't help me'. There are some suggestions that withholding help may have a moral dimension. For instance one respondent mentioned 'sexual orientation' as the reason for not being helped. This is likely when read in relation to the question regarding the role that social identity plays in SHR service delivery (see section 4). This should be further investigated using qualitative methods which are argued to be best suited to pick up on these kinds of negative experiences (Williams et al., 1998).

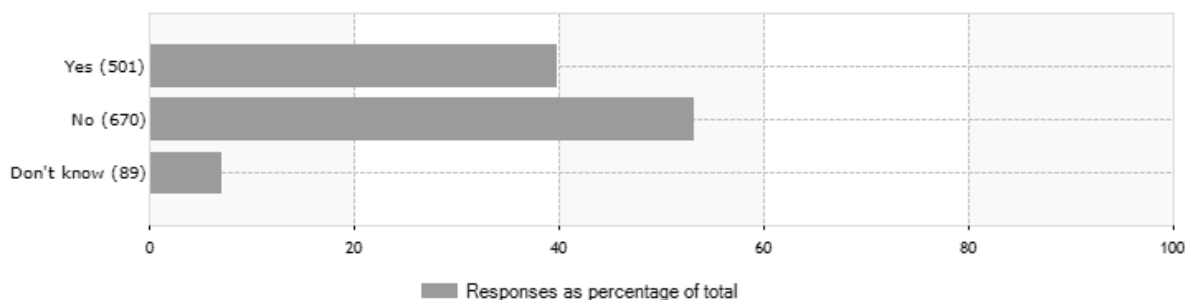
When asked about why they said they had communication problems with staff (12% of the sample), people reported problems with understanding, either due to language barriers or because staff were not listening to them properly. They said that they felt that nurses and doctors did not have time to listen properly and/or ensure they understood. Several reported problems with interpersonal skills, such as rudeness, a 'bad attitude', or being 'shouted at'. Many patients also cited a lack of care, respect, or privacy as communication barriers (e.g. "Nurses don't care about a person, they embarrass you"; "The nurses are rude they don't have humanity"; "There is no privacy because of the facilities, so you have to talk in front of people [about] private things.").

Domain B: Knowledge, perceptions, and utilisation of SRHS

1. Knowledge and awareness of availability of SRHS and types of services

When asking about local facilities offering SRHS, the researchers attempted to make clear what services might entail, asking: "Is there a place in your community where people can go for help or information about sexual and reproductive health, that is, relationships, sex, contraception, sexually transmitted infections, HIV/AIDS and so forth?" Surprisingly, over half (53.2%) of the people answered that there was not, a small percentage (7.1%) said that they did not know, and just under two fifths (39.8%) answered 'yes'.

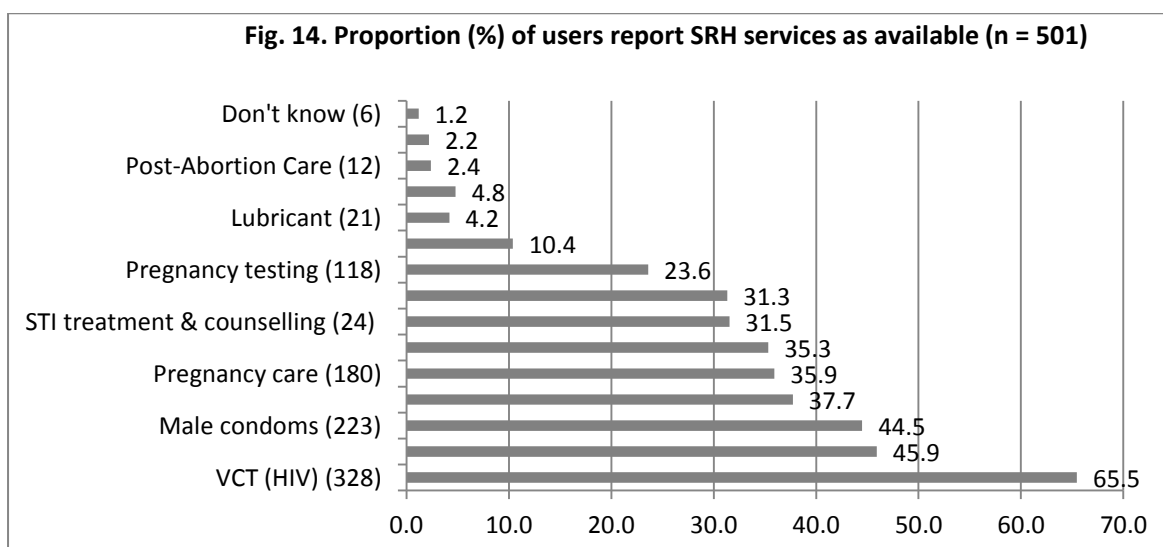
Fig. 13. Knowledge of SRHS in the area



Given that most of the patients attending the facilities where the services were administered had sought HIV-related care, it is strange that so many would have said no. It is possible that many respondents interpreted the question as asking whether there was a special facility for this that is separate to public clinics and hospitals. It is also likely that, in addition to misunderstanding the question, that some did not know what SRH services are offered at public health facilities and answered 'no' rather than saying that they did not know.

Those who responded that there was a local place offering SHRS were then asked about the services offered there. Field researchers were instructed to allow participants to spontaneously mention those that they knew of and then to probe further by reading from the following list: (1) VCT for HIV; (2) Family planning information/assistance; (3) Pregnancy care / delivery; (4) Contraception (the pill, the injection etc.); (5) Male condoms; (6) Female condoms; (7) Dental dams; (8) Lubricant (lube); (9) Termination of Pregnancy (abortion); (10) Information & counselling regarding SRH; (11) Miscarriage/Post-Abortion Care; (12) STI treatment & counselling; (13) Mental health and Psychosocial support; (14) Pregnancy testing; and (15) Other.

As the figure below shows, only a fraction of this sub-group said that they did not know what services were available (1.2%). Most people named familiar or common services such as voluntary counselling and testing (VCT) for HIV (65.5%); family planning services (45.9%); and provision of male condoms (44.5%). A much smaller number listed abortion-related services (4.6%); psychosocial services (4.8%); or less common contraceptive measures like dental dams (10.4%) and lubricant (4.2%). Again, this could imply that users are unaware of these services, and this should be followed up by those working on SRH in these areas. However, it is also quite likely that these services really are not available. Indeed, research suggests that many designated Termination of Pregnancy facilities are non-operational, do not inform patients of the services, or refer them elsewhere (Harries, Orner, Gabriel, & Mitchell, 2007; Harries, Stinson, & Orner, 2009; Harries, 2010; Stevens, 2012). In addition, while male condoms are generally freely available, other barrier methods are less sought after and less commonly available. Given the difficulty in increasing uptake of female condoms (Arogundade, 2014; Guerra & Simbayi, 2013), it is interesting to note that over a third of people mentioned these as being available at clinics. Furthermore, when considering the actual services, people said that they had used these less-cited services, suggesting that they are indeed available, but perhaps less known of and/or sought after. As we show later (see fig. 14) the response patterns related to knowledge of services mirrors those related to reported utilisation patterns, implying a lack of awareness of these services.



2. Use of SRHS

In addition to their knowledge about SRHS, respondents were also asked about their utilisation of these services. Just over two fifths (44%) said that they had used SRHS. More than half of the respondents (54%) said that they had never visited a public health facility to access SRH services, with a small proportion (5%) saying that they had wanted to but that services were unavailable. The remainder (2%) said that they had not needed/desired SRH services, or declined to answer.

Almost half of the women (47%) said they had used SRHS, compared to just over two thirds (35%) of men. Around half of each of the various age groups said they had used SRHS. Those who said that they had used SRHS were asked when their last visit had been and the reason of the visit. Almost three quarters (70.4%) had used SRH services within the past 3 months (fig. 17). This suggests that their experiences of these services would be quite fresh and thus improve recall. The remaining responses are summarised in the figure below.

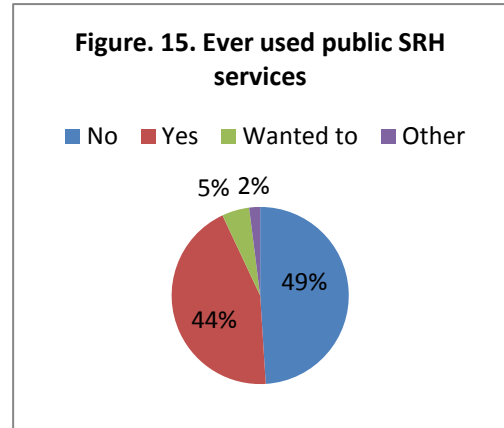
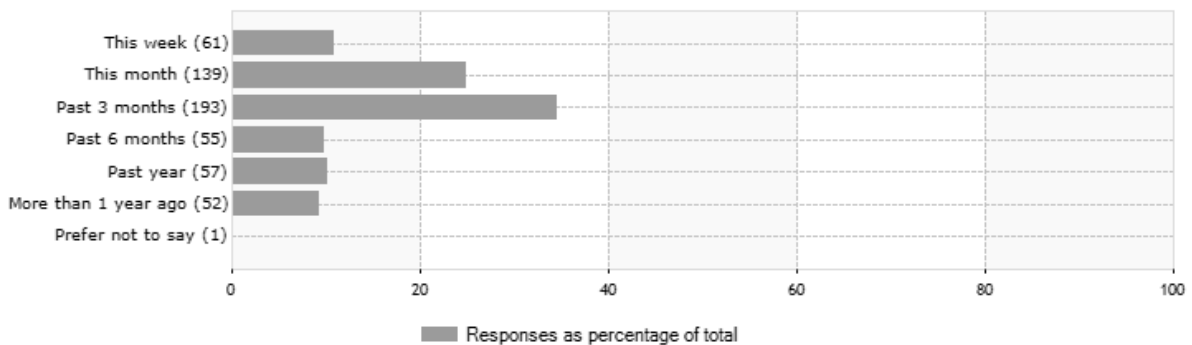
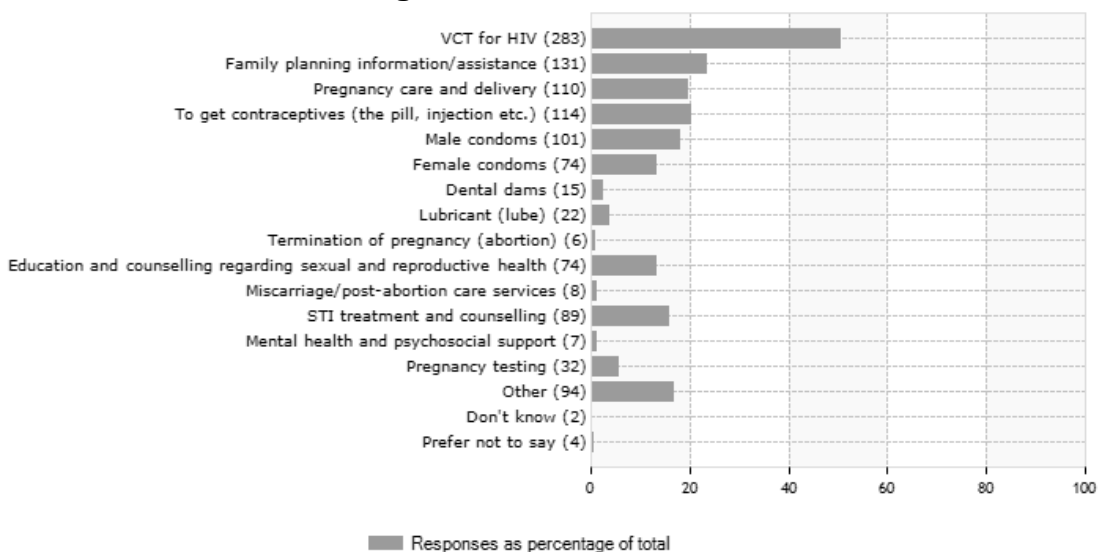


Fig. 16. Timing of last visit

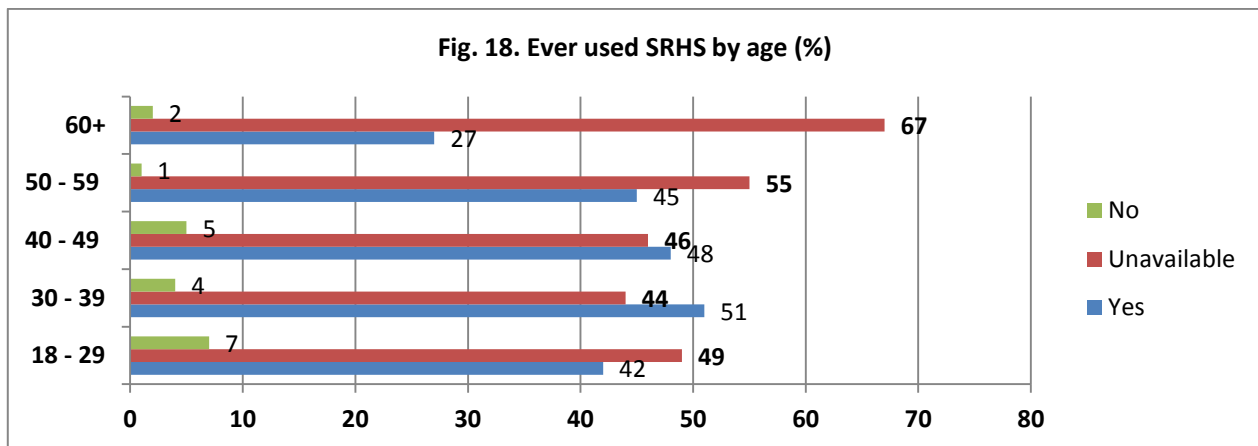


In terms of reasons their last visit, as discussed earlier the response pattern to this question mirrors those related to respondents' knowledge of services discussed above, suggesting a lack of knowledge about these services.

Fig. 17. Reason for last visit



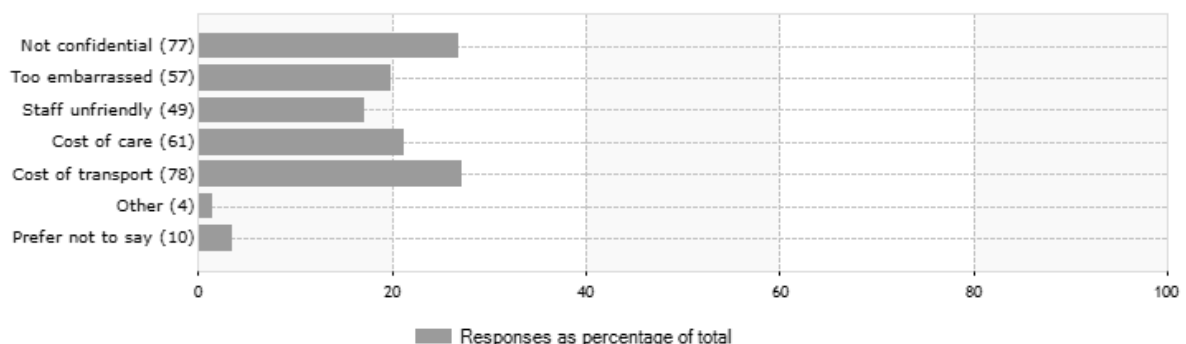
Interestingly, a large proportion answered that they had wanted to utilise SRHS, but that these were not available to them. Two-thirds (67%) of respondents older than 60 years of age gave this as their answer.



Those who said they had not used SRHS were asked follow up questions to determine if they would seek treatment if needed and possible reasons for not seeking SRH care. When asked “Would you feel comfortable going to a health facility found in your area for sexual and reproductive health services?”, more than three quarters (77.2%) said that they would, while less than a fifth (16.3%) said they would not; and the remaining share (6.5%) said that ‘it depends’.

In order to ascertain possible reasons for discomfort with SRHS, and reluctance to use services, we provided a number of reasons that have been cited in other studies (Klugman et al., 2011; Stevens, 2008) for participants to select. These included: (1) confidentiality; (2) embarrassment; (3) staff unfriendliness; (4) cost of care; and (5) transport costs. We also allowed participants to provide further reasons or to opt out of answering if they wished. As the figure below shows, the main deterrents were cost of transport and concerns regarding confidentiality; followed by cost of care; and feelings of embarrassment.

Fig. 19. Reason for not seeking SRHS



3. Experiences of SRHS and care

In addition to utilisation rates, we were also interested in how respondents had experienced SRHS. They were asked about their encounter with the specific healthcare worker who had attended them at their last visit and more broadly about their experience of the staff and facility at their last visit. Finally,

they were also asked about the likelihood of returning to that facility. The results of each of these sets of questions are reported in this section.

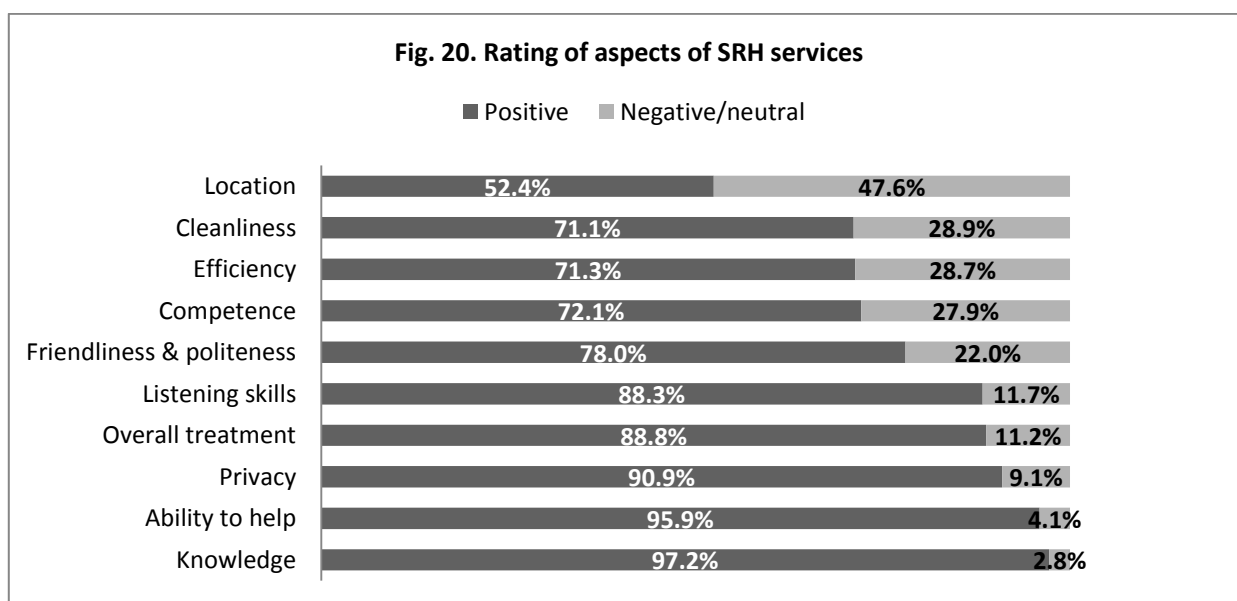
3.1 Perceptions of healthcare worker who attended them

For those who had sought SRH care, unsurprisingly, most respondents had been attended by a nurse (69.4%) and then either by a doctor (15.1%) or peer educator/counsellor (14.3%). Respondents were asked to describe their experience of the health professional who attended them by selecting a range of professional and interpersonal skills. Most people selected the descriptors 'knowledgeable and well-qualified', 'friendly and polite', and 'good communicator'. The descriptors chosen the least were 'patient', 'honest and direct' and 'concerned about your privacy'. The results for this question are summarised in the figure below.

When investigating what variables influenced these responses, gender, age, and sexuality were found to play a significant role. Gender had an influence on the rating of whether the service provider was a good listener or not. Women were more likely than men to perceive the healthcare worker as a good listener, but were less likely than men to see her/him as able to help. The age of respondents was found to have a significant relationship with the perceptions of knowledge and qualification, with older persons less likely to see the caregiver who had attended them this way. Older persons were also less likely to perceive the health worker as a good communicator, good listener, or able to help them.

3.2. Experience of the staff and facility providing SRHS at their last visit

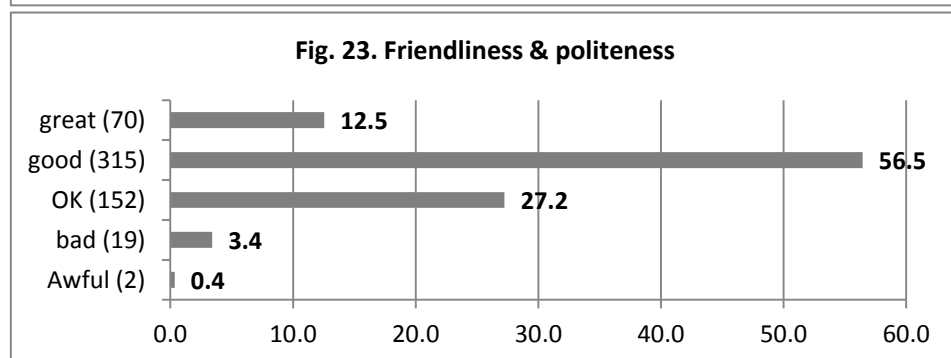
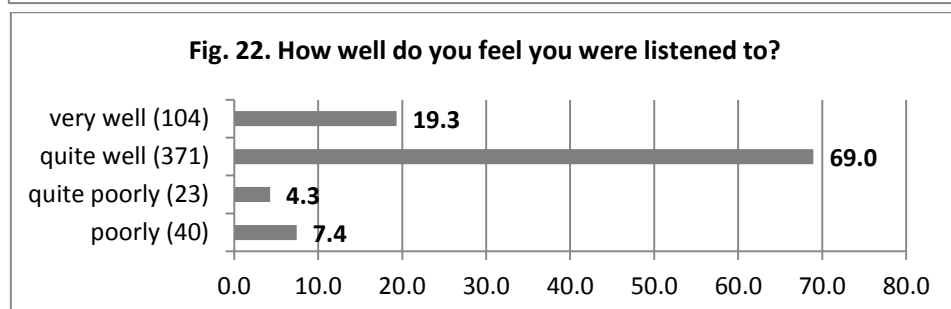
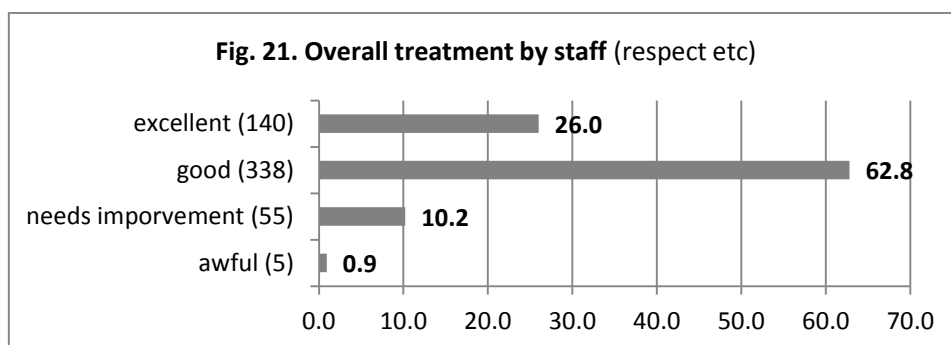
Respondents were asked to rate (a) the interpersonal skills of the staff; (b) their perception of the staff's knowledge and ability; and (c) various physical aspects of the facility. Overall, most respondents gave a positive assessment of these aspects captured on a four or five point scale. This pattern is illustrated in the figure below in which ratings are grouped into positive responses and negative or neutral responses. Grouping the latter category together might somewhat alter the pattern, but nevertheless, it still appears that the overall tendency was for positive scores.



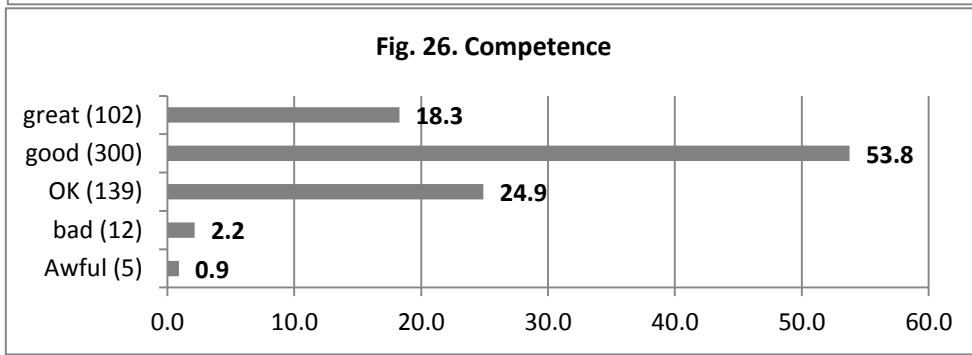
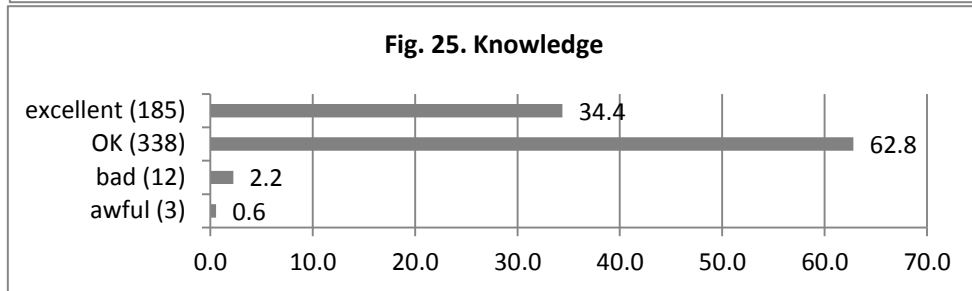
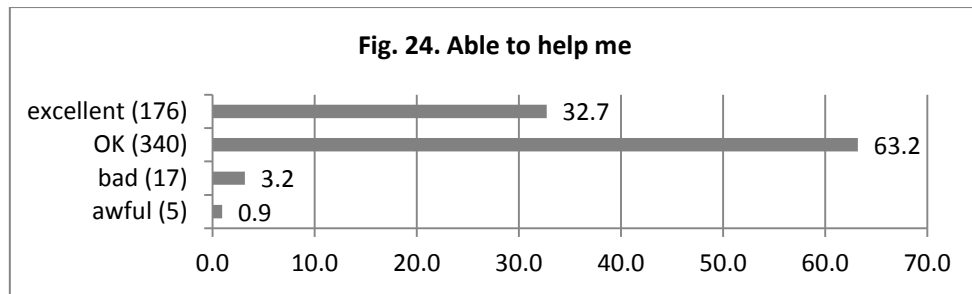
Despite the overall positive ratings, as with other surveys on patient experiences of public health services (e.g., Chimbindi et al., 2014; Peltzer & Phaswana-Mafuya, 2012; Shisana et al., 2013; Wouters,

Heunis, van Rensburg, & Meulemans, 2008), of those who responded affirmatively, more people gave a moderately positive response (e.g. 'quite well' or 'good') than an extremely positive (e.g. 'very well' or 'excellent') ones. Across the board, more women gave extremely negative responses (e.g., 'awful') than men. Each set of ratings are discussed below.

(a) *Interpersonal skills:* Firstly, in terms of perceptions of the staff's interpersonal skills, the clear majority (88.8%) rated their overall treatment positively. A very small share rated this aspect of service as 'awful' or 'needs improvement', with a similar percentage of women (10.1%) and men (12.6%) expressing these views. Only women rated services as 'awful', but this comprised a tiny proportion (1.1%). Again, most respondents (88.3%) rated listening skills favourably, with slightly fewer (78%) saying that they found the staff to be friendly and polite. On average, most people did not choose the most positive rating for this aspect of service, particularly for those under 50 years old. These results are represented in the figures below.

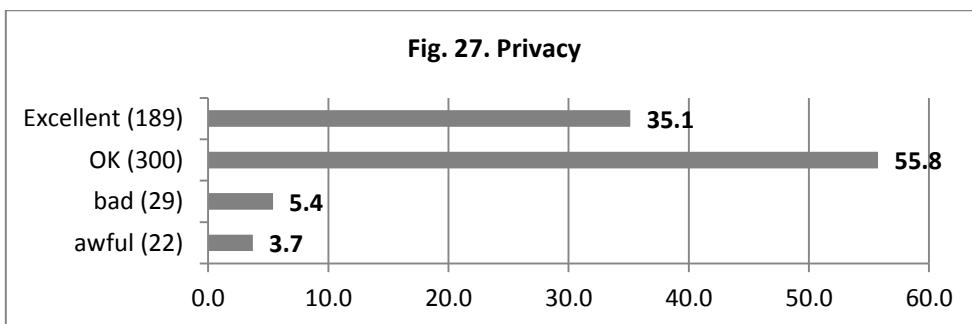


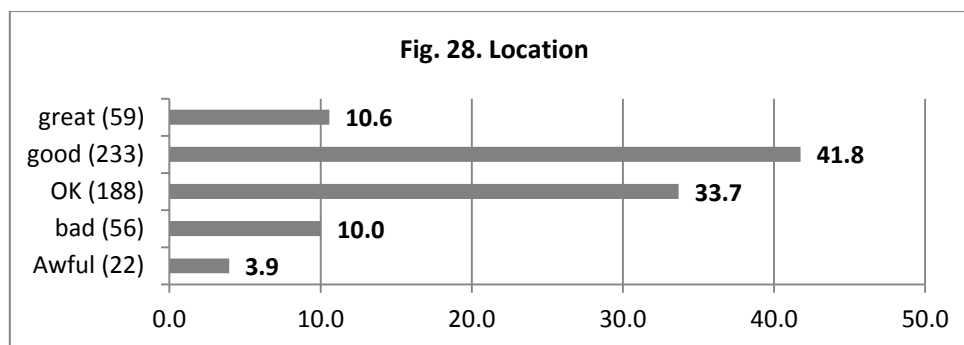
(b) *Knowledge and ability:* Perceptions of staff's knowledge and ability generally showed more extremely positive responses ('excellent') than in the previous set of variables. Almost all the respondents felt that the staff was able to help them with the problem that they were presenting with (95.9%) or perceived the staff as knowledgeable (97.2%). In contrast, a lesser proportion experienced the staff as competent, but this was still a fairly high proportion at just less than three quarters (72.1%).



(c) *Physical aspects of facility*: Finally, in terms of their perceptions of physical aspects of the facility, again, the majority held positive views. Interestingly the most people rated privacy positively (90.9%), with almost two-thirds (35.1%) rating this aspect as excellent. More women (46) than men (3) rated privacy poorly. Further to this, younger people (aged under 39 years) gave more negative responses or moderately good ratings ('OK').

Similar proportions held positive views of the cleanliness (71.3%) and efficiency (71.1%) of the facilities, with slightly more giving higher extremely positive assessments of cleanliness (17.7%) than efficiency (13.8%). In keeping with the other findings in this report around the importance of facilities proximity to service users, only around half (52.4%) perceived location positively, with a third (33.7%) rating this as just 'OK' and just over a tenth (13.9%) rating this aspect as 'bad'.





When asked if they would return to the facility, the majority (88.4%) said that they would. One of their main reasons was that they were happy with the care that they had received, even though they recognised problems like understaffing. The other main reason was the nearness of the facility. This was either expressed in conjunction with satisfaction or as having no choice. The small minority who said that they would not (8.6%) or were unsure (4.3%) cited transport costs and time to get there as their main reasons for their response. These responses indicate the importance of proximity of services for patients. This is important to consider given that only around half (52.4%) of the patients positively rated the location of the facility they attended.

4. Awareness of discrimination on basis of social characteristics

In order to explore perceptions and experiences of discrimination at facilities on the basis of social characteristics, respondents were asked “In general, do you think that your experiences of the sexual and reproductive health care services have been/would be affected by who you are (i.e. your gender, sexuality, age etc.)?” A large percentage of respondents indicated ‘yes’ to this question.

A little more than half (53.2%) of responses to this question were ‘no’. This suggests that about half of respondents do not believe that they face discrimination at public health facilities, with only a small percentage (7.1%) indicating uncertainty.

A relatively large percentage of respondents, just shy of two-fifths (39.8%) - indicated ‘yes’ to this question, and an open-ended question was used to probe around the reasons for this answer. Some respondents mentioned sexuality as a factor, for example:

‘I am a lesbian so [they] programme us full of information.’
 ‘I’m a bisexual in the closet.’
 ‘People will know their sexual orientation.’

Community politics was also cited as a reason for perceived discrimination. (‘Depends on which is on duty’; ‘it’s that you don’t get help when you need it and it depends on your popularity in the community’). However, most people who gave explanations cited ‘gender and age’ as factors that affect the way that people are treated at SRHS. Mostly this seemed to concern youth and/or young women (e.g., ‘sometimes nurses don’t talk to you with the best tone because of your age especially towards young people’; ‘at my age [18] they are unkind if you come for SRH services’; ‘because of my age [23] they treat me differently’). However, a few suggested that older persons were discriminated against (‘at my age [44] they have a problem with getting contraceptive’; ‘they don’t care for us old people’).

DISCUSSION – IDENTIFYING ‘LEVERS FOR CHANGE’

The healthcare user survey identified patients’ perceptions and experiences of general health services as well as services related specifically to SRH. In this section the main findings are discussed, namely (i) overall positive user perceptions and high satisfaction levels; (ii) potential problems; and (iii) alignment with NHI objectives.

(i) Overall positive use perceptions and high satisfaction levels

The results for both survey domains (general and SRH services) indicate positive perceptions and high levels of satisfaction among patients attending public health facilities in the two districts studied. This is in line with other similar research conducted in South Africa (Chimbindi et al., 2014; Mashego & Peltzer, 2005; Nunu, 2015; Peltzer & Phaswana-Mafuya, 2012; Shisana et al., 2013), within the region (Dansereau et al., 2015; Hardon et al., 2007) and in other ‘developing’ countries (Andaleeb, 2001). In South Africa, for example, Nunu (2015) compared patient satisfaction with primary healthcare services in the Free State and Gauteng Provinces and found that more than 90% of patients were satisfied with services in both provinces. Similarly, Chimbindi et al. (2014) reviewed patient satisfaction with HIV and TB treatment in a public programme in rural KwaZulu-Natal and found: “Almost all patients (95% HIV, 97% TB) reported to be globally satisfied with the healthcare services received on the day of the interview” (p. 1). It is of course important to note that while users gave positive responses, these were more often *moderately positive* than not. This is similar to findings from other research done in the public health system that indicates only moderate satisfaction in relation to public services (Shisana et al. 2013).

Low utilisation of SRH services

This finding of overall positive perceptions and high user satisfaction should have positive implications for service utilisation. However, utilisation levels for SRH were not particularly high, with around half of service users saying that they had not accessed these services and/or that they had not been available when they wanted to use them.

The problem could be with the availability, since a large proportion of people – especially older persons – reported these services as being unavailable, despite a desire to use them in the past or a willingness to do so in future. However, as discussed above, there also appeared to be some indication that service users might not have adequate knowledge of services offered or how to access these. Follow-up research would be required to ascertain people’s knowledge and awareness of available SRH services. This is particularly important when considering that existing research points to low levels of knowledge regarding less socially accepted services such as abortion (Assifi et al., 2016; Macleod, Seutlwadi, & Steele, 2014; Meel & Kaswa, 2009).

The finding (of positive perceptions) must also be interpreted in relation to existing data. As Shisana et al. (2013) argue: “...if judged only on current perceptions, the many real problems in the South African health care system could be overlooked” (p. 332). As these researchers highlight, there is other recent research that contradicts the generally positive findings in surveys of user perceptions. For instance, a recent audit of South African public healthcare facilities rated compliance with minimum standards and performance as extremely low across the board (Visser, Bhana, & Monticelli, 2013). Similarly, a secondary analysis of data from the General Household Survey by Hasumi and Jacobsen (2014) considered reports about problems experienced during the most recent visit to the usual healthcare provider. The researchers found that commonly reported problems included: long waiting times,

unavailable medications and staff who were perceived as being unfriendly. Qualitative research also paints a similar picture, with participants commonly reporting long waiting times, unavailability of medications, and poor treatment from staff as problems with public health services (e.g., Harris et al., 2011, 2014; Rispel, Metcalf, Cloete, Moorman, & Reddy, 2011).

A number of possible explanations for the disparity in findings are put forward in the research literature, all of which may be relevant in the South African setting. One explanation is the 'gratitude bias', which causes recipients of free or low-cost healthcare to gloss over problems; complaints may be particularly problematic in public health settings where patients feel grateful to have received any services. Patients may also be reluctant to provide negative answers due to fear of retribution or dependence on the service provider (Bernhart et al., 1999). In addition, socially disadvantaged individuals may be less likely to perceive, and thus report, the presence of illness or health deficits, which we can assume to include poorer quality treatment. Their lack of knowledge, awareness, and experience of better facilities may create low health expectations (Sen, 2002). Research in other contexts also highlights the importance that patient expectations play in levels of satisfaction (Hardon et al., 2007; Williams et al., 1998). For example, in a study in the USA, Hardon and colleagues (2007) found that a "lack of unmet expectations was a powerful predictor of satisfaction at all time-points" (p. 609).

Shisana et al., (2013) argue that there is a lack of data to support the view that low expectations may contribute to more positive perceptions of services, but qualitative data might shed some light on this issue. In a recent qualitative study by Harris and colleagues (2014), researchers interviewed both service users and service providers, and noted that patients did indeed have very negative experiences, often based on a disparity between what they expected from services and what service providers thought services should be like and how patients ought to behave. They concluded that access barriers "are exacerbated by differences in the expectations that patients and providers have of each other" (p. 1). Further to this, patients may also moderate their responses to take into account the circumstances that public healthcare providers are working under (Williams et al., 1998). A few of the qualitative comments support this notion. For example, when discussing waiting times users mentioned 'long lines' as a mitigating factor or maintained that health workers were 'doing their best'.

Mahomed and colleagues (2008) assert that managing patient expectations is an important part of improving experiences of services. Yet, little is known about this aspect of patient experiences in South Africa. Further research around the role of patient expectations in South Africa would usefully shed light on this dynamic. This information could also be used to educate and mobilise people around their SRHR, allowing them to advocate for improved health services.

Chimbindi et al., (2014) argue that negative perceptions and dissatisfaction with specific aspects of healthcare may be hidden in global assessments of satisfaction. The current study goes some way to address this by including questions specifically dealing with SRHS. Still, follow-up research would assist with providing further understanding of areas that were not rated highly, including the meanings that patients attached to their experiences. Moreover, as Williams and colleagues point out, it is important to pay attention to negative responses or expressions of dissatisfaction, however marginal, which can provide useful avenues for follow-up research (Williams et al., 1998).

(ii) Expression of dissatisfaction and possible problem areas

Youth and young women

An important limitation associated with exit interviews as methodology is that those who avoid seeking healthcare are not included in the research. A proxy for this, in the current study, is the extent to which different groups were represented in the sample. With this in mind, under-representation of youth under the age of 20 is significant and points to avoidance of healthcare by this group. Further research is needed to explore different reasons for this. The findings do, however, indicate that when youth access SRH services at these facilities, they are more likely than other age groups to give negative ratings of privacy at facilities. Concerns about privacy and confidentiality are thus key aspects of potential constraints to the health-seeking behaviour of this group.

Qualitative responses provide further evidence for marginalisation of youth, who indicate that when seeking SRH services they are met with responses that such services are not appropriate for young persons. This could be because adolescent sexuality remains stigmatised and providing SRH services such as contraception or ToP to youth is construed as tacit condoning of youth sexual activity (Muller, Rohrs, Hoffman-Wanderer, & Moul, 2015). O'Reilly and Washington's (2012) study demonstrated that health workers reprimanded young women seeking SRH services, saying that they were too young to have sex and denying young women contraceptives. This form of discrimination is often unnoticed and invisible because of prevailing heteronormative institutional cultures that deny young women agency to make their own SRH decisions. Considering that both districts studied face high levels of teenage pregnancy, coupled with high levels of maternal mortality, interventions focused on improving youth and particularly young women's access to SRH services are critical.

Sexualities

Gender and sexual minorities were less likely to perceive health workers as having been able to assist them. Some participants indicated that their sexual identification influenced the SRH services they received. In general, respondents identified communication with staff at facilities as a barrier to optimal healthcare service provision. This is an important finding but particularly relevant to marginalised groups sensitive to possible judgment or hostility. Müller and Hughes (2016) note that lesbian and bisexual women differ from their heterosexual counterparts in that they are less likely to use healthcare services, including important preventative SRH services, such as pap smears. Similar findings are reported for gay and bisexual men, with Rispel et al. (2011) reporting that respondents either avoid seeking care or avoid disclosing their sexual identification to healthcare providers. Healthcare workers are not trained to respond professionally and appropriately to sexual and gender minorities, and interventions to this end are key.

Men's uptake of SRHS

The low number of men attending SRH services—or even disclosing that they are doing so—should be a central concern. Male involvement in SRH is generally considered to be integral to the social justice goal of gender equity, as well as meeting other reproductive health goals, such as decreasing population growth rates and lowering rates of sexually transmitted infection (Helzner, 1996). The International Conference on Population Development's 20-year Programme of Action encourages countries to:

promote the full involvement of men in family life and the full integration of women in community life, to ensure equal female-male partnerships, and, in particular, to call attention to men's shared responsibility and to promote their active involvement in responsible parenthood, sexual and reproductive behavior,

including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; [and] prevention of unwanted and high-risk pregnancies (cited in Alan Guttmacher Institute, 2003, p. 7).

South African policy has shifted to align with this view and, in line with the gender equity agenda, emphasis is laid on involving men in sexual and reproductive decision-making (Cooper et al., 2004). In addition, as Figueroa-Perea (2003) points out: “It is not sufficient to consider the participation of men within the health of women; rather, men should be thought of as actors with sexuality, health, reproductive, and concrete needs that should be considered, in their interaction with women and in their own specific right” (p. 114).

In South Africa, a promising approach to including and involving men in SRH is the Men as Partners approach that has largely focused on informing policies and programmes, such as the Men as Partners (MAP) programme (see Peacock & Levack, 2004), the Mobilising Young Men To Care project (see Greene, White, & Murphy, 2006) and the Men in Maternity Care Study (Mullick et al., 2005). These programmes seek to address gender dynamics and many also concentrate on assisting men to question their gender roles in terms of the advantages and disadvantages that these bring them. The Men as Partners approach “acknowledges the fundamental role men play in supporting women’s reproductive health and in transforming the social roles that constrain reproductive health and rights” (Greene, 2002, p. 4). This approach provides a good foundation for improving men’s representation in SRHS.

(iii) Alignment with NHI objectives with respect to SRHS

The aim of NHI is to provide equitable, universal health coverage for all. The challenge is making necessary services accessible without placing an unaffordable burden on any particular individuals or households (Harris et al., 2011). The following four objectives are identified with respect to the NHI pilot scheme:

- access to quality health services, with a particular focus on rural and previously disadvantaged areas;
- improving health outcomes for the most vulnerable in South Africa;
- reducing maternal mortality and the burden of disease borne by women;
- prioritising maternal and reproductive health services as ‘non-negotiable’ components of the health system, to be protected from under-funding.

Based on the findings, how well aligned are the facilities with these goals? In terms of access to healthcare, it is generally acknowledged that accessibility has several overlapping dimensions, viz., non-discrimination; physical accessibility; economic accessibility (affordability); information accessibility. In addition, services must be available and acceptable. Acceptability encompasses cognisance of cultural, gender, and life-cycle requirements (World Health Organisation, 2013). It is clear that some progress is being made in terms of providing access in rural and socially disadvantaged areas. As other research has shown, access to general healthcare is generally good (Shisana et al., 2013). However, the findings of this study suggest that age spatial inequity and interpersonal interactions with healthcare staff may act as access barriers.

When considering SHR services in particular, there are also several barriers to accessibility. A large proportion of people reported that these services were not available to them. It was pointed out that this is likely due to a combination of lack of knowledge of services and particular services not being offered (such as ToP). It appears that these services are acceptable to a very narrow range of people: married, heterosexual women, of childbearing age. The findings point to particular

challenges for young people generally and young women in particular when accessing SRH services, notably around concerns about privacy and confidentiality. Considering that the NHI pilot districts are intended to include measures that improve maternal health it seems *strategically valuable for advocacy by AFSA partners to focus on young women's SRH*, towards reducing unwanted pregnancies and improving access to ToP. This will include ensuring that NHI pilot districts have sufficient resources (e.g., ToP facilities, access to and availability of contraception, access to information) and that these resources are youth-friendly. The low uptake of these services by men is also of concern (see further discussion below).

As discussed above, the findings also point to sexual and gender minorities as marginalised groups that experience discrimination when accessing SRH services. Further to this, respondents indicated low awareness of SRH commodities relevant to LGBTI persons, such as lubricant and dental dams. This points to this group being overlooked in service provision and *advocacy by AFSA partners can focus on mechanisms to remedy the neglect of LGBTI SRHR in implementation of NHI*.

Spatial inequity in the provision of health care

Higher dissatisfaction in the Eastern Cape suggests inconsistency in services across provinces. This may be linked to various issues in the public health system. One issue is that of budgeting in the district health system (see report from year 1 of the research programme on this). A lack of human resources in these clinics is another issue which has negative impacts on health care delivery (Lembani, de Pinho, Delobelle, Zarowsky, Mathole & Ager, 2015). Other well-documented health system challenges in the Eastern Cape include shortages in medical supplies, medication and equipment such as x-ray machines. Furthermore, patient transport and emergency medical services such as ambulances are entirely absent in many places and insufficient in others (Bhagwanjee & Scribante, 2007; Kandel, Mfenyana, Chandia & Yogeswaran, 2008).

RECOMMENDATIONS

This section presents recommendations for advocacy, levers for change, and suggestions for further research.

1. Improving knowledge of SRH services that are/should be available

In relation to SRHR, the findings indicate low levels of knowledge about services that are/should be available. Advocacy efforts can focus on sensitising healthcare users, particularly those from marginalised groups, to the different SRH services to which they are entitled.

2. Meanings and expectations of experiences

Research is needed that captures the meaning that people make of their experiences in healthcare. Further research around the role of patient expectations in South Africa would usefully shed light on this dynamic. Such data could also be used to educate and mobilise people around their SRHR, allowing them to advocate for improved health services.

3. A life-cycle approach to SRHS

At present, SRH services are welcoming of, and are acceptable to, a very narrow range of people. A recent report produced for the Department of Health also pointed to this gap and the need for increased knowledge about sexuality and sexual development across the life-cycle (Klugman et al., 2011). In terms of age, services and policy need to address people at both ends of the age spectrum. As the results showed, young people did not feel that SRH services were available or accessible. Likewise, young people were also not accommodated. Advocacy efforts focused on ensuring youth-friendly SRH

services can highlight the need for privacy and confidential services for this group, to improve uptake of SRH services among youth. The findings demonstrate low awareness of services that are stigmatised for youth in particular, yet are intimately involved in reducing teenage pregnancy (i.e., ToP, pregnancy testing and contraception). Tackling knowledge about and access to these services in particular is important.

4. Support for sexual and gender diversity

“There is a policy lacuna in relation to gender identity and addressing the needs of transgender or gender variant people, and intersex people. There is also a policy vacuum in relation to sexual orientation, both in terms of the ability of the health services to provide a supportive environment for young people exploring their sexual identities and in terms of healthcare providers’ ability to provide appropriate information and outreach to people with diverse sexual practices and identities” (Klugman et al., 2011, p. 151). One need in this regard is for policy development and advocacy.

In addition to policy work, there is a need to assist people with non-normative sexual and gender identities to access services and to advocate for their rights. Sexual and gender minorities do not necessarily disclose their sexual identification to healthcare workers, yet fear discrimination regarding their sexuality when accessing services. Advocacy around healthcare workers communicating support for sexual and gender diversity may go some way towards improving access to and quality of SRH services for this group.

5. Continued advocacy regarding healthcare budgeting and work to hold duty bearers accountable

The key challenges of understaffing and underspending on health budgets in both districts, and particularly the partial achievement in staffing District Clinical Specialist Teams, highlights the importance of advocacy initiatives aimed at evaluating the impact of the NHI pilot programmes on SRHR of marginalised groups. It is important to monitor the establishment, functioning and impact of the District Clinical Specialist Teams in the pilot areas.

6. Addressing the interpersonal dimension as a potentially ‘easy win’

Previous research has found that seemingly trivial measures, like friendliness or cleanliness, can vastly affect patient experiences and increase satisfaction (Harris et al., 2014; Mahomed et al., 2008; Nunu, 2015; Roberts, 2002). Interactions between service providers and service users have been found to be particularly influential. For example, more than 65% of respondents in a 2005 household survey identified care and compassion as more important for satisfaction than technical proficiency. Satisfaction was promoted by (in order of importance) dignity and respect; speed and efficiency; comfort; information, and communication; and emotional support (Mahomed et al., 2008). Roberts (2002) reports that good quality practitioner-patient relationships promote adherence and lesser quality relationships impede it. Positive interactions can therefore make a considerable difference to patients. In fact, Harris and colleagues report that “caring, respectful communication, individual acts of kindness, and institutional flexibility and leadership may mitigate key access barriers and limit threats to the contract, fostering more positive forms of inclusion and facilitating easier access to health care” (Harris et al., 2014, p. 35). Thus, strengthening and promoting the bonds between health workers and users should be a priority, within practitioner-patient interactions as well as at an organisational level (Roberts, 2002).

Further research is needed to inform this goal. Implementation partners need to find ways to assist health workers to improve this aspect of care, including offering training and addressing low morale and adverse working conditions. Work needs to be done with regard to maintaining professionalism,

possible through emphasising the *Batho Pele* principles, in relation to *all* patients, including those from vulnerable and marginalised groups.

References

- Alan Guttmacher Institute. (2003). *In their own right: Addressing the sexual and reproductive health needs of men worldwide*. New York: Alan Guttmacher Institute. Available from http://www.guttmacher.org/pubs/itor_intl.pdf
- Amnesty International. (2014). *Struggle for maternal health*. London: Amnesty International. Available from: <http://www.amnesty.ca/sites/default/files/southafricamaternalhealthreport9october14.pdf>
- Andaleeb, S. S. (2001). Service quality perceptions and patient satisfaction: A study of hospitals in a developing country. *Social Science and Medicine*, 52(9), 1359–1370. doi:10.1016/S0277-9536(00)00235-5
- Assifi, A. R., Berger, B., Tunçalp, Ö., Khosla, R., Ganatra, B. (2016). Women's awareness and knowledge of abortion laws: A systematic review. *Plos One*, 11(3), e0152224. doi:10.1371/journal.pone.0152224
- Benetar, S. R. (2013). The challenges of health disparities in South Africa. *South African Medical Journal*, 103(3), 154 -155.
- Bernhart, M. H., Wiadnyana, I. G. P., Wihardjo, H., & Pohan, I. (1999). Patient satisfaction in developing countries. *Social Science & Medicine*, 48(8), 989–996. doi:10.1016/S0277-9536(98)00376-1
- Bhagwanjee, S., & Scribante, J. (2007). National audit of critical care resources in South Africa—unit and bed distribution. *South African Medical Journal*, 97(12), 1311-1314.
- Chimbindi, N., Bärnighausen, T., & Newell, M.-L. (2014). Patient satisfaction with HIV and TB treatment in a public programme in rural KwaZulu-Natal: evidence from patient-exit interviews. *BMC Health Services Research*, 14, 32. doi:10.1186/1472-6963-14-32
- Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: historical roots of current public health challenges. *Lancet*, 374(9692), 817–34. doi:10.1016/S0140-6736(09)60951-X
- Cullinan, K., Nkosi, S., Lopez Gonzalez, L., & Mkhwanazi, A. (2015). NHI far from reality but progress made in improving public health. *Health-E News*. Available from: <https://www.health-e.org.za/2015/06/01/nhi-far-from-reality-but-progress-made-in-improving-public-health/>
- Dansereau, E., Masiye, F., Gakidou, E., Masters, S. H., Burstein, R., & Kumar, S. (2015). Patient satisfaction and perceived quality of care: evidence from a cross-sectional national exit survey of HIV and non-HIV service users in Zambia. *BMJ Open*, 5(12), e009700. doi:10.1136/bmjopen-2015-009700
- Department of Health. (n.d.). *National health insurance: Healthcare for all South Africans*. Pretoria, South Africa: Department of Health. Retrieved June 2016 from www.doh.gov.za
- Eastern Cape Department of Health. (n.d.). *NHI Business Plan OR Tambo*. Available from www.hsr.org.za
- Gilliam, M. L., Neustadt, A., & Gordon, R. (2009). A call to incorporate a reproductive justice agenda into reproductive health clinical practice and policy. *Contraception*, 79(4), 243–246. doi:10.1016/j.contraception.2008.12.004
- Gilson, L., & McIntyre, D. (2007). Post-apartheid challenges: Household access and use of health care in South Africa. *International Journal of Health Services*, 37(4), 673-691.
- Hardon, A. P., Akurut, D. C., Comoro, C., Ekezie, C., Irunde, H. F., Gerrits, T., Kglatwane, J., Kinsman, J., Kwasa, R., Maridadi, J., Moroka, T. M., Moyo, S., Nakiyemba, A., Nsimba, S., Ogenyi, R., Oyabba, T., Temu, F., & Laing, R. (2007). Hunger, waiting time and transport costs: time to confront challenges

- to ART adherence in Africa. *AIDS Care*, 19(5), 658–665. doi:10.1080/09540120701244943
- Harries, J. (2010). *Abortion services in South Africa : Challenges and barriers to safe abortion care : Health care providers ' perspectives*. Cape Town: University of Cape Town.
- Harries, J., Orner, P., Gabriel, M., & Mitchell, E. (2007). Delays in seeking an abortion until the second trimester: a qualitative study in South Africa. *Reproductive Health*, 4, 7. doi:10.1186/1742-4755-4-7
- Harries, J., Stinson, K., & Orner, P. (2009). Health care providers' attitudes towards termination of pregnancy: a qualitative study in South Africa. *BMC Public Health*, 9, 296. doi:10.1186/1471-2458-9-296
- Harris, B., Eyles, J., Penn-kekana, L., Thomas, L., & Goudge, J. (2014). Adverse or acceptable : negotiating access to a post-apartheid health care contract. *Globalization and Health*, 10(1), 1–14. doi:10.1186/1744-8603-10-35
- Harris, B., Goudge, J., Ataguba, J. E., McIntyre, D., Nxumalo, N., Jikwana, S., & Chersich, M. (2011). Inequities in access to health care in South Africa. *Journal of Public Health Policy*, 32(S1), 102–123. doi:10.1057/jphp.2011.35
- Hasumi, T., & Jacobsen, K. H. (2014). Healthcare service problems reported in a national survey of South Africans. *International Journal for Quality in Health Care*, 26(4), 1–8. doi:10.1093/intqhc/mzu056
- Hongoro, C. (2014). *Developing a framework for the long term monitoring and evaluation of National Health Insurance*. Pretoria, South Africa: HSRC.
- Human Rights Watch 2011 'Stop making excuses': *Accountability for maternal health care in South Africa*. New York: Human Rights Watch.
- Kandel, T. R., Mfenyana, K., Chandia, J., & Yogeswaran, P. (2008). The prevalence of and reasons for interruption of anti-tuberculosis treatment by patients at Mbekweni Health Centre in the King Sabata Dalindyebo (KSD) District in the Eastern Cape province. *South African Family Practice*, 50(6), 47-47.
- Klugman, B. (2007). Parallel or integrated "other worlds": Possibilities for alliance-building for sexual and reproductive rights. *Journal of International Women's Studies*, 8(3), 88–112.
- Klugman, B., Treger, L., Conco, D., & Moorman, J. (2011). *Sexual and reproductive health and rights: Reviewing the evidence*. Pretoria, South Africa.
- Kon, Z. R., & Lackan, N. (2008). Ethnic disparities in access to care in post-apartheid South Africa. *American Journal of Public Health*, 98(12), 2271-2277.
- Lagomarsino, G., Garabrant, A., Atikah, A., Richard, M., & Otoo, N. (2012). Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia. *Lancet*, 380, 933–943.
- Lembani, M., de Pinho, H., Delobelle, P., Zarowsky, C., Mathole, T., Ager, A. (2015). *A case study of maternal health service provision in OR Tambo District, Eastern Cape, in the context of chronic poor health performance*. Available from: <https://www.gov.uk/dfid-research-outputs/a-case-study-of-maternal-health-service-provision-in-or-tambo-district-eastern-cape-in-the-context-of-chronic-poor-health-performance>
- Macleod, C., Seutlwadi, L., & Steele, G. (2014). Cracks in reproductive health rights: Buffalo City learners' knowledge of abortion legislation. *Health SA Gesondheid*, 19(92), 1–10. doi:10.4102/hsag.v19i1.743
- Macleod, C., & Tracey, T. (2009) *Review of South African research and interventions in the development of a policy strategy on teen-aged pregnancy*. Pretoria, South Africa: World Health Organization & Department of Health.
- Mahomed, Z., Wallis, L., & Motara, F. (2008). Patient satisfaction with emergency departments. *South African Medical Journal*, 105(6), 429. doi:10.7196/SAMJ.9376

- Marten, R., McIntyre, D., Travassos, C., Shishkin, S., Longde, W., Reddy, S., & J, V. (2014). An assessment of progress towards universal health coverage in Brazil, Russia, India, China, and South Africa (BRICS). *Lancet*, *384*, 2164–2171.
- Mashego, T. a B., & Peltzer, K. (2005). Community perception of quality of (primary) health care services in a rural area of Limpopo Province, South Africa: a qualitative study. *Curationis*, *28*(2), 13–21.
- Massyn, N., Day, C., Peer, N., Padarath, A., Barron, P., & Africa, S. (2014). *District Health Barometer 2013 / 14*. Available from: https://www.health-e.org.za/wp-content/uploads/2014/10/DHB_2013-14.pdf
- Mathibe, M. D., Hendricks, S. J., & Bergh, A. M. (2015). Clinician perceptions and patient experiences of antiretroviral treatment integration in primary health care clinics, Tshwane, South Africa. *Curationis*, *38*(1), 1-11.
- Matsoso, M. P., & Fryatt, R. (2013). National Health Insurance: The first 16 months. *South African Medical Journal*, *103*(3), 156–158. doi:10.7196/samj.6601
- McIntyre, D. (2012). *Health service financing for universal coverage in east and Southern Africa*. EQUINET Discussion Paper 95. Harare: Regional Network for Equity in Health in Southern Africa.
- Meel, B. L., & Kaswa, R. P. (2009). The impact of the Choice on Termination of Pregnancy Act of 1996 (Act 92 of 1996) on criminal abortions in the Mthatha area of South Africa. *African Journal of Primary Health Care & Family Medicine*, *1*(1), 1-3. doi:10.4102/phcfm.v1i1.36
- Morison, T. (2013). Moving from reproductive choice to reproductive justice. *HSRC Review*, (May).
- Morison, T., & Macleod, C. (2013). When veiled silences speak: reflexivity, trouble and repair as methodological tools for interpreting the unspoken in discourse-based data. *Qualitative Research*, 1–17. doi:10.1177/1468794113488129
- Mpinga, E. K., & Chastonay, P. (2011). Satisfaction of patients: A right to health indicator? *Health Policy*, *100*(2-3), 144–150. doi:10.1016/j.healthpol.2010.11.001
- Muhondwa, E. P. Y., Leshabari, M. T., Mwangu, M., Mbembati, N., & Ezekiel, M. J. (2008). Patient satisfaction at the Muhimbili national hospital in Dar es Salaam, Tanzania. *East African Journal of Public Health*, *5*(2), 67-73.
- Myburgh, N. G., Solanki, G. C., Smith, M. J., & Lalloo, R. (2005). Patient satisfaction with health care providers in South Africa: the influences of race and socioeconomic status. *International Journal for Quality in Health Care*, *17*(6), 473–477. doi:10.1093/intqhc/mzi062
- Naidoo, S. (2012). The South African national health insurance: a revolution in health-care delivery! *Journal of Public Health*, *34*(1), 149–150. doi:10.1093/pubmed/fds008
- Nunu, W. N. (2015). *Comparing patient satisfaction with Primary Health Care Services in the Free State and Gauteng Provinces*. Unpublished Masters Thesis. University of the Witwatersrand.
- Pearson, L., & Cockcroft, A. (1999). *Republic of Maldives reproductive health*. Maldives.
- Peltzer, K., & Phaswana-Mafuya, N. (2012). Patient experiences and health system responsiveness among older adults in South Africa. *Global Health Action*, *5*, 1–11. doi:10.1186/1472-6963-9-117
- Rispel, L. C., Metcalf, C. a, Cloete, A., Moorman, J., & Reddy, V. (2011). You become afraid to tell them that you are gay: health service utilization by men who have sex with men in South African cities. *Journal of Public Health Policy*, *32*(s1), S137–S151. doi:10.1057/jphp.2011.29
- Rispel, L., & Hunter, J. (2015). The Millennium Development Goals and healthcare reforms in South Africa: Progress and challenges, 536–556.
- Roberts, D. (2015). Reproductive justice , not just rights. *Dissent*, *62*(4), 79–82.
- Roberts, K. J. (2002). Physician-patient relationships, patient satisfaction, and antiretroviral medication Adherence among HIV-infected adults attending a public health clinic. *AIDS Patient Care and STDs*, *16*(1), 43–50. doi:10.1089/108729102753429398
- SARRAH. (2013). *Status of NHI Pilot districts: 12-month progress report*. Available from:

www.health.gov.za

- Sen, A. (2002). Health: perception versus observation. *British Medical Journal*, 324, 860–861. doi:10.1136/bmj.324.7342.860
- Shisana, O., Labadarios, D., Rehle, T., Simbayi, L., Zuma, K., Dhansay, A., Reddy, P., Parker, W., Hoosain, E., Naidoo, P., Hogoro, C., Mchiza, Z., Steyn, N. P., Dwane, N., Makoae, M., Maluleke, T., Ramlagan, S., Zungu, N., Evans, M. G., & Jacobs, L. (2013). *The South African National Health and Nutrition Examination Survey (SANHANES-1)*. Cape Town, South Africa: HSRC Press.
- Stevens, M. (2008). *UNGASS report on sexual and reproductive health indicators*. Available from www.hst.org.za
- Stevens, M. (2012). Maternal Mortality – HIV and unsafe abortion – a silent epidemic. *Agenda*, 26(2), 44-50. doi:10.1080/10130950.2012.700219
- Visser, R., Bhana, R., & Monticelli, F. (2013). *The National Health Care Facilities Baseline Audit: National summary report 2012*. Cape Town.
- Williams, B., Coyle, J., & Healy, D. (1998). The meaning of patient satisfaction: An explanation of high reported levels. *Social Science and Medicine*, 47(9), 1351–1359. doi:10.1016/S0277-9536(98)00213-5
- Wouters, E., Heunis, C., van Rensburg, D., & Meulemans, H. (2008). Patient satisfaction with antiretroviral services at primary health-care facilities in the Free State, South Africa-a two-year study using four waves of cross-sectional data. *BMC Health Services Research*, 8, 210. doi:10.1186/1472-6963-8-210
- World Health Organisation (2013). *Health and human rights*. Fact sheet N°323. Available at <http://www.who.int/mediacentre/factsheets/fs323/en/>

APPENDIX I

Survey questions

Section	Question	Question text
Questionnaire Details	Province	Province.
	Researcher name	Researcher name.
	Researcher Name - EC	Researcher Name:
	Other - Researcher	Please type your name:
	Facility name	Facility name.
	Other - Facility	Please specify the Facility name:
	Type of facility	Type of facility.
Demographic	Age	How old are you (years)?
	Gender	What is your gender?
	Gender - Other	Please specify:
	Relationship status	What is your relationship status?
	Relationship status - Other	Please specify:
	Your sexuality	How do you describe your sexuality? [This question is about who you find attractive romantically or sexually]
	Your sexuality - Other	Please specify:
	Main language spoken at home	What is the main language spoken in your home?
	Main language at home - Other	Please specify:
	Highest level of school	What is the highest level of school you attended?
	Level of School	Level of School:
	Describe your race	How would you describe yourself in terms of your race?
	Describe your race - Other	Please specify:
	Employment	Are you working?
	Employer	Who do you work for?
	Supporting yourself	What ways do you support yourself? [Select all that apply].
	Supporting yourself - Other	Please specify:
Medical aid	Are you covered by any medical aid?	
Medical Aid owner	Is the medical aid your own or someone else's?	
Medical Aid - Other	Please specify:	
A. Access to general care	Main service1	Was there a main service that you came for today?
	Main service	What was the main service that you came for today?
	Transportation	How did you get here today?
	Transportation - Other	Please specify:
	Travel time	How long did it take you to get here?
	Received service you needed	Did you receive the service that you needed?
	Wait to be seen	How long did you wait to be seen?
	Satisfaction with care received	Overall, how satisfied are you with the care you received today?

	Reason you did not receive care	What was the reason that you did not receive care?
	Experience what it usually is like	Is your experience today what it is usually like here?
	Times when you did not receive care	Has there ever been a time when you did not receive care when you came to this facility?
	In the past - getting treatments prescribed	In the past, have you been able to get the treatments or medicines prescribed for you at this facility?
	Treatment delay	Please specify the length of the delay [Example: 1 week or 1 month]:
	Challenges receiving healthcare	In general, do you have any challenges in receiving the healthcare you need from ANY of the places you have visited? [Select all that apply][If respondent does not mention any of the options listed, probe by reading the list][If none of the options apply, write in 'Other'].
	Challenges receiving healthcare – Other	Please specify:
	In the past - problems communicating with doctors	In the past, have you had any problems communicating with doctors or other healthcare professionals? [Clarify: trouble understanding or being understood].
	Reason for answer	Can you give a reason why you answered 'Yes' to the previous question?
B. Knowledge, perceptions & utilisation Of SRHS	Place for information on sexual health	Is there a place in your community where people can go for help or information with sexual and reproductive health (i.e. relationships, sex, contraception, sexually transmitted infections, HIV/AIDS etc.)?
	Place for sexual health - name	Can you name the facility/place and/or tell me where it is?
	Place for sex health - services provided	What kinds of services are provided? [Select all that apply][If respondent does not spontaneously mention any of the options listed, probe by reading the list][If none of the options apply, write in the service in 'Other'].
	Place for sex health - services provided - Other	Please specify:
	Visited facility for sexual health services	Have you ever visited a health facility or other place to get sexual and reproductive health services?
	Last visit	When was your last visit?
	Most recent visit - sex health information	Where did you go for your most recent visit to obtain sexual and reproductive health care/services? [Name facility and location].
	Reason for most recent visit to facility	What was the reason(s) for your most recent visit to a health facility for sexual and reproductive health care/services? [Select all that apply][If respondent does not spontaneously mention any of the options listed, probe by reading the list][If none of the options apply, write in 'Other'].
	Reason for most recent visit to facility - Other	Please specify:
	Health workers you saw at facility	Who did you talk to or see (health workers) at the health facility the last time you went to for sexual and reproductive health services/care? [Select all that apply][Probe by reading list][If none of options apply, write in 'Other'].
	Health workers you saw at facility - Other	Please specify:
	Rate service providers at facility	What was the service provider(s) like in general at the health facility the last time you went to for sexual and reproductive health services/care? [Select all that apply][Probe by reading list][If none of the options apply, write in 'Other'].
	Rate service providers - Other	Please specify:
	PRIVACY at facility	How would you rate the PRIVACY at that facility?
	Listened to at facility	How well did you feel that you were listened to?
	Staff KNOWLEDGE at facility	How would you rate the KNOWLEDGE of the staff at the facility in general?
	Addressing issues at facility	How would you rate the staff's ability to address the issue that you came for?
	Treatment at facility	How would you rate the way that you were treated (friendliness, politeness, respect) by staff in general?
	Details - Service at Facility	Would you like to provide some more detail about any of the questions I've just asked?
	Service providers explaining things	Did the sexual and reproductive health service providers explain things to you in a way that you understand?
How well you were listened to at facility	How well do you feel that you are/were listened to at the health facility the last time you went to for sexual and reproductive health services/care?	
Skill and ability of the staff	Skill and ability of the staff.	
Overall how clean the facility is	Overall how clean the facility is.	

	Overall how efficient healthcare workers are	Overall how efficient healthcare workers are.
	Friendliness and politeness of the staff	Friendliness and politeness of the staff.
	Nearness of location to you	Nearness of location to you.
	Going back to the health facility	Would you go back to that health facility to get sexual and reproductive health services?
	Reason you will not return to facility	What is the reason that you won't return to the health facility for sexual and reproductive health services/care? [Select all that apply].
	Reason you will not return to facility - Other	Please specify:
	Reason you will return to facility	Can you give a reason for why you WOULD go back to the Health facility?
	Rate general services received at any facility	Overall, how would you rate the general sexual and reproductive health services that you have received in the past, at any facility?
	Improving sex health services in general	Is there something that you think could be done to improve sexual and reproductive health services in general?
	Comfortable going to facility in your area	Would you feel comfortable going to a health facility found in your area for sexual and reproductive health services?
	Not comfortable going to facility in your area	Why wouldn't you feel comfortable going to a health facility in your area for sexual and reproductive health services? [Select all that apply].
	Not comfortable at facility in your area - Other	Please specify:
	Experiences affected by who you are	In general, do you think that your experiences of the sexual and reproductive health care services have been/would be affected by who you are (i.e. your gender, sexuality, age etc.).
	Please explain your answer	Can you please explain your answer?
	Additional Info	Is there something else that you'd like to tell me about that we might not have covered?'
End	Respondent Comments	Please ask the respondent to provide their impressions/comments of the survey.
	Researcher Comments	Please provide your impressions/comments of the survey.

NOTES

ⁱ Source: Genesis Healthcare Consultants presentation <http://www.slideshare.net/samclay111gp/nhi-presentation-2012-healthcare-2012-business-resuscitation-marcus-evans>

ⁱⁱ The Ideal Clinic programme was launched by South African National Department of Health (NDoH) in July 2013 in response to the problems identified in baseline standards audit in 2011/12. It is intended to systematically improve public Primary Health Care clinics. An 'ideal clinic' should have (1) good infrastructure and administrative processes; (2) adequate staff, medicine and supplies; and (3) applicable clinical policies, protocols, guidelines. It should also work with partners and stakeholders to provide quality health services to communities and cooperate with other government departments, the private sector, and civil society to address the social determinants of health (e.g. poverty, crime, violence). For further information visit the Department of Health website: <https://www.idealclinic.org.za/>

ⁱⁱⁱ With the exception of the Free State Province.

^{iv} Age is negatively correlated with the level of satisfaction.