

**A STUDY OF THE PERCEPTIONS AND EXPERIENCES
OF PATIENTS RECEIVING HOMOEOPATHIC CARE IN
THE CONTEXT OF PRIMARY HEALTHCARE SERVICES
WITHIN THE PUBLIC SECTOR**

By

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DECLARATION

I, Kirsty Jane Love, do declare that this dissertation is representative of my own work and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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DEDICATION

This work is dedicated to all patients and healthcare professionals alike; may peace and love prevail for all.

Dedicated with love to my family.

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ABSTRACT

Introduction

Homoeopathy is recognised as a well established form of alternative medicine in the private healthcare sector of South Africa (Caldis, McLeod, Smith, 2001). Whilst local research supports the viability of homoeopathy as a primary healthcare resource; patient perception and experience with the homoeopathic service remain largely unknown (Smillie, 2010). The study addresses shortfalls in existing literature on homoeopathy, providing a qualitative evaluation of the homoeopathic healthcare service in the context of public healthcare in South Africa. The task of the study was to develop substantive theory with the aim to better understand health behaviour of patient's utilising homoeopathic and allopathic healthcare services.

Methods

The study employed a qualitative study design, and explored the perceptions and experiences of patients receiving homoeopathic care at the Kenneth Gardens Homoeopathy Clinic, within the context of primary healthcare services and public sector healthcare. Data was generated through in-depth, semi-structured interviews conducted with 14 participants. Data was systematically analysed using grounded theory methods to generate substantive theory (Glaser and Strauss, 1967; Schreiber and Stern, 2001; Holloway and Wheeler, 2010).

Results

Data analysis revealed five main themes of influences affecting the utilisation of homoeopathic services at the Kenneth Gardens Clinic; these include context specific factors to healthcare utilisation, factors influencing healthcare utilisation, health beliefs and practices, health outcome factors and trust. The study results illustrate that participants trusted their homoeopathic provider and homoeopathic treatment outcomes; and subsequently demonstrate the direct positive influence

which trust had on the utilisation of homoeopathic services in the study population.

Discussion

The discussion explores the significance of influences, barriers and discerning factors identified in the study on decision-making pathways in healthcare utilisation behaviour of homoeopathic and allopathic healthcare services. The significance of trust in healthcare utilisation behaviour is explored as the principle finding of the study. The study's conceptual model is based on Anderson's (2005) behavioural model of health service utilisation and has been adapted to demonstrate the relationship in health seeking behaviours between homoeopathic and allopathic care modalities.

Recommendations

The relationship between the variables illustrated in the study's proposed adapted model need to be further tested using quantitative research methods. Trust in healthcare, and in particular with homoeopathy, is a subject which merits further exploration.

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ABBREVIATIONS

AHPCSA	Allied Health Professions Council of South Africa
AIDS	Acquired Immune Deficiency Syndrome
DUT	Durban University of Technology
GHH	Glasgow Homoeopathic Hospital
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HSA	Homoeopathic Association of South Africa
KGHC	Kenneth Gardens Homoeopathy Clinic
NHI	National Health Insurance
PHC	Primary Healthcare
TB	Tuberculosis
UNHC	Ukuba Nesibindi Homoeopathic Clinic

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GLOSSARY

Allopathy: A system of medical practice which treats disease by conventional means; with the use of treatment (drug/surgery) that produces effects different to or incompatible with those produced by the disease.

Alternative medicine: Any therapy not regarded as orthodox by the medical professional.

Complementary medicine: Any therapy not regarded as orthodox by the medical professional, which can be used alongside orthodox medicine in treatment of disease.

Health behaviour: Actions taken by patients regarding healthcare which are motivated by a combination of knowledge, practices and attitudes.

Healthcare intervention: The provision of a type of therapeutic care which is undertaken to help treat/cure a condition.

Healthcare utilisation: The usage of a healthcare service/intervention.

Health-seeking behaviour: Describes the pattern of healthcare utilization within a population group.

Holistic approach: An approach characterised by the treatment of the whole person; with emphasis on the importance on the whole and the interdependence of its parts; and where the mental and emotional aspects of a patient's health are taken into account along with physical symptoms.

Primary healthcare: Is the first point of contact/level of healthcare offered in a healthcare system.

Primary healthcare clinic: An institution providing first level healthcare to the public.

CHAPTER ONE: OVERVIEW OF STUDY

1.1 INTRODUCTION

Healthcare today is multifaceted with resources diverse in origin, methodology and philosophy. In South Africa, a healthcare provider is defined as a person who provides a healthcare service in terms of any of the laws recognizing the healthcare practice within the country (Hassim, Heywood & Berger, 2007). South African law recognises a wide variety of healthcare service providers; from orthodox medical professionals to many alternative healthcare professionals. Homoeopathy is legally recognised as a primary healthcare profession in South Africa (Caldis, McLeod, Smith, 2001, Hassim et al, 2007), and regulated under the Allied Health Professions Council of South Africa (AHPCSA); homoeopathy has become a well-established form of complementary healthcare within the private sector despite not being incorporated into public healthcare systems. Internationally homoeopathy is gaining recognition as a sustainable healthcare resource with movement toward the integration of homoeopathic services into public healthcare systems of developing countries (Rossi *et al*, 2010). The potential value of homoeopathy in its capacity as a healthcare modality and as a resource for public healthcare is of particular interest in this research dissertation.

1.2 RESEARCH SETTING

Kenneth Garden's municipal housing estate in Durban, KwaZulu Natal, provides housing for 1500-1800 residents who received placement in the estate according to economic need; designated primarily to those families in which a member/members suffer physical/mental disablement (Erwin *et al*, 2012). Given the socio-economic need of the Kenneth Gardens community and in light of a lack of accessible healthcare provision for the community (Erwin *et al*, 2012); the Department of Homoeopathy at The Durban University of Technology (DUT), in collaboration with The University of KwaZulu-Natal's (UKZN), Community

Development Department established the Kenneth Gardens Homoeopathy Clinic. The clinic operates from the Kenneth Gardens community hall and is open once a week between 9am-12pm; providing cost-free primary healthcare and homoeopathic medication to the community.

1.3 RESEARCH PROBLEM AND RATIONALE

With the establishment of a privately funded homoeopathic clinic, residents of the Kenneth Gardens community and surrounding areas are now able to access homoeopathic healthcare services.

Local research demonstrates the clinical value of homoeopathy (Smilie, 2010) and illustrates positive findings in patient satisfaction (Forster, 2005; Herr, 2008). However; the patient's personal experience and perception of the homoeopathic service remains unexplored. Patient perspective is regarded as a valuable source of information in the evaluation of healthcare as it assists the identification of values, motivations and expectations which researchers can translate directly into clinical practice (Holloway *et al*, 2010).

Within the context of the Kenneth Garden's community, patient perception and experience with healthcare assisted in identifying how patients in a public healthcare setting evaluate homoeopathic care. The insights and knowledge generated from the research may be useful in efforts made to incorporate homoeopathy into the public health sector through the National Health insurance. Information attained may also favour the future development of Kenneth Gardens Community Clinic and Project and be of use in demonstrating the value of homoeopathic healthcare services.

1.4 THE RESEARCH AIM

The aim of the study was to explore patient perception and experiences with receiving homoeopathic care in a Primary Health Care (PHC) setting and to develop a conceptual model which illustrates the relationship between homoeopathy and allopathy as primary healthcare modalities, and discerning factors which influence patient choice and preference relating to their use of these modalities within the public sector.

1.5 OBJECTIVES OF THE STUDY

The research has been designed to address the following research objectives:

1. To explore and identify the perceptions of patients with regard to their experience of homoeopathy at Kenneth Gardens in terms of provider care.
2. To determine patient acceptability, perceptions and experiences with homoeopathic medication/treatment.
3. To determine the perceptions of patients with regard to their experiences of other medical modalities in terms of provider care.
4. To investigate patient experiences of medication/treatment of other medical modalities and reasons for access to the different care modalities.
5. To identify and describe factors motivating patients to access care at the homoeopathic clinic in Kenneth Gardens.
6. To develop a conceptual framework illustrating patient health seeking behaviour dynamics/pathways, patient influences and barriers to seeking specific care modalities and the relationship between homoeopathy and allopathy as primary healthcare modalities as from a patient perspective.

1.6 OUTLINE OF DISSERTATION

Chapter 1: Overview of study

Introduction and background information on the study.

Chapter 2: Literature review

Includes reviews of homoeopathy, public healthcare in South Africa, homoeopathy in the primary healthcare sector of South Africa, homeopathic primary healthcare clinics, local and international literature of perspectives on homoeopathic care, and research related to healthcare utilisation and behaviour.

Chapter 3: Research methodology

Theoretical framework and research methodology utilized in the study.

Chapter 4: Results

Presentation of study results.

Chapter 5: Discussion

Discussion of study results.

Chapter 6: Conclusion

Conclusions, recommendations and study limitations are presented in this chapter.

1.7 CONCLUSION

Data obtained from the study on patient perspective may be valuable in the evaluation of healthcare services providing insight into the values, motivations and expectations of patients utilizing different types of primary healthcare services.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

The literature review gives an overview of homoeopathy; public healthcare in South Africa; homoeopathy in primary healthcare both locally and internationally; homoeopathic primary healthcare clinics including a full review of Kenneth Gardens Homoeopathy Clinic and local and international literature illustrating patient perspective on homoeopathy. Furthermore; the review explores healthcare utilisation behaviour theories and models which have been established through healthcare service research and discusses their relevance to the study.

Current literature suggests that healthcare interventions should be evaluated according to whole systems research methods; where qualitative and quantitative outcomes are held in equal esteem and research is focused to the unique theory and therapeutic context of the healthcare intervention (Verhoef *et al*, 2005). Whole systems research is of particular importance to alternative and complimentary healthcare practices which have, in the past, been inadequately evaluated with classical randomized control trials (Verhoef *et al*, 2005). This study contributes to whole systems research and addresses shortfalls in existing literature on homoeopathy by providing a qualitative evaluation of the homoeopathic healthcare service in the context of public healthcare in South Africa.

The identification of patient values, motivations and expectations relating to the use of homoeopathy within the context of public sector healthcare are of significant importance primarily because patient perspectives on homoeopathy are largely unknown in South Africa. Secondly, these perspectives assist in providing information which can be translated into clinical practice and provide

descriptive data on the value, limitations and applicability of homoeopathy as a primary healthcare resource (Holloway *et al*, 2010).

This research explores the utilisation of homoeopathic healthcare interventions in order to increase knowledge and understanding regarding healthcare utilisation within plural healthcare systems.

2.2 HOMOEOPATHY

Past writings, including those of Hippocrates, have alluded to the curative powers of a medicine being aligned to its ability to arouse similar disease symptoms (O'Reilly, 1996). The fundamental importance of this principle was recognised by the German physician Samuel Hahnemann (1777-1843) who founded and developed the practice of homoeopathy, late in the eighteenth century, accordingly. Hahnemann began his career in medicine as a conventional medical practitioner of the time. He became disillusioned with the medical practices of the time and chose instead to pursue a career as a linguist, translating medical and other texts (O'Reilly, 1996). It was in his translation of a medical text by William Cullen that Hahnemann first gained insight into the true nature of medicines, which spurred him on to further enquiry and the development of homoeopathy (O'Reilly, 1996). Through unbiased observation, experience and careful consideration Hahnemann constructed and refined principles on the philosophy and practice of medicine, from which he compiled the *Organon of the Medical Art* in successive editions (O'Reilly, 1996).

2.2.1 HOMOEOPATHIC PHILOSOPHY

The homoeopathic method as developed by Samuel Hahnemann is highly systematised and based on constant and clearly recognizable laws and principles (O'Reilly, 1996; Swayne, 1998). Medicines selected according to these principles are specific to the individual's disease and are prescribed in the simplest, smallest and most gentle form.

The law of similars; “Similia similibus curentur” or “like cures like” is the fundamental principle upon which homoeopathy is based (Kent, 2007; O’Reilly, 1996; Swayne, 1998). Homoeopathic medicines are prepared, according to this principle, from substances which cause disease in healthy individuals, and are applied in the treatment of similar diseases in the sick to bring about cure (O’Reilly, 1996).

In accordance with homoeopathic theory; knowledge of the unique curative powers of a medicine is acquired by the experimental means of a proving (O’Reilly, 1996). The materia medica of homoeopathic medicines is compiled from clinical experience, toxicological findings and proving studies (Swayne, 1998), and described in the *Organon of the Medical Art* as; “a collection of genuine, pure and unmistakable modes of action of simple medicinal substances” (O’Reilly, 1996).

Homoeopathic medicines are selected and prescribed according to the law of similars, the law of single dose and the law of minimal dose (O’Reilly, 1996). Medicines are prescribed only one medicine at a time and the dosage is to be of the correct size/smallness in correspondence to the patient’s disease state (O’Reilly, 1996).

Homoeopathic philosophy recognises that there is an enlivening component within a human being, which governs feeling and function of the organism and keeps all parts in harmony; this is known as the vital force (O’Reilly, 1996). Alterations in the state of the being or that which is perceived as deviating from the former healthy condition are identified as symptoms of the disease (O’Reilly, 1996). These abnormal sensations and functions of the material organism manifested in disease are considered to be the result of a derangement of the vital force by morbid influence (O’Reilly, 1996). It is the restoration of the vital force through homoeopathic treatment which restores health to the organism and allows for self-healing (O’Reilly, 1996).

2.2.2 THE HOMOEOPATHIC APPROACH

The practice of homoeopathy sets itself apart from allopathic medical practice primarily through its philosophical approach to disease. In homoeopathy, disease and sickness are seen as originating beyond the material form in which they present and it is understood that removing the material presentation of a disease does not remove the disease process or cure the sickness (Kent, 2007). With this understanding, the homoeopathic physician approaches illness with the intention of improving health by restoring healing mechanisms within the organism. This may be compared with allopathic medicine which attempts to correct or moderate disease processes through the use of chemical, hormonal or surgical interventions (Kent, 2007; Swayne 1998).

Homoeopathically relevant symptoms are those which individualize the disease state of the patient; it is important that general, mental and particular symptoms of the individual are considered (Swayne, 1998). By comparison allopathic prescriptions are based on clinical diagnoses and symptoms which are characteristic of a particular disorder and are important by conventional standards in the identification and treatment of that disorder (Swayne, 1998).

The homoeopathic approach is a holistic and individualized approach which understands, respects and supports the dynamic healing mechanisms of the body in the most gentle and appropriate manner possible so as to restore health as quickly and effectively as possible with the least disadvantage to the individual (O'Reilly, 1996; Swayne, 1998).

2.2.3 HOMOEOPATHIC REMEDIES

Homoeopathic remedies are prepared from a variety of natural substances which are reduced to their homoeopathic form through potentization (O'Reilly, 1996; Swayne, 1998). According to the doctrine of drug dynamization, potentization allows the latent medicinal properties of the substance to be elicited from the crude substance (O'Reilly, 1996). Potentization is a process of serial dilution and

succession or trituration (O'Reilly, 1996; Swayne, 1998). Dilution with succession, a manner of vigorous shaking, is used in the potentization of soluble substances (O'Reilly, 1996; Swayne, 1998). Trituration is the process of potentization of insoluble substances; where the substance is processed with lactose powder to produce a triturate (O'Reilly, 1996; Swayne, 1998).

Homoeopathic remedies are commonly dispensed as impregnated lactose-based granules/pillules/powders/tablets. These lactose based remedies are taken orally and are sweet tasting and white in colour.

2.3 OVERVIEW OF PUBLIC HEALTHCARE IN SOUTH AFRICA

In South Africa, the Health Professions Council of South Africa (HPCSA) and the Allied Health Professions Council of South Africa (AHPCSA) are the respective statutory bodies established to represent and oversee the provision of allopathic and complementary healthcare services to the public. The South African public healthcare system provides healthcare services at public healthcare facilities and primary healthcare clinics distributed throughout the country. Complementary healthcare services are not included in the public healthcare system of the country and exist almost exclusively in the private sector within South Africa.

Disparities in health and wealth in South Africa are considered to be amongst the widest in the world. Expenditures for the private and public healthcare sectors are currently roughly the same; this despite the public sector catering for a predominant 84% of the population who are generally poorer and previously disadvantaged communities (Naidoo, 2012). The South African Health Review of 2011 illustrates an increase in cost of primary healthcare facilities and hospitals and identifies that an insufficient number of healthcare workers are being trained to meet the current healthcare needs of the country (Gray, Vawda & Jack, 2011). At present the shortage of medical professionals within the public healthcare system in South Africa means that medical personnel are struggling to meet current healthcare demands (Kautsky & Tollman, 2008). Daviaud and Chopra

(2008) highlight the insufficient number of healthcare workers within the South African healthcare system and the challenges around the poor distribution of healthcare workers within the system, in particular in rural areas. The study identifies an absence of doctors visiting clinics or that too few doctors visited clinics as required; reflecting that current systems operate with only 7% of the required number of doctors and that wide variation in staffing levels between facilities and across districts results further in inefficient use of staff (Davaiud & Chopra, 2008). The consequence of challenges facing the South African healthcare system is that patients seeking care from public healthcare facilities are often turned away and further reports suggest that in rural areas peripheral clinics are not only understaffed but also often do not have pharmaceuticals (McIntosh, 2008).

Commonly known as the quadruple burden of disease, South Africa faces the additional challenge of a huge burden of disease consisting of HIV/Aids and TB, maternal and childhood diseases, non-communicable diseases and violence and injuries (Naidoo, 2012). Almost 17% of the world's population living with HIV/Aids reside in South Africa. The South African healthcare system currently offers the largest antiretroviral treatment programme in the world however despite this only 40% of eligible adults in the country are receiving the treatment (Benatar, 2013). High burden of disease coupled with increasing demand on public healthcare services and limited material and human resources available are the realities facing the current public healthcare system (Benatar, 2013; Kautsky & Tollman, 2008).

In KwaZulu-Natal (KZN), there are serious concerns over the ability of the public healthcare system to manage current health needs of the province. KwaZulu-Natal faces the additional challenge of being the second most densely populated province in South Africa accommodating 21.4% of the total population of South Africa; with almost 90% of this population being uninsured (KwaZulu-Natal Department of Health, 2010). High vacancy rates for critical skills, high burden of

disease, inadequate resources and increasing demand on facilities further compromise healthcare provision in the province (KwaZulu-Natal Department of Health, 2010). The KZN Department of Health recognises the implication which high workload and demand on healthcare professionals has on professionals and healthcare service delivery. The KZN health strategic plan 2010-2014 identifies the lack of appropriate staffing norms, ineffective recruitment and retention strategies and poor management capacity as components of human resource management which need to be strengthened.

The South African Department of Health recognises the need to further develop the existing public healthcare system so that the adequate provision of healthcare services becomes a reality for all members of the public (Department of Health, 2012). The Department of Health has embarked on the implementation of a financing system, the National Health Insurance (NHI), in order to overcome the challenges facing the healthcare system and to ensure the provision of equitable and essential healthcare to all South African citizens (Department of Health, 2012).

Bentaar (2013) suggests that the cost of healthcare and associated benefits for all patients accessing healthcare within the country has been significantly impacted by the digression of healthcare provision away from socially valued services to marketable commodities. With limited material and human resources; meeting the NHI objectives may be exceptionally challenging and take decades to accomplish (Benatar, 2013). Benatar (2013) acknowledges that whilst basic access to healthcare is a highly desirable goal; expanding access through the implementation of the NHI may only be a part of the solution to achieving equity in health outcomes and suggests that the greater social context of the country must be considered more closely in meeting this end. Identifying and providing socially valued services may be important in meeting healthcare needs of the public within the limitations of the current healthcare system and social context of the country.

2.4 HOMOEOPATHY IN PRIMARY HEALTHCARE IN SOUTH AFRICA

Homoeopathy is recognised as an allied health profession in South Africa and regulated under the AHPCSA. The AHPCSA was established, in accordance with the Allied Health Professions Act no. 63 of 1982, in order to monitor and regulate all allied health professionals. The role of the AHPCSA is primarily to protect the public against illegal and fraudulent behaviour as only practitioners registered under the council, who have legitimate qualifications, are permitted to practice in the country.

Professional homoeopathic training is offered at either The University of Johannesburg (UJ) or The Durban University of Technology (DUT) and is the only academic qualification in South Africa approved and recognised by the AHPCSA. Legislation dictates that homoeopathic practitioners practicing in South Africa must possess the accredited qualification and be registered with the AHPCSA in order to practice in the country. Foreign qualifications meeting AHPCSA education standards may be approved on application to the AHPCSA.

Educational standards for homoeopathy in South Africa are closely aligned to those of medicine and are recognised internationally for excellence (Durban University of Technology, 2012). The qualification entails a five year full-time Masters Degree (M. Tech. Hom.) and subsequent completion of a Masters dissertation (Homoeopathic Association of South Africa, 2012). Efforts are currently being undertaken by the Homoeopathic Association of South Africa and the AHPCSA to establish an internship program for graduates in order to further facilitate training and the establishment of the homoeopathic profession with South Africa.

The scope of homoeopathic practice as described in the Allied Health Professions Act no. 63 of 1982 is extensive. Legally recognised as a primary healthcare provider the homoeopathic practitioner is authorised to diagnose and

treat medical conditions including physical and mental diseases, as well as prescribe and dispense appropriate treatment.

In South Africa, homoeopathy has become an increasingly recognised and utilised form of complementary medicine within the private sector (Caldis, McLeod, Smith, 2001). The increased use and interest in homoeopathy by South African consumers as illustrated by Cladis *et al* (2001) is supportive of the therapeutic value of homoeopathy as a healthcare modality.

2.5 HOMOEOPATHY IN PRIMARY HEALTHCARE WORLD-WIDE

Homoeopathy is recognised internationally as a complementary and alternative healthcare approach. It is a system of medicine which has been subject to marginalization as a result of mainstream allopathic medical dominance in healthcare around the world (Prasad, 2007). Despite the challenges facing marginalized medical systems (Martin, 2004) homoeopathy continues to flourish in many countries around the world and has made a significant contribution to plural healthcare systems (Rossi *et al*, 2010).

International standards for homoeopathic practice have considerable variance according to governing legislation and regulations within the country. Similarly, the integration of homoeopathy into public healthcare systems around the world is observed according to varying governmental policy, systems and values.

In Europe standards for homoeopathic practice differ between Member States of the Union. Ten countries within the EU, including; Armenia, France, Germany, Israel, Lithuania, Luxembourg, Netherlands, Poland, Romania and the United Kingdom have incorporated homoeopathy into their public healthcare system (ECCH, 2014). Whilst in India the Indian Government acknowledges the preventative, promotional and curative role of Indian Systems of Medicine and homoeopathy in healthcare; with efficacious treatment and cost effectiveness being key components for their inclusion in the public healthcare strategy of the

country (Ministry of AYUSH, 2014). Public health developments in the region of Tuscany, Italy have encouraged the use of natural medicine as a means to reducing pharmacological dependence within the community and have found great success in the level of integration achieved with homoeopathy and other complementary medicines (Rossi *et al*, 2008). In Cuba, health co-operations with the Tuscany Region have been central to the integration of homoeopathy into the public health system of the county (Rossi *et al*, 2010). The utilisation of homoeopathy as an integrated public healthcare service is being recognised internationally for its value in establishing sustainable healthcare systems, and presenting a plausible solution to healthcare challenges faced by developing countries (Rossi *et al*, 2010).

2.6 HOMOEOPATHIC PRIMARY HEALTHCARE CLINICS

In Durban, KwaZulu-Natal, the Durban University of Technology has been instrumental in the establishment of two satellite, homoeopathic primary healthcare clinics which provide cost-free primary healthcare to the public; namely Ukuba Nesibindi Homoeopathic Clinic (UNHC) and Kenneth Gardens Homoeopathy Clinic (Erwin *et al*, 2012; Smillie (2010). UNHC was established in 2004 through collaborations between Life-Line South Africa and the DUT (Smillie, 2010). The clinic operates as a satellite clinic to the Durban University of Technology Homoeopathy Clinic and is located on the 3rd floor of the Ukuba Nesibindi Life Line House, in Warwick Junction (Smillie, 2010). UNHC is run by 4th and 5th year homoeopathy students under the supervision of a qualified homoeopathic clinician; and open Monday, Wednesday and Friday afternoons between 1pm-4pm. An audit of the clinic showed positive findings related to the growth of the clinic since its inception in 2004 (Smillie, 2010).

2.7 KENNETH GARDENS HOMOEOPATHY CLINIC

2.7.1 Kenneth Gardens Community

Kenneth Gardens Municipal Housing facility is located in Umbilo, Durban, KwaZulu-Natal and is Durban's largest municipal housing estate, providing subsidised housing to approximately 1500-1800 residents (Erwin *et al*, 2012). Placement in the estate is discerned according to economic need and designated primarily to families supporting members with physical/mental disablement (Erwin *et al*, 2012). The community struggles with many socio-economic problems; from alcohol and drug abuse to domestic violence, poor education and unemployment; with the added high mental/physical disablement amongst the population (Erwin *et al*, 2012).

The gradual withdrawal of state services managing social, medical and welfare problems at the Kenneth Gardens Estate has meant that these socio-economic problems are largely unaddressed and being left to deteriorate. Healthcare services formally provided to members of the Kenneth Gardens community have been drastically altered. The residents of Kenneth Gardens formally accessed public healthcare services at King Edward Hospital which is within walking distance of the estate. With the recent transition in public service provision, Kenneth Gardens resident's now access Wentworth Hospital for healthcare services; a public facility which is approximately 20km's away (Erwin *et al*, 2012). Given the poor socio-economic state of the Kenneth Gardens community this alteration in service provision has had a direct impact on healthcare accessibility for the residents.

2.7.2 Senzokuhle Home Based Care

In 2009, a group of woman from Kenneth Gardens started Senzokuhle Home Based Care (Erwin *et al*, 2012). The volunteers of this non-profit organization provide informal home-based care for residents of the estate in need of assistance with daily activities from cooking and cleaning to wound dressing, therapeutic massage and accompanying residents on hospital visits (Erwin *et al*,

2012). The women of Sensokuhle play an instrumental role in the facilitation of healthcare and healthcare service provision to the residents of the Kenneth Gardens estate and are invaluable in the operation of the Kenneth Gardens clinic.

2.7.3 Kenneth Gardens Homoeopathy Clinic

Recognizing the plight of the Kenneth Gardens community and the need for intervention; the University of KwaZulu-Natal (UKZN), Community Development Department has become intimately involved at Kenneth Gardens. UKZN undertook partnership with a range of organizations in the development of an intervention and research program with the Kenneth Gardens residents. A comprehensive survey undertaken at the onset of the project revealed that access to healthcare was of greatest concern to the residents of Kenneth Gardens (Erwin *et al*, 2012). The intervention program set about establishing a primary healthcare facility within the grounds of the estate in order to address the healthcare needs of the community (Erwin *et al*, 2012). The partnership between UKZN, Community Development Department and the DUT, Department of Homoeopathy resulted in the establishment of the Kenneth Gardens Homoeopathy Clinic, which has been operational since 2012 (Erwin *et al*, 2012).

The Kenneth Gardens Homoeopathic Clinic offers the services of 4th and 5th year student homoeopaths who practice under the supervision of a qualified homoeopath, Dr Ingrid Couchman (Erwin *et al*, 2012). The clinic operates from the Kenneth Gardens community hall and is available once a week, every Wednesday, between 9am-12am. Privately funded by the DUT, the clinic provides residents with cost-free primary healthcare and homoeopathic medicines. Herbal medications are not dispensed at the clinic due to the high cost of herbal products. Erwin *et al* (2012) report that conditions treated at the clinic vary greatly however conditions most prevalent include; respiratory conditions, arthritis, hypertension and gastro-intestinal conditions.

Senzokuhle members are an integral part of the Kenneth Gardens clinic providing assistance with patient administration and management, as well as mediating isiZulu translations and providing nursing aid where necessary (some members possess nursing assistant qualifications enabling them to assist with basic wound dressing). Senzokuhle members often identify patients unable to attend the clinic and accompany the homoeopathic doctor and students on home-visits.

In this way Senzokuhle plays an important role in the communication between community members and the homoeopathy clinic and the integration of services offered at the clinic into the community. An informal case study of the Kenneth Gardens Clinic indicates that the clinic has received a high level of responsiveness from the community (Erwin *et al*, 2012).

2.8 LOCAL AND INTERNATIONAL LITERATURE RELATED TO PATIENT PERSPECTIVES ON HOMOEOPATHY

Studies conducted locally considered many aspects of homoeopathy in the South African context and provided a platform of information supporting the credibility, viability and success of homoeopathy in South Africa (Forster 2007; Herr, 2005; Smillie, 2010; von Bardeleben,2009). A clinical audit of the Ukuba Nesibindi homoeopathic clinic was conducted by Smillie in 2010. Ukuba Nesibindi homoeopathic clinic is a satellite clinic to the DUT, Department of Homoeopathy and is located in a public health setting in Warwick Junction, Durban. The results of this audit illustrated the relative success of the clinic since its establishment in 2004. The audit reflected a significant increase in patient numbers at the clinic since its establishment in 2004 and that a significant 60%, or more, of patients returned for one or more follow-up consultations (Smillie, 2010).

In the private sector, research conducted with regard to patients' perception of homoeopathy illustrated the perceived value of the homoeopathic service and patient usage of homoeopathy within the private sector. Von Bardeleben's (2009) perception survey of parents of children 3-7 years of age revealed that 37.5% of

respondents seek homoeopathy as their first choice in treatment, 37.6% viewed it as a supportive medicine and 40% as preventative medicine. Positive findings were also established in the assessment of patient satisfaction at two private homoeopathic clinics in South Africa; the Durban University of Technology Homoeopathic Day Clinic and the University of Johannesburg Homoeopathy Clinic (Forster, 2005; Herr, 2008). Forster (2005) noted that patient satisfaction with homoeopathy was linked to the affordability of the intervention, quality of the physical examination, positive provider qualities of friendliness and approachability and health outcomes related to the treatment. Herr (2008) confirms that friendliness and approachability of the homoeopathic provider contributed to high levels of patient satisfaction. Additionally, research by Harripershad (2009) and Von Bardeleben (2009) both indicated that the majority of their participants were of the opinion that homoeopathy should be integrated into clinics and hospitals in South Africa.

International research illustrates the potential value of homoeopathy as an integrated public healthcare service. Elio *et al*, (2014) showed a direct relation between patient treatment with homoeopathy and the reported improvement of symptoms in a variety of chronic and recurring diseases which had previously been treated with conventional medicines. The study results indicated that 47% of patients found major improvement or even resolution with homoeopathic treatment; with a low 10% of patients finding no results with treatment. The study findings suggest that the younger the age of the patient the greater the success in treatment outcomes and also that longer treatment appeared to yield better results. The research further acknowledged the potential role of homoeopathy, as an integrated public healthcare modality, in ensuring safety and equity in access for patients. (Elio *et al*, 2014).

In Czech, research illustrated that homoeopathy has become firmly integrated into primary healthcare; this despite poor economic conditions and poor public support (Krizova, Byma, 2014). A community of Czech general practitioners (GP's) (approximately 20% of GP's practicing in Czech) practice homoeopathy

as an additional form of medical care; Krizova *et al* (2014) indicated that these GP's practice of, experience with and attitude toward homoeopathy did not correlate with conventional socio-demographic variables (Krizova *et al*, 2014). Instead the study concluded that practitioner experience, practice of and attitude toward homoeopathy was most likely associated with clinical factors, along with life-style and individual values and suggested further research into factors predicting use of homoeopathy by Czech GP's (Krizova *et al*, 2014). This research is of significant interest as it supports a qualitative enquiry of homoeopathy as a means of establishing an understanding of the utilisation of homoeopathy and demonstrates the relative value of homoeopathy to conventional allopathic practitioners in the Republic of Czech.

International research provides comparative information for the qualitative study of homoeopathic care. A study conducted at the Glasgow Homoeopathic Hospital presents qualitative data on the homoeopathic consultation with principal findings indicating that patients placed great value on the holistic approach taken by homoeopathic doctors at the hospital (Mercer and Reilly, 2004). The research further illustrated aspects of the homoeopathic consultation, according to patient perception, which were found to be important to patients. The study concluded that the time made available for consultation, the empathy which the doctor exhibited toward the patient, doctor-patient discussions and shared decision-making, and the ongoing therapeutic doctor-patient relationship were sought-after factors of care offered in a homoeopathic consultation (Mercer *et al*, 2004). The Glasgow Homoeopathic Hospital is an integrated complementary and orthodox National Health Service facility in the United Kingdom. In a study conducted at this institution around patient perspectives, participants expressed demand for integration of complementary therapy in primary healthcare (Mercer *et al*, 2004). The study also highlights that participants felt that orthodox practitioners should be taught the holistic, "whole-person" approach used in consultations at the GHH (Mercer *et al*, 2004).

Other studies on patient perspectives of homoeopathy suggest that homoeopathy was sought when mainstream medical care was perceived to be unsatisfactory (Avina & Schneiderman, 1978). Dissatisfaction was noted with regard to the negative side effects experienced with mainstream medical treatment, lack of preventative medical counselling and lack of health education (Avina & Schneiderman, 1978). The study notes that 74% of respondents seeking homoeopathic care suffered from chronic disease (Avina & Schneiderman, 1978). Positive reasons for choosing homoeopathic care included; seeking improved health education, seeking improved health maintenance and disease prevention, seeking dietary consultation and being consistent with personal principles and beliefs related to their treatment regimen (Avina & Schneiderman, 1978).

2.9 RESEARCH RELATED TO HEALTHCARE UTILISATION AND BEHAVIOUR

2.9.1 The importance of healthcare utilisation and behaviour

The ever present need for healthcare around the world is in itself an important reason for understanding healthcare behaviour and utilisation. Healthcare utilisation behaviour provides insight into multiple factors influencing the use of a healthcare service within a population. This knowledge may be useful to healthcare organizations in determining provision of healthcare services; for the general management of healthcare within a population or in addressing diversity in the needs and values of a population according to cultural and social influence (Rebhan, n.d.).

2.9.2 Healthcare utilisation behaviour models

When considering patient health seeking behaviour and healthcare utilisation, it is apparent that the decision-making process which a patient follows is dynamically influenced by an extensive range of factors (Rebhan, n.d). Many factors influence the patient's choice to seek healthcare and their assessment of

healthcare options such as culture, age, gender, knowledge, perception, economics and healthcare access (Rebhan, n.d.). Ultimately determining which factors are most influential in the patients decision to utilize a healthcare service is difficult to distinguish. The development of healthcare utilisation theories and models assist in understanding the complexities related to healthcare utilisation (Rebhan, n.d.).

Healthcare utilisation and behaviour models provide a framework guiding researchers in identifying variables, defining the relationship between these variables and evaluating factors related to the access and utilisation of healthcare services (Aday & Anderson, 2005). These models may be applied to a number of different study types, from descriptive and analytical to experimental and quasi-experimental (Aday *et al*, 2005). For descriptive studies the main focus is on profiling variables specific to the population or subgroup under study, into the model (Aday *et al*, 2005).

Four main types of conceptual models have emerged in the description of healthcare utilisation behaviour; these include i.) models of patient decision making ii.) the health belief model iii.) economic models of the demand for medical care iv.) and the behavioural model of health service utilisation (Aday *et al*, 2005; Aday, 1993; Grossman, 1972).

The behavioural model of health service utilisation focuses on access to and use of healthcare services and is most noted for its comprehensiveness and applicability to health service research (Aday *et al*, 2005; Aday, 1997; Anderson, 2005). First developed in the 1960's, the model has undergone four phases of alteration.

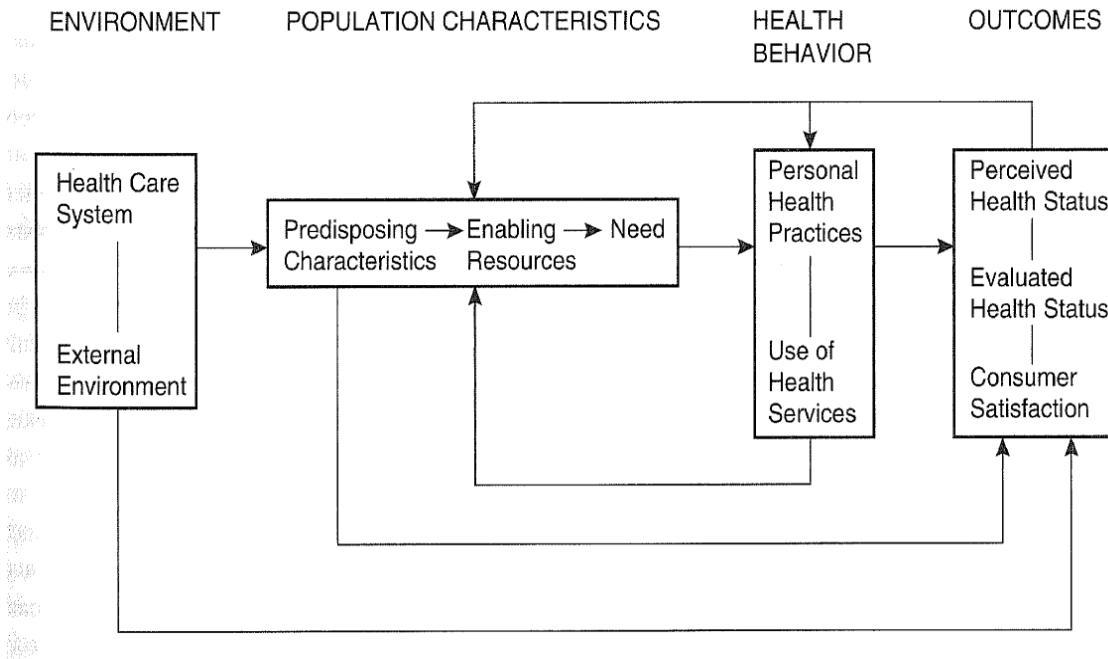


Figure 1: Anderson's Phase 4 Model of Health Service Utilisation (Aday, Anderson, 2005)

Initially Anderson's model of health service utilisation illustrated health service utilisation as a function of three variables (Aday *et al*, 2005):

- 1.) Predisposing variables; which include demographic, social structure factors and health beliefs. These variables contributed to the predisposition of the person to utilize a healthcare service.
- 2.) Enabling variables; which include the individual's resources and the resources available to the individual within the community. These variables either enable or impede the person in health service utilisation.
- 3.) Need variables; as perceived by the individual themselves or by providers assessing the individuals need for care.

In the 1970's Anderson's model was expanded to include the healthcare system, satisfaction and health service use (Aday *et al*, 2005). The healthcare system was recognised for its role in the delivery and distribution of health services according to organisational and financial factors (Aday *et al*, 2005). Patient

satisfaction was included as a subjective indicator in healthcare utilisation (Aday *et al*, 2005). Furthermore the model now recognised that a number of healthcare services were available and delineated use according to service type and purpose (Aday *et al*, 2005; Rebhan, n.d.).

Most recently the model has been further refined to incorporate variables of the external environment (defined as being physical, political or economic factors) as well as of personal healthcare practices; both are recognised for their influence in health service utilisation and health outcomes (Aday *et al*, 2005). Furthermore perceived and evaluated health status variables have been included with consumer satisfaction in the identification of health outcomes (Aday *et al*, 2005). As depicted in Figure 1, feedback loops have been incorporated into the model to illustrate the interrelation of health outcomes variables with predisposing factors and perceived need as well as health behaviour (Aday *et al*, 2005).

2.9.3 Limitations of healthcare utilisation behaviour models

One of the main shortfalls of healthcare utilisation models and theories is their limited ability to be generalized (Rebhan, n.d.), (Aday *et al*, 2005). Critics recognise that some predictors of healthcare utilisation are not adequately considered by models and are an additional source of variance. Some of these factors identified include; the impact of prior experience of illness on healthcare utilisation, the effect which different types of disease have on healthcare utilisation and the utilisation of a healthcare service in maintaining healthy lifestyles (Rebhan, n.d.)

The limitations of healthcare utilisation models has also been recognised relative to their ability to fully consider utilisation of varying types of healthcare service and further in predicting the utilisation of different services (Rebhan, n.d.). Aday and Anderson (2005) recognise the importance of the extension of utilisation variables within the healthcare utilisation behaviour model. In their critique of the model, Aday and Anderson (2005) suggest exploring the interrelation between

the types of services utilized and how utilisation related to patient satisfaction and health outcomes.

Historically research focus in healthcare utilisation has been restricted to biomedical models of medicine with the result that healthcare utilisation models which have been established have limited capacity to consider the role of alternative and traditional medicines (Rebhan, n.d.). As such these models are limited in their ability to illustrate and predict healthcare utilisation of plural medical systems.

2.9.4 Relevance of healthcare utilisation model's to the study

The study's conceptual model was constructed according to the guiding framework of Anderson's Phase 4 Model of Health Service Utilisation (Aday *et al*, 2005). Themes identified in the analysis of study data correlated with the variables distinguished in Anderson's model of health service utilisation and for this reason the main framework of Anderson's model was maintained in the development of the study's conceptual model. Variables were profiled accordingly and distinguished factors identified by the study which were relevant to the study population. Limitations of Anderson's model in its ability to simultaneously depict healthcare utilisation of different types of healthcare services (allopathic and alternative) within plural healthcare systems meant that adaptations were necessary in the study's conceptual model; as findings identified in the study did not fit into variables defined by Anderson's model.

2.10 THEORETICAL FRAMEWORK

The study draws on a social constructionist theoretical framework. Social constructionist theory shifts the focus from individual processes in the construction of knowledge to instead looking at the socio-cultural context within which the individual is located. The socio-cultural context is viewed as

fundamental to understanding society and how knowledge is constructed (Burr 1995). This theoretical perspective views 'reality' as socially constructed and looks at the ways in which individuals and groups are involved in this construction. According to social constructionist theory, a social construct is an idea, which is perceived as the norm to those who accept it, but which is actually an invention or artefact of that particular society.

Many social factors contribute to shaping understandings and assumptions towards health, illness and healing. Social constructionist theory is useful for making sense of health and illness and is a theory used extensively in medical sociology (Brown, 1995). The social constructionist perspective considers the role of social influences on the development of understandings and assumptions about health and illness and provides insights into these processes (Brown, 1995). As described by Brown (1995), after the initial stages of illness and diagnosis, secondary factors of treatment, outcomes and illness experience recursively affect the social construction of a condition. The research draws on the theoretical framework of social constructionist theory and thereby explores the role of homoeopathy in the social construction of illness amongst individuals within a particular community.

CHAPTER 3: RESEARCH METHODOLOGY

This chapter outlines the research methodologies applied to the study.

3.1 STUDY DESIGN

A qualitative study design was used for the study in order to uncover knowledge and provide insight into the subjective perspective of participants through generation of contextually rich data (Glaser and Strauss, 1967; Schreiber and Stern, 2001; Holloway et al, 2010). Qualitative research in the field of healthcare is a process of enquiry into how people make sense of their experiences and suffering and is useful in attaining perspectives on care and treatment within a healthcare system (Holloway et al, 2010). Grounded theory is an analytical method used in qualitative research, which systematically generates theory based on the data collected throughout the study (Holloway et al, 2010). The dynamic process of grounded theory is suited to research for which there is insufficient knowledge or theory existing on the phenomenon under study (Glaser and Strauss, 1967; Schreiber and Stern, 2001).

3.3 STUDY SITE AND POPULATION

Setting:

The study was conducted at the Kenneth Gardens Community Clinic located in Selbourne Road, Umbilo, Durban, South Africa. The availability of primary healthcare from two different medical modalities, (homoeopathy and allopathy) is a distinctive feature of the healthcare available to the Kenneth Gardens community. Until recently, the community of Kenneth Gardens has relied solely upon allopathic public healthcare service provisions. The introduction of a privately run homoeopathic clinic has meant that the community now has an additional healthcare resource available to them.

Study Population:

The study population consisted of patients attending the Kenneth Gardens homoeopathy clinic who met the required inclusion criteria, as stipulated below.

Inclusion criteria:

- Patients of Kenneth Gardens Clinic utilizing services of student homoeopaths.
- Patients must have had one or more follow-up consultations at the Kenneth Gardens Homoeopathy Clinic.
- Patients must be 18 years or older.

3.4 DATA COLLECTION METHOD

3.4.1 Sampling

Study participants who met the required inclusion criteria and who provided informed consent were consecutively recruited and enrolled into the study. In-depth, semi-structured interviews were conducted for a total of 14 participants. As appropriate to qualitative enquiry, the final sample size was determined by data saturation during the course of the study (Holloway *et al*, 2010). On the day of interviewing, a purposive sample of participants was recruited from patients attending the Kenneth Gardens Homoeopathy Clinic. Every consecutive patient, who was willing and who met the inclusion criteria (as specified above) was selected for interviewing until data saturation had been achieved. Research interviews were conducted during clinic operating hours, between 9h00 and 12h00 every Wednesday mornings.

3.4.2 Recruitment and interview procedure

Patients were approached by the researcher, informed of the study being conducted and offered the opportunity to voluntarily take part in the research.

Interviews took place at the convenience of the participant either before or after their visit to the clinic and were conducted at an interview station situated in the gardens outside the Kenneth Gardens Community Hall (clinic venue) as this was the most private venue which could be accessed.

Prior to the interview, willing participants who met the inclusion criteria received a letter of information (Appendix A/ Appendix B), and were required to provide written informed consent (Appendix F/ Appendix G). Interviews were between 20-30 minutes long.

3.4.3 Data Collection

Interviews were conducted by the researcher with the aid of an isiZulu translator who had background experience in qualitative interviewing. The translator facilitated communication between the researcher and participants in all non-English interviews. The researcher undertook interviews with the assistance of an interview guide (Appendix C, D). The approach to interviewing was flexible with the use of probes to extend information in areas of interest to the study. The interviews were audio-recorded in order to accurately preserve the participant's words and later transcribed and translated.

Observational ethnographic data was also collected by the researcher on an on-going basis; this includes description of the clinical context, types of clientele and healthcare workers and non-verbal behaviour of interviewees. This data was useful in enhancing the understanding of participant experience beyond verbal explanation and was recorded in the form of field-notes by the researcher as soon after the interview as possible (Padgett, 2012).

Data saturation takes place when each category is conceptually dense, when variations in data are identifiable and explainable, and when no new data relevant to the existing categories emerges during collection (Strauss and

Corbin, 1998). Data collection ceased once data saturation had been achieved at 14 interviews.

3.5 DATA ANALYSIS

Grounded theory was used for the analysis of research data. In accordance with grounded theory; analysis was conducted as soon as the first interview had been transcribed from audio recording (Bluff, 2005). Data analysis was an iterative process and was systematic and continuous; there was constant comparison in order to identify similarities, differences and connections between the data (Holloway *et al*, 2010). The grounded theory method of analysis allowed for the identification of concepts and themes within the research (Holloway, *et al*, 2010).

The process of data analysis using grounded theory was achieved through three phases of coding. The coding of data began with *open coding* (Strauss and Corbin 1998). Each sentence/incident was coded using keywords (Glaser and Strauss, 1967). Strauss (1987) refers to these codes as *in vivo* codes indicating that they should be suggestive of the participants' reality. Often, "in-vivo" codes which have been derived from the words of the participants are used (Bluff, 2005).

Axial coding was the next step in the coding process, connections between categories and sub-categories were identified in this process and a conceptual framework began to emerge (Bluff, 2005).

Following on from this, *selective coding* was utilized to link all categories and sub-categories to the core category and assisted in establishing an emerging theory (Strauss and Corbin, 1998). The *core category* is explained by Strauss and Corbin (1998) to be that category which is central to and linking of the data and which also accounts for variations in data.

Data analysed was manually coded for themes under the guidance of the co-supervisor. Codes and themes were independently derived by the researcher and co-supervisor and then compared against each other. Where there was no agreement, these concepts were discussed until consensus was reached.

3.6 DATA MANAGEMENT AND STORAGE

Data was collected and stored in a way which ensures that participant confidentiality was maintained throughout the study. Participant information was not recorded on any of the interviews, field notes or audio recordings. At the onset of the research, participants were assigned an anonymous identification code. A record of each participant's name and assigned code was held by the researcher only and stored in a locked drawer. This record was kept separate from the data collected in order to maintain participant confidentiality.

All data collected including interviews, field notes and audio recordings were kept secure by the researcher in a locked cabinet for the duration of the research and then stored in a locked office of research study personnel at Durban University of Technology, Homoeopathy department. The data will be destroyed after 15 years. Only those conducting the research were allowed access to the stored data. No patients will be named in related reports/articles/publications.

3.7 MECHANISMS TO ASSURE STUDY QUALITY, CREDIBILITY AND TRUSTWORTHINESS

Strategies employed by the researcher were crucial to ensuring credibility and trustworthiness of the data collected and subsequent theory generated.

In order to adequately preserve the words of the participant each interview was audio-recorded. In the event that information/translations on interview transcripts require verification the audio-recording could be cross-referenced.

The researcher and an isiZulu translator conducted interviews. The translator assisted with translations between the researcher and isiZulu-speaking

participants. This allowed each participant the option of conversing in the language they were most comfortable with, and it ensured each participant the freedom to express themselves fully and adequately during the interview.

The continuous and systematic process of data analysis in grounded theory provided the researcher with feedback on the quality of data being collected; hence issues of concern arising in this area were identified during the research period and dealt with accordingly.

The interview data were triangulated in two ways, methodologically and by using more than one investigator to evaluate the findings (Guilon, 2002). Methodological triangulation of data served to further establish validity of the study. Within-method triangulation of interview data with observational data provided depth to the analysis of the information (Holloway *et al*, 2010).

Peer review was sought from the co-supervisor who was qualified and competent in the field of qualitative research procedures and provided insight into factors about which the researcher may have been concerned. This process was useful in detecting possible bias and improper subjectivity from the researcher and in maintaining the integrity of the study (Holloway *et al*, 2010). As a further measure towards ensuring quality of data, this study provides a clear description of the study context, the data collection and analysis process, as well as a discussion of the personal characteristics of the researcher and disclosure of any bias that she may hold (Mays & Pope, 2000). In this way, it is possible for the readers to make their own decisions about the quality of data and whether it is appropriate to transfer the research findings across into another setting.

Since qualitative research focuses on the individual's perspective, it often runs the risk of being subjective. Practicing reflexivity and following systematic procedure throughout the analysis process were both useful strategies to balance subjectivity. Reflexivity was applied throughout the research process.

3.8 ETHICAL CONSIDERATIONS

Three basic ethical principles were adhered to at all times, the principles of respect for persons, beneficence and justice. Respect for persons refers to respecting their autonomy and that if they have reduced autonomy, respect that they are entitled to protection. Beneficence refers to doing no harm and to giving consideration to the potential benefits and/or risks that the individual may encounter as a result of this research. The researcher sought ways to maximize any possible benefits that the research may embody for research participants while still upholding the principle of justice. Of utmost importance was the maintenance of the safety, confidentiality and anonymity of all the participants, both in the data analysis and discussion and dissemination of findings.

In addition, appropriate referrals were made if the participant raised issues or questions that could not be addressed and were not in the medical scope of training of the investigator. This research refrained from coercive measures in the recruitment of participants.

Written informed consent was sought from all the participants (informed consent form attached in Appendix F and G).

Permission to conduct the study was sought from the Durban University of Technology Ethics Committee. The study commenced on ethics approval from this body, IREC 023/14.

Permission for the study to proceed was obtained, following ethics approval, from the community representative, Mrs Khanyisiwe Sibiyi as well as the relevant clinic authorities, Dr Ingrid Couchman (DUT representative) and Professor Monique Marks (UKZN representative). Permission letter is included in Appendix E.

CHAPTER 4: RESULTS

This chapter presents data collected from interviews with patients attending the Kenneth Gardens Homoeopathy Clinic. Concepts arising from the data were identified through manual coding, these concepts were then grouped into categories and sub-categories (Bluff, 2005; Glaser and Strauss, 1967; Strauss and Corbin, 1998). Final analysis through selective coding was applied to integrate categories and sub-categories and revealed emerging theory which is presented in the results under the main themes identified in the analysis (Strauss and Corbin, 1998).

The behavioural model of health service utilisation (Anderson, 2005) was used as a guiding framework to organize the emergent themes and adapted in order to demonstrate the relationship in health seeking behaviours between homoeopathic and allopathic care modalities. The themes identified through analysis are supported by excerpts taken directly from interview material.

The aim of the study was to:

Explore patient perception and experiences with receiving homoeopathic care in a PHC setting and to develop a conceptual model which illustrates the relationship between homoeopathy and allopathy as primary healthcare modalities, and identifies discerning factors which influence patient choice and preference relating to their use of these modalities within the public sector.

The results are presented as five inter-related groups of perception/experience which influenced participant choice and preference in their selection and use of primary healthcare services. The first section presents primary determinants of healthcare utilisation. The second section depicts context specific perspectives which participants identified as influential in their use of a healthcare service. The third section presents participant perception and experience of prior healthcare service use (health behaviours). The fourth section provides an account

perceived healthcare outcomes. Finally, the fifth section reflects on the concept of trust which emerged in participant narratives as a key underlying driver behind health behaviour and healthcare utilization.

Participant characteristics

The participant base of the study was derived from a sample of patients attending the Kenneth Gardens homoeopathy clinic. The table below illustrates demographic information of the study participants. The sample was comprised of older members of the community with a mean age of 61 years and with more than half of participants being pensioners. More than 70% of the study population were black African females.

Table 1: Participant characteristics

Sex (N=14)		
Male	4	28%
Female	10	72%
Age (N=14)		
Mean age	61.5 years	(range 29-79 years)
Ethnic grouping		
Black	10	72%
Coloured	2	14%
White	2	14%
Employment status		
Unemployed	5	36%
Pension	9	64%
Number of clinic consults		
>10 consultations	11	79%
>2; <10 consultations	3	21%

4.1 CONTEXT SPECIFIC FACTORS TO HEALTH CARE UTILISATION

4.1.1 PARTICIPANT EXPERIENCE OF HEALTHCARE SYSTEMS

Participant narratives highlight three main healthcare system factors that influenced service utilisation and health outcomes: service availability, lack of service integration and health care zoning.

Service availability

Participants reported that the limited opening hours of homoeopathic services at Kenneth Gardens was a significant factor determining their use of the facility. Many participants described that they would have to access other healthcare facilities if they required treatment on days that the homoeopathic clinic was not open:

“Coming to this clinic means it’s not an emergency cos it can wait ‘til Wednesday. If it’s an emergency you have to go somewhere which is available all the time. That’s the disadvantage; you don’t find it open all the time, only on Wednesdays at particular times.” (Female, 71 years old)

In contrast to allopathic facilities, the homoeopathic clinic was also described by participants as providing only limited healthcare services. Being accustomed to allopathic healthcare, participants expected that the homoeopathic clinic would provide similar services and medicines as participants had experienced in conventional clinics. Some suggested that the homoeopathic clinic should offer more services.

“I wish they have everything! Like an eye clinic and to do all these things, pap smear, all these things. I wish they have those things to be a full clinic.” (Female, 67 years old)

The following participant explains the benefit of having many services under one roof:

“Let’s say you have a severe headache. Now (the homoeopath) has treated you; when you come back you still have the complaint, sometimes they says let’s do this now let’s go for the scan. While (at the homoeopath) you come for that (headache), and if seeing that is still feeling the same [then] that is when the (homoeopaths) say oh let me refer you to the hospital. While (at the Hospital), they have got everything in the same place.” (Female, 70 years old)

Some participants expressed frustration toward the limited service at the homoeopathic clinic:

“But here we don’t have everything here like [name of public Hospital] you see. They don’t test us for everything, this is what I hate, there are the things that they don’t treat. Lets take for instance when I was here for this wound, they don’t have the treatment for this wound. They use to clean me and then they just put the bandage on, and then they give me the powders. They don’t have the injection.” (Female, 53 years old)

Another participant identified key services in allopathic medicine which were able to address community needs:

“Yes can’t come here maybe for, like I said maybe immunization... And some services that you will find in government hospitals...Ya, and the checking for HIV and AIDs, all those, they don’t have those here... That’s the problem because many people here they need those services, immunization, contraception, HIV testing and counselling and for cancer.” (Female, 43 years old)

Despite perceptions of limited services, participants still frequented the homoeopathic clinic regularly and showed preference for homoeopathic treatment. These same participants also accessed allopathic facilities when necessary, often on instruction from their homeopathic provider for needs which the homoeopathic provider was not able to meet.

In contrast, some participants found that services offered by allopathic clinics were limited as the clinics were unable to dispense chronic medication prescribed to patients; patients were then referred to a hospital to collect their medication.

“...my medication I take it at [name of public Hospital]. They haven’t got all the medications (at the allopathic clinic). Yeah that’s why they transfer me to the hospital.” (Female, 61 years old)

In terms of public sector healthcare, participants commented that access was restricted by residential zoning. Residents of Kenneth Gardens had been reallocated to receive services from Wentworth hospital, a public facility which is significantly further away than King Edward Hospital, where they had previously been receiving care. Many participants described difficulties in accessing care due to this change in service allocation.

“It is far (to the public hospital) but the reason I am using it is because they don’t allow us in at [name of another public Hospital]. I used to go there while I was living at Umlazi, but since I am now living here, they don’t accept us.” (Female, 57 years old)

Another participant explains the difficulties she had encountered on attempting to access emergency services at hospital:

“The procedure was that once you came inside you had to see the sisters first. They are the ones that had to refer you to the doctors. It was early in the morning. They took my card, looked at it and then shouted, ‘How did you get in here! How did you get in here! We don’t want people who come from other places to come and fill our hospital. We don’t take any people here! I was already inside.’ (Female, 57 years old)

Perceived discontinuity of care between provider types

Many participants described the need for greater integration of both homoeopathic and allopathic services. Participants identified some perceived limitations of the homoeopathic clinic due to weak referral systems and poor presence in the public health community. The participant below describes her difficulty in acquiring allopathic assistance on referral from her homoeopath:

“Before (allopath providers) didn’t understand the referral from the homoeopath, in such a way that some of the patients which come from (Kenneth Gardens); unfortunately for them sometimes they chase them away... (The allopath providers) just act funny because of this referral letter, cos they don’t understand and then you start explaining “If you don’t understand let me give you the phone number for him” and then it’s ok.” (Female, 70 years old)

Participants observed a difference in the type of treatments available from the different provider types. Participants identified that the homoeopathic providers were unable to perform particular diagnostic tests and offered limited emergency care. Further they were unable to provide certain preventative treatments which were offered in allopathic clinics. Participants viewed the homoeopathic clinic as being insufficiently equipped to function as a full clinic and felt that it would be beneficial if allopathic services were integrated with the homoeopathic clinic, even though these services were available to them at other local clinics.

“Pap smears, all those things are not here, and we need the general services... If it’s together (homoeopathy and allopathy), it will work properly, because here they don’t (have) a clinic.” (Female, 43 years old)

“The challenge is that when you are here for your medication, you have to start all over and go to your hospital for your other medication. This is not yet a general clinic whereas we want it to be a general clinic where everything is done.” (Female, 57 years old)

4.1.2 OTHER FACTORS IMPACTING HEALTH CARE UTILISATION

External environmental barriers to healthcare utilisation were rooted in socio-economic inequities. Two key, interlinked factors were described: distance to the health facility and transport costs associated with travelling to the facility.

Distance

Participants reported that their healthcare services were situated at some distance from their place of residence which directly impacted their access of that service, especially if they were very ill at the time.

“It’s too far for me to travel.” (Male, 60 years old)

“... you’ll have to take two transports... if they are sick, they can’t go, they can’t walk on their own.” (Female, 70 years old)

Transport costs

Although both homoeopathic and public sector health care services are provided free of charge, participants expressed concern over the cost of the transport to get to their allocated Hospital:

“... I spend a lot of time (at the Hospital) and I have to use several transport systems. I have to pay a lot of money while I am unemployed.”

(Female, 57 years old)

The further away the service, the greater the costs incurred by the patient:

“... you’ve got to catch a bus or a taxi from here to Clairwood, from Clairwood you have got to go to Wentworth. That’s 2 different (road transports)... that’s a lot of money that you use on bus fares.” (Male, 60 years old)

One participant reported that when she was unable to pay transport costs to access public healthcare, she was forced to delay seeking out care until such time that the homeopathic clinic, which was more conveniently located, was open:

“But if you haven’t got money then you have to wait till Wednesday”

(Female, 71 years old)

4.2 FACTORS INFLUENCING HEALTHCARE UTILISATION

This section identifies predisposing and enabling factors influencing the participant selection and use of healthcare services as well as perceived need of service.

4.2.1 CLIENT PERCEPTIONS OF THE HEALTH CARE FACILITY

Lack of knowledge/availability

Participants reported that prior to the Kenneth Gardens homoeopathic clinic; homoeopathy had been a completely unfamiliar healthcare modality within their community.

“Not that they didn’t like it, they just didn’t understand about the homoeopathy. Even the word “homoeopathy”, most of the people they didn’t know about it. They just started to know when they see it and they are having it here, because it is now close to them.” (Female, 70 years old)

Limited public awareness of homoeopathy influenced participant perception of the homoeopathic clinic. Participants in the study reflected that their lack of knowledge and recognition of homoeopathy as a medical modality had negatively affected the perceived legitimacy and trust of the treatment.

“No, no it was my first time... I didn’t trust it...” (Female, 43 years old)

Even when participants began accessing homoeopathic treatment, the more established routes to health care continued to drive their health seeking behaviour. The participant below described a preference for homoeopathic medicine, but explained that she continued to access allopathic care out of habit:

“I have already been taking medication from [name of hospital] for arthritis. When I am sick I normally go there because I am used to going there.”
(Female, 57 years old)

Convenience

For many participants, the relative convenience of a service was a significant consideration related to their health seeking behaviour. For participants of the Kenneth Gardens community the close proximity of the homoeopathic clinic was significant in determining the convenience of the clinic.

“It’s nearer and you don’t have to pay bus fare. And when you’ve got no energy it’s easy cos you stay here.” (Female, 71 years old)

Other participants identified service related factors as contributing to the convenience of the clinic. The participant below describes that the service provided at the clinic was efficient and beneficial to her health:

“They help me and the second thing, they won’t take so long!”

(Female, 53 years old)

Another participant described the additional benefit of home visits provided by the clinic:

“The clinic is near us, because we don’t have any other clinic nearby. It is far away. This one is near us. Also we see the difference from the medication they give us. It helps us a lot. Also if you cannot get to the clinic, they visit you at home.” (Female, 57 years old)

Valued social networks

Social networks between community members were found to be an important factor facilitating the use of a healthcare service. Participants described that they communicated their experiences of the homoeopathic clinic with friends and family and most had recommended or been recommended to visit the homoeopathic clinic. Many of the participants in the study explained that they had sought healthcare from the homoeopathic clinic after hearing about how the treatment had worked for their friends and family.

The participant below describes how she had come to hear about the homoeopathic clinic:

“Like the other one who told me about this clinic she told me that she has got a pain in the legs, arms. They said that by taking these powders she is all right now.” (Female, 61 years old)

Another participant explained how through her social network others had come to learn of the homoeopathic clinic:

“Those that had arthritis used to ask me where I got help and I told them. So they came here and got help and they no longer have those illnesses. There are lots of them here who have testified of how their illnesses got cured.” (Female, 57 years old)

4.2.2 PERCEIVED HEALTH NEED

Perceived type of health need

Patient use of a healthcare modality related to the nature of the health complaint. For preventative healthcare treatments such as immunization or contraception participants explained that they would have to access public allopathic healthcare facilities as the homoeopathic clinic did not supply these services:

“The thing that I want at the government hospital or clinic is the injection maybe, if they give me the injection, it’s ok or to the private doctors.” (Female, 43 years old)

Participants indicated that injury and emergency care was best sought from public healthcare facilities as the homoeopathic clinic was not fully equipped to treat conditions of this nature. The participant below describes how she perceived the homoeopathic clinic to be inadequately equipped:

“But there are some of the things that (the homoeopathic clinic)...if you have got a wound maybe you have been hurt by something maybe, they don’t even have the bandages.” (Female, 43 years old)

Despite the apparent lack of facilities at the clinic participants still sought treatment from the clinic; as described by the participant below:

“Lets take for instance when I was here for this wound, they don’t have the treatment for this wound. They use to clean me and then they just put the bandage on, and then they give me the powders” (Female, 53 years old)

For many participants, homoeopathic treatment was utilized as an adjunctive treatment to their chronic allopathic medication. In cases of chronic disease, participants tended to report accessing both homoeopathic and allopathic care.

“I come for different types of illnesses. It happens sometimes that I come for flu and a headache, but I come mostly for arthritis.”(Female, 57 years old)

Participants explained that they utilized the homoeopathic clinic as a primary healthcare facility for all general and chronic complaints and relied on the clinic for referral if the complaint was beyond homoeopathic management.

“... if (the homoeopath) thinks you have to be referred to another G.P. then she writes a letter. If it’s more than she can manage then she writes you a letter, referral letter.” (Female, 71 years old)

Perceived urgency of health need

The one major factor determining the use of a healthcare service, relative to the nature of the complaint, is the perceived urgency of the health need. Participants expressed differing views regarding their access of homoeopathic and allopathic treatment. Many participants explained that given the limited availability of the homoeopathy clinic, they would be forced to seek other healthcare if the condition required urgent treatment.

“I go there (allopathic clinic) because this (homoeopathy) clinic comes only once a week. So if you get sick before then, obviously you have to go to the (allopathic) clinic. You can’t wait for next week.” (Female, 57 years old)

By comparison, a 67 year old woman explained how she would be inclined to wait and access treatment at the homoeopathic clinic rather than seeking allopathic treatment:

“Yea I’ll wait! Ya I wait till Wednesday, yes I wait. I tell the problem: ‘Sleep there, stay where you are, Wednesday is coming, I’m going to see the doctor’s.’ Really! I always say that!” (Female, 67 years old)

4.3 HEALTH BELIEFS AND PRACTICES

4.3.1 PERSONAL HEALTH CARE PRACTICE

Participants in the study described a range of healthcare services which they accessed to assist with their health needs. A number of themes arose during interviews which were directly related to participant health care behaviour.

These included dual access, complimentary care and retail pharmacy.

Perceptions and Experiences of Dual-access to care

Although many of the participants interviewed in the study demonstrated a clear preference for homoeopathic care, the most common perspective regarding access to the varying medical modalities was that dual-access was indeed necessary and of greatest benefit to the participant. The below participant expresses a definitive need for allopathic treatment despite his preference for homoeopathic treatment:

“Ya I’m receiving both. I’m receiving injections as well. Ya but the only reason why I go to the hospital all the time is because of the heart. I’ve got

an inflammation inside on the heart, so I need the injections to try and heal the heart.” (Male, 60 years old)

The participant further explained that allopathic treatment had not been able to assist him with his high blood pressure and that he had responded very well to homoeopathic interventions for blood pressure. Similarly another participant regarded both options of medical care as important and opted to utilize both despite her preferences:

“As I have said (homoeopathic) treatment is much better, but you don’t stop taking your other doctors treatment” (Female, 70 years).

Dual-access afforded patients multiple treatment options and as suggested by one participant when one is unwell it is useful to have more than one treatment approach available:

“Because when people are sick you just mix everything because when you are sick you don’t know what’s going to help you! That’s the thing!” (Female, 71 years old)

Perception and Experience of Complementary Care

Many of the participants involved in the study utilized the complimentary healthcare services provided at the Kenneth Gardens Clinic. Participants described how the different services offered at the clinic had been beneficial to them in the education and management of their health. One participant explained how the advice offered by the nutrition students was beneficial to her:

“With the nutrition there’s a lot you learn. Because of the pamphlets they have got, you read them carefully and you will find a lot of things you didn’t know and that allows you to have experience. Especially with the diabetic patient so you know exactly what it is...” (Female, 71 years old)

Participants reported that the Kenneth Gardens Clinic had been able to assist in the provision of their general needs.

“... there are other people that got wheelchairs out of this clinic, ... food parcel, you know” (Female, 43 years old)

Perception and Experience with Retail Pharmacy

Retail pharmacies were identified as an important healthcare resource utilized by study participants. Participants frequently described the use of pharmacist prescription and over-the-counter medication in the management and treatment of a variety of complaints. Many participants explained that they utilized their local pharmacy prior to accessing primary healthcare facilities.

“Well I get some (medication) down there or something for- you know for the nose or something, small cough, don't really do medicine for everything. I just don't, I don't run to the doctor for every small thing” (Male, 29 years old)

Other participants relied on pharmacy's to assist them when they did not receive adequate treatment from their healthcare provider:

“Because sometimes I take the medicines from the hospital- it doesn't help me. I end up to go to the pharmacy. Sometimes I am here, I took these powders, I can't feel better- then to the pharmacy again. Sometimes I take them and I feel better.” (Female, 61 years old)

4.3.2 ASPECTS OF HEALTHCARE SERVICE UTILISATION

Perception of provider qualities

Participant experiences with the quality of provider care directly influenced feelings of trust in their provider and subsequent health seeking behaviour.

Participants valued providers who showed interest in their complaint and took the time to communicate with them.

Participants expressed appreciation of the personalised care provided by homoeopathic providers.

“It’s more empathetic here (at the homoeopathic clinic). It’s more, they empathize more on the person itself not to treat one patient like the rest of the world. So it’s more personal.” (Male, 29 years old)

One participant likened the homoeopath to a *sangoma*¹ in terms of their empathic approach.

“I think it’s really *sangoma*! Hahaha!

Ya because you know he guess what I’m doing at home!

Yes, the time you talk to them, the time you... they read you. They find where the problem is. Really haha!” (Female, 67 years old)

Participants expressed appreciation in receiving feedback from homoeopathic providers:

“I’ve had more feedback from a homoeopathic doctor than from a normal doctor. A normal doctor seems to hide things away from you, not telling you the truth what’s actually really wrong with you.” (Male, 60 years old)

¹ *Sangoma* is defined as (South African) a witch doctor, healer or herbalist, from the Zulu word isangoma (Online dictionary, 2015).

Further to providing adequate feedback, is the provider's ability to adequately communicate aspects of care and health. Participants described that when there was adequate communication regarding the healthcare approach, disease and possible methods of management; an experience of care and trust in the provider was established.

“So basically here the (homoeopath) gives you all that advice which is true and you take it and you got time to discuss. They teach you mentally, medically with your problems.” (Male 78 years old)

“They ask you questions. “How are you at home? How's your body going? Are you feeling all right? What are you eating? ”. They ask you all those questions. But if you go to a normal doctor he will never ask you all those questions at all.” (Male, 60 years old)

Listening skills was identified as an important provider care quality.

“I like the way they welcome you and how well they speak to you and they listen very well.” (Female, 73 years old)

Participants frequently commented on their difficulties in communicating with allopathic practitioners who they felt did not pay proper attention or listen to them during the consultation:

“No you don't know! You go to you get your medication, the doctor will, you don't even know whether the doctor heard what you said or he will give you the right medication because she is hurrying to see somebody.” (Female, 43 years old)

Experiences of different care approaches

Participants described the differing methodologies or care approaches underlying the allopathic and homoeopathic care modalities.

“Because the doctors from the hospital you sit like this and you talk to her what is your sickness. Then she orders the medicine for you- you see. You don’t take any time to ask you other things in your body.” (Female, 61 years old)

In contrast, the homoeopathic approach was seen to engage with the whole state of the patient.

“They ask you questions! How are you at home? How’s your body doing? Are you feeling all right? What are you eating? They ask you all those questions. But if you go to a normal doctor he will never ask you all those questions at all. Completely different to normal doctors, they want to know everything of your body.” (Male, 60 years old)

Participants noted that the homoeopathic provider generally asked more questions than their allopathic counterpart and that the questions were more in-depth and holistic in nature.

“It’s different because (allopathic providers) just give you the medication. If you say I’ve got an ulcer they just give you the medication of ulcer, they don’t go deep. They don’t ask questions or go in details about your ulcers or headache or stomach ache.” (Female, 43 years old)

The same participant goes on to explain what she means by homoeopathy’s in-depth approach:

“And even emotionally; you will just cry after you have met the doctor. You will just cry because he will ask you maybe “What happened? Why is it you have a headache a pain like this, maybe you lost somebody... you know. He will ask you everything, then you cry there then after you have seen the doctor you become free.” (Female, 43 years old)

Many participants perceived the allopathic treatment approach as impersonal and generalized.

“Yes same procedure its same thing for everybody. They give same medication for everybody. Because if I’m sick and you sick I give you Brufen and you take it, I give it to somebody else-take it. So it’s something like that... because there’s not medication especially for you, for that thing you got- no” (Female, 67 years old)

Medication preferences

A strong concern of participants was the perceived safety of a medicine. Participants evaluated the level of safety of a medicine according to its perceived/experienced strength, side-effects, appearance and source/nature of the medicine. Participants expressed concern over the perceived strength of a pharmaceutical drug and the dangers associated with its use. In particular, participants were anxious about the side-effects they had previously experienced as a result of using allopathic medicines.

“You find that there are no side-effects with the homoeopathy treatment. You don’t feel dizzy or whatever. It’s only that it is working.” (Female, 70 years old)

The appearance of the medicine was another commonly raised concern. Because homoeopathic medicine was dissimilar in appearance to conventional

allopathic medicines with which they were familiar, participants expressed doubt toward the effectiveness of homoeopathic medicines.

“Because I just saw these powders. Everybody’s given these same powders. I didn’t trust it at all. I thought it won’t work or something like that. I never saw it in my life.” (Female, 43 years old)

Interestingly, participants were unconcerned about the safety of a medicine which did not conform to the appearance of conventional medicine. Their primary concern related to the effectiveness and validity of the medicine.

The perceived source/nature of a medicine was viewed as an indicator of safety. ‘Safe’ medicines were viewed as being natural or pure as opposed to being of the scheduled drug type.

“So homoeopathy ...is medicine without any drugs. I believe your homoeopathic medicine, there’s no side effects because it’s made with herbs and flowers and something like that so we believe. And that’s why I came” (Male, 78 years old)

Participants described characteristic “user friendly” features of homoeopathic medicine which contributed to its popularity amongst participants. Homoeopathic medicines were described as convenient and easy to use and that they could be safely taken in conjunction with other medicines.

“It feels right to take it as I have said it goes down nicely and it is not bitter. Also you don’t have to take it everyday. You take it once after every two days unlike the pills which you have to take in the morning, at day time and in the afternoon. With this medication you only take it once... It helps me because as I am also taking medication from the hospital, I

would say it doesn't reject it. You continue taking your medication from the hospital while you are taking this one as well." (Female, 57 years old)

4.4 PERCEPTIONS AND EXPERIENCES OF HEALTHCARE UTILISATION OUTCOMES

4.4.1 PARTICIPANT PERCEPTIONS OF HEALTH OUTCOMES

Two key criteria influenced patients' perceptions regarding their health outcomes after accessing care: quality of life and perceived effectiveness of treatment.

Perceived quality of life

Participants were primarily concerned about the ability of a medicine to improve their health and quality of life. Participants described how homoeopathic medicines, in particular, had improved mental, emotional and physical aspects of their health.

One participant, with a history of bipolar disorder, explains the positive effect which homoeopathic medicines had had on his health and how his emotional state has changed since treatment:

"Everything is better. I mean senses, smell, taste um thinking, thoughts, less anxious, I can talk more, express myself more. I used to feel flat. Otherwise the two extremes or flat, just nothing like" (Male, 29 years old)

Another participant explains the dramatic effect which homoeopathic treatment had on her health and quality of life:

"Like I said my legs would not let me walk properly even when I was using the (allopathic) medication but once I started getting this (homoeopathic) medication there was a difference... The pain stopped." (Female, 57 years old)

Some participants described negative health effects related to the use of allopathic medicine. The pill burden and side effects of allopathic treatment was often found to overshadow the more positive effects of the treatment.

“I’ve been having a lot of headaches with these tablets I’ve been taking. Cos I take about 17 tablets day.” (Male, 60 years old)

Perceived effectiveness of treatment

Most participants believed that homoeopathic medicines worked quicker than allopathic medicine to restore health:

“You can see the two differences. It does not work (allopathic medicine). The homoeopathic stuff works quicker than the normal doctor stuff works.” (Male, 60 years old)

Homoeopathic treatment was often perceived to be effective in cases where allopathic medicines were perceived as not helpful:

“And I went to government hospitals and to special doctors and I didn’t get help. I only got help here. That’s why I say it’s working.” (Female, 43 years old)

“First of all at the hospitals and clinics they give you a lot of medication and you are expected to take it everyday and finish it; whereas here they give you a small packet with three sachets of powders and you have to take it once every other day and you feel the difference...Once you have finished those three sachets the pain goes for a long time and it doesn’t come back.” (Female 52 years old)

4.4.2 EXPERIENCE OF HEALTH SERVICES

A number of healthcare service related factors linked to consumer satisfaction were identified as important contributing factors in healthcare utilisation; these include service efficiency, medical practice, quality of care, and the continued availability of care.

Service efficiency

Service satisfaction was linked primarily with the efficiency of the service provided at a healthcare facility. Participants viewed the efficiency of a healthcare service relative to its ability to adequately process and respond to their health need. Homeopathic clinic staff were viewed as proficient in managing participant health needs effectively and timeously.

“Service is quick, friendly and the remedies work!” (Male, 29 years old)

Participants placed value in the efficient service they received from the Kenneth Gardens homoeopathy clinic. Many participants described the benefits of the efficient service:

“As I have said before the difference is that one you have to stand wait a long time for dispensary to get your treatment while you are sick, you need it now. But here (homoeopathic clinic) when they have already dispensed for you, you can just take your medication. You have to wait for 2 hours for dispensary (allopathic clinic).” (Female, 70 years old)

In contrast most participants reported that the service they had received from public allopathic healthcare facilities had been poor. Participants reported that public facilities appeared unable to adequately attend to the large volumes of patients. Many participants reported experiences of the staff at public healthcare treating patients poorly and not attending to healthcare needs adequately.

A 53 year old woman describes the attitude of staff at public healthcare facilities:

“They make “go slow” – you know “go slow” that thing. And they told us we are short just wait. But when they come to 3 or 4 they are coming fast and then they finish the people. The thing that they can do in the morning or during the day they just take for a long time, never get take out the medication for the people. All those things are hurting. They are hurting us. They make us angry.” (Female, 53 years)

Another participant described his perception of healthcare providers at public healthcare facilities and explains his dissatisfaction with the service provided:

“They’ll have their tea, their tea-time is about half an hour to an hour long, when it comes to lunch time it’s 2 hours long. So you can sit there for the whole day, depends on what time you came in there. That’s the only problem, that’s why I get so fed up with that hospital! (Male, 60 years old)

Participants described how the fragmentation of services at allopathic facilities impacted the perceived efficiency of the service:

“While you are still waiting she dispense your treatment unlike going to the hospital where you see the doctor and you have to wait, go to for X-ray go for blood test or whatever so you have to wait for the results of whatever. It means you wait for 55 minutes waiting for results sometimes and then after that you have to wait for dispensary.” (Female, 70 years old)

Perception of medical practice

Some participants described the poor service received at public healthcare facilities as bordering on unethical and infringing upon the rights of the patient. Participants shared concerns over poor medical care and undignified treatment at public healthcare institutions. Many participants explained that doctors at

public facilities spent very limited time taking their case and often did not even examine the patient before prescribing:

“At times he won’t even examine you, he will only listen to what you tell him and he will write that down and then give you medication and off you go.” (Female, 52 years old)

Participants described experiences of negligence in care and a lack of trust in the allopathic practitioners at public healthcare facilities.

“The doctor gave me brufen you see, when you come back and say I have been using this and the doctor says; “No you are not suppose to get the brufen because brufen is dangerous it eats the diaphragm, it makes the joints dry”. So what are you going to say? So you don’t understand it! You don’t trust what is the better for you.” (Female, 70 years old)

“I’ve had experience with people that stay here where babies were born and died in hospital eh. The nurse is not even actually looking after, the place is filthy! Filthy! Filthy!” (Male, 60 years old)

Quality of care

Quality of care identifies aspects of a healthcare service which patients valued most. Probably the most important aspect of a healthcare service, which quickly determined the quality of care and overall patient satisfaction, was the amount of quality time which the patient spent with the doctor. Participants described their experiences of the homoeopathic service offering more quality time with the doctor and explained how this was, to them, an important aspect of care:

“The difference is that here (homoeopath) you are talking with the doctor face to face, taking your time. You tell the doctor everything that is

worrying you... Here there is a lot of help that you get here. The service is very good.” (Female, 43 years old)

Many participants commented on how the doctor-patient relationship influenced the perceived quality of care and satisfaction with a health service. Where the doctor-patient relationship was open and clear with good communication the patient expressed satisfaction with the service. The participant below contrasted the quality of care received from female and male doctors; indicating positive experience with female doctors in orthodox clinics:

“Because she could give me all the details, exactly what’s going on, why they giving me this injection, what, what, what...But the men doctors don’t explain nothing to you. They say no wait until we get the samples and stuff. Wait until we get this back, wait until we get that back. And it takes ages before you get anything out of a male doctor. Women doctor will tell you anything. I’ve had an African woman doctor and I’ve had an Indian woman doctor and I tell you what they give you better service than a male doctor.” (Male, 60 years old)

Many participants expressed how the personal care received from the homoeopathic provider enhanced the quality of care, and service satisfaction:

“I like it because they take care of us. Ya. At any time you come. Even if you didn’t come for a few weeks they ask you: “Why didn’t you come? Are you all right? How are you feeling?” (Female, 61 years old)

A 73 year old woman expressed how the quality of care received at the homoeopathic clinic contributed to service satisfaction and compared it to the service received at allopathic clinics:

“I don’t know what the others feel but I like it because you are welcomed. The minute you get inside you are well received and the people who work here are welcoming. At the other clinics (allopathic) they just shout at you out of the blue and you tell yourself that at the end of it all they are going to give you the pills you need.” (Female, 73 years old)

Continuity of care

Participants perceived the continuity of care with a service as being an important characteristic of a healthcare service. Participants valued the continuity of care offered by the homoeopathic provider. Many participants expressed that they followed-up with their homoeopathic provider regularly to receive feedback and support as needed and relied upon continuous care in the management and resolution of health complaints:

“You come to see the (homoeopath), if they still problems there then they change your (medication) or they give you something or they carry on to give you this thing until the (illness) is stopped” (Female, 67 years old)

Another participant explains how continuous care available at the homoeopathic clinic was useful to him personally in the management of his health:

“You see the (allopath) every 6 months there, that’s the problem! Where here you see the (homoeopath) every time, and she can tell me how I’m going. How’s my blood pressure going, up or down. That’s why I always use them (homoeopath).” (Male, 60 years old)

The lack of continuity in care from allopathic providers negatively affected patient satisfaction:

“When you go for a check up the doctor (allopath) asks you how the arthritis is and how you feel. You tell him it does not improve. He then looks at the medication you are using and he prescribes it again. There is

nothing new that you get... It doesn't make me feel good because if the medication they are giving me does not help, they have to start all over again and check me and then change the medication.” (Female, 57 years old)

4.5 THE ROLE OF TRUST IN HEALTHCARE UTILISATION

The concept of trust emerged as a strong consideration in the decision-making processes in healthcare utilisation and is directly related to many aspects of the themes already presented.

Participants explained that they trusted the homoeopathic provider and health outcomes related to homoeopathic treatment. Trust in the effectiveness of the treatment and related health outcomes were a primary reason for homoeopathic provider preference:

““A lot of improvements. That is why I come here (homoeopath). Otherwise I wouldn't come back here...I had doubts (in homoeopathic medicine), I always thought that (allopathic) doctors knew everything or that they could cure everything or, but its much better here (at the homoeopath clinic).” (Male, 29 years old)

Participants described how trust directly influenced their decision-making processes regarding healthcare utilisation.

“No I come here (homoeopath) because that's where my trust is now.” (Female, 43 years old)

“To me they (homoeopaths) do more work for me than any other (allopathic) doctors do... I trust them (homoeopaths) more ya. I've got

more of a trustful feeling with these (homoeopathic) doctors than any other doctors.” (Male, 60 years old)

This was comparable to the lack of trust which was frequently expressed by participants with regards to allopathic provider care. The participant below explains why she stopped visiting her former allopathic healthcare provider:

“I went there one day they give me high blood pressure tablets... when I’m going there they say “oh your tablets is finished, now we change you we give you this”. I said, “Listen here! My body is not a testing ground! And I’m not taking anymore!” And I stopped (attending) from then.” (Female, 67years old)

Another participant describes how her lack of trust in the allopathic provider had a direct influence on her uptake of allopathic services:

“I didn’t trust them, I said no, I will die if I die but I will not do this (allopathic procedure)” (Female, 43 years old)

CHAPTER 5: DISCUSSION

This chapter discusses the findings presented in the results section and provides an in-depth interpretation of study participant perceptions and experiences related to their use of homoeopathic care as a primary healthcare modality. Drawing on social constructionist theory (Burr 1995), the discussion considers the role of social, cultural and healthcare environment factors in the development of understandings and assumptions about health and illness within the study population (Brown, 1995). Focus is placed on analysing the individual's subjective experience and perception of the homoeopathic service within the context of social influence and the discussion builds an understanding of how participants make choices about the type of primary healthcare they access (Brown,1995; Burr, 1995).

The discussion in this chapter is structured according to the five groups of themes identified in the results section followed by discussion on the study's conceptual model. Sections are discussed as follows i.) Context specific factors to healthcare utilisation ii.) Factors influencing healthcare utilisation iii.) Health beliefs and practices iv.) Perceptions and experiences of healthcare utilisation outcomes v) The role of trust in healthcare utilisation and vi.) Conceptual Model.

5.1 CONTEXT SPECIFIC FACTORS TO HEALTHCARE UTILISATION

Healthcare access is one of three factors common to healthcare models and theories, which seek to explain the influences on healthcare seeking behaviour and healthcare utilisation (Rehban, n.d.). The study findings indicate that ease of access to a particular healthcare facility was a strong condition determining the use of a healthcare service for participants. Participants in the study generally perceived that healthcare access was limited and healthcare system and socio-economic factors were cited as barriers to participant access.

The findings indicated that service availability at the homoeopathy clinic negatively impacted healthcare utilisation within the community. There were several reported reasons for this. Firstly, the homoeopathic clinic was found to have limited operating hours. Secondly, in contrast to conventional clinics, the homoeopathic clinic was perceived to provide only limited services. The findings suggest that the existence of preconceived ideas and expectations surrounding healthcare, based on orthodox allopathic models and societal norms, is an important factor in healthcare seeking behaviour and healthcare utilisation in this study. The results indicate an underlying expectation and demand for conventional medical care and suggest the need for access to closer medical facilities. Comparative assessment of service availability at public healthcare facilities was minimal, with the exception of local clinics being unable to dispense chronic medication.

The study findings illustrated that residential zoning negatively influenced participant access to public healthcare services since the zoning restricted participant access to 'non-zoned' services, which included hospitals/clinics outside of their allocated zone. For participants in the study who were residents of the Kenneth Gardens community, the increased costs associated with access to 'zoned' public healthcare services were often prohibitive.

Participants also highlighted that the lack of service integration between allopathic and homoeopathic service providers caused difficulties for them when they were referred between facilities. Participant perception and experience suggests weak referral systems between homeopathic and allopathic providers in the study and identifies a lack of awareness in the public health community for homoeopathy and the KGHC. Participants described that a combination of homoeopathic and allopathic services would provide the ideal platform for their healthcare needs since it would be a 'one stop shop'. These findings lend support to earlier research showing patient demand for integrated medical care with homoeopathy (Mercer *et al*, 2004).

Transport costs and distance were two important barriers to participant's access of healthcare services. As mentioned above, healthcare which was located at a distance incurred transport costs which the community members were often unable to afford. Results highlighted that the Kenneth Gardens clinic was the most conveniently located service for residents and that participants relied on these services when they could not afford to access other healthcare services. Distance and transport costs are a common barrier to health care access for patients and underline the need to bring health services to the community as much as is possible (Ensor & Cooper, 2004).

5.2 FACTORS INFLUENCING HEALTHCARE UTILISATION

Three categories of factors, characteristic of the population under study, were identified in this section for their influence on healthcare seeking behaviour and healthcare utilisation.

Firstly, predisposing factors identify features which define the study population and predispose the population to a particular influence in healthcare seeking behaviour and healthcare utilisation (Aday *et al*, 2005); as discussed below:

The demographic represented by the study population was characteristic of an aging population with chronic health complaints in a community of low socio-

economic status (Table 1). Participants in the study relied upon cost-free healthcare services provided by public healthcare and the homoeopathy clinic for their healthcare needs. Furthermore participants were selected according to their usage of the homoeopathic facility in order to ensure that the participant could provide adequate experience with homoeopathic treatment. This meant that participants who did not utilise the service or did not return for follow-up consultations were excluded from the study. These demographic features provide the socio-economic parameters and health care needs of the study population and form the predisposing characteristics for a particular set of health seeking behaviours that cannot be generalized to a broader population.

Preconceived ideas and expectations for healthcare in conjunction with the lack of knowledge and availability of homoeopathy to the community initially influenced patient perceptions of homoeopathic care and health seeking behaviour. Participants expressed that they had initially doubted the legitimacy of homoeopathy as a medical modality and its potential effectiveness as a treatment; however personal experience with the treatment had facilitated their acceptance thereof. As discussed under primary determinants, findings showed that participants' expectations of healthcare services were firmly based on the orthodox, allopathic model for healthcare with which they were familiar. As such participants described a comparative lack of service provision at the homoeopathic clinic. Despite perceived lack of service provision and prior lack of knowledge and availability of homoeopathy to the community, participants still utilised homoeopathic care at the clinic and reported apparent satisfaction with homoeopathy. These findings suggest that other enabling factors were likely to have overcome any barrier posed by preconceived ideas and expectations and the prior lack of knowledge/availability of homoeopathy to the community. It is difficult to assess the true impact which lack of prior knowledge had on the community as the study population only included patients who regularly made use of clinic services. The strong body of evidence in the results describing lack of knowledge of homoeopathy indicates the need for provision of information and

education on healthcare service choices and available providers within the community, in order to facilitate health seeking behaviour and remove potential barriers to utilisation (Ensor *et al*, 2004).

Enabling factors which facilitated healthcare seeking behaviour and healthcare utilisation of the homoeopathic service were also identified. The results highlighted that participants valued the convenience of the homoeopathic clinic based on the proximity of its location, the type of treatment offered and prompt service. The relative convenience of the homoeopathy clinic positively influenced utilisation of the clinic.

Social networks existing between members of the community and staff at the clinic were also found to positively influence utilisation of homoeopathic services. As reported in the results, social networks promoted awareness and positive attitudes toward homoeopathy and played an integral role in correcting misconceptions about homoeopathic medicine. These findings correlate with existing research which recognises the informative role of social networks and their importance in healthcare utilisation (Deri, 2002; Devillanova, 2005). Utilizing social networks within communities to encourage the use of homoeopathic services may be an important component of scaling up homoeopathic services.

Perceived need is also an important aspect in the process of determining whether an individual will access a healthcare service (Johnson *et al*, 2010). Study participants selected their healthcare provider based on the nature of their health complaint, the perceived urgency of their need and the perceived ability of the provider to attend to the need. The study findings challenge earlier arguments that homoeopathic treatment tends to be most frequently used and sought for the treatment of chronic conditions (Avina & Schneiderman, 1978; Goldstein & Glik, 1998). Rather, findings showed that homoeopathic provider care was perceived as valuable for the treatment of both general and chronic health complaints. The results suggest that the homoeopathic clinic was also relied upon as a primary healthcare facility, which utilized referral-systems to

public healthcare where necessary. Some participants indicated that they preferred utilizing homoeopathic healthcare for their primary healthcare needs but that allopathy was preferred for emergency healthcare needs and allopathic preventative medicines. These findings provide legitimacy to the argument regarding the scope of practice for homoeopathy and its value in primary healthcare beyond the treatment of chronic disease. However, the modality's limitations as an emergency care medicine are also acknowledged.

5.3 HEALTH BELIEFS AND PRACTICES

Results in this section provide insight into the dynamics associated with healthcare decision-making processes and health seeking behaviour of participants in the study. A lack of comparative studies and dearth of information in this section are suggestive of the need for further research in this area.

Findings showed that retail pharmacy is an important resource for some participants who relied upon these services for their healthcare needs, often as an adjunct to primary healthcare when allopathic or homoeopathic facilities were unavailable or when participants were not satisfied with treatment outcomes. Results revealed that retail pharmacy played an important role in healthcare management and health education of participants and illustrated the importance of retail pharmacy in healthcare service provision. These results also highlight the role and importance of pharmacist-client interactions in healthcare (Kamat & Nichter, 1998). Similarly the Kenneth Gardens Clinic offers complementary healthcare resources such as the nutritionists and home-based care workers which are utilised as an adjunct to primary healthcare and participant experience showed that these services were valued for their educational approach to healthcare and assistance in health management.

As documented in other research, study participants tended to seek plural health care, accessing both homoeopathic and allopathic primary healthcare modalities (Bhardwaj, 1980; Bishop, Yardley & Lewith, 2008). Participants reported that the

different healthcare modalities addressed different healthcare needs and that the overall benefit of dual access was necessary for the perceived optimal health benefits. Given these realities, the findings suggest that stronger linkages between the different modalities may reduce the burden of disease and enhance overall quality of healthcare provision within a community.

Participants identified important factors related to determining healthcare seeking behaviour and healthcare utilisation. Firstly, findings revealed that provider care qualities were strongly influential to decision-making processes in healthcare utilisation, acting as a fundamental building block in the participant's foundation of trust in the provider and facilitating utilisation (Lings *et al*, 2003; Lise, Rosendal, Østergaard, 2015). Participant's identified personalised care, empathy and listening skill combined with open communication and good patient feedback as highly valued provider care qualities. Perceptions and experiences of study participants revealed that the positive provider care qualities associated with the homoeopathic provider positively influenced participant use of the homoeopathic clinic. These findings are congruent with research at the Glasgow Homoeopathic Hospital, suggesting that the empathetic, listening and individualized provider care qualities which patients experienced with homoeopathy may be generalized to homoeopathic providers (Mercer *et al*, 2004). These results indicate the importance of positive provider care qualities in healthcare utilisation of homoeopathy. Participant perception and experience further revealed that a lack of the abovementioned provider care qualities in allopathic provider care was identified as a cause of concern for participant accessing allopathic care. Results of participant experience with allopathic and homoeopathic providers correspond to existing findings which suggest a comparative lack of positive provider care qualities in allopathic providers however these results are not generalisable (Mercer *et al*, 2004). Allopathic care described by participants in the study falls within the context of public healthcare in South Africa and as such participant perception and experience are likely to have been influenced by inadequacies and challenges facing the public healthcare system (Benatar, 2013;

Kautsky & Tollman, 2008). Study results illustrating services related aspects of healthcare provide insight into the possible impact of inadequacies in public healthcare (Benatar, 2013; Kautsky & Tollman, 2008).

The study findings illustrate that participants identified distinct differences between the homoeopathic and allopathic approach to healthcare; namely in the type of questions which were asked and type of knowledge which was sought from the participant. Findings show that homoeopathy was viewed as a holistic and individualized approach whilst allopathy was negatively expressed as being an impersonal and generalized treatment. The holistic approach which homoeopathic treatment offered was highly sought after by participants and a strong determinant in participant use of the homoeopathic clinic. Findings strongly add evidence to the value of the holistic approach employed in homoeopathic care as an important factor behind health seeking behaviour (Marian, 2008; Mercer *et al*, 2004).

Participants also showed preference for a medicine type according to four key factors related to use: side-effects; appearance; nature/source of medicine and “user friendly” qualities of the medicine.

Results illustrate that preconceived ideas related to medicine appearance were important in the initial processes of health seeking behaviour as they negatively influenced participant perception, deterring the initial use, trust and acceptance of homoeopathic medicine. Some participants in the study reported that they initially doubted the validity and effectiveness of homoeopathic medicine because the medicine did not conform to the appearance of conventional medicines.

Study findings indicate that the perceived safety of a medicine positively influenced healthcare utilisation. Interestingly, participant preference for the safety of homoeopathic medicine was based on its dissimilarity to allopathic medicines. Allopathic medicine was described as a “drug” type and participants voiced concern for the dangers and risk of side-effects associated with its use. Conversely, homoeopathic medicines were perceived as constituting natural

medicines and were not associated with the risk of side-effects or other dangers of conventional drug use.

Participants identified unique characteristics of homoeopathic medicine which made the medicine “user-friendly” and positively influenced participant use of and preference for homoeopathy. Findings reveal that homoeopathic medicines were perceived to be safe to use in conjunction with other medication and that the low volumes prescribed and infrequency of administration contributed to the “user friendly” nature of homoeopathic medicine. These findings add to the body of evidence supporting that the low-risk and “user-friendly” nature of homoeopathic medicine may encourage preference and utilisation (Marian, 2008).

5.4 PERCEPTIONS AND EXPERIENCES OF HEALTHCARE UTILISATION OUTCOMES

The study identifies two broad categories of healthcare utilisation outcomes; those that are health related and those that are service related.

Participants in the study placed greatest value on improved health and quality of life and showed preference for treatment according to benefits which they experienced in healing and well-being. Findings indicated that perceived health outcomes associated with the use of homoeopathic treatment were positive and were favoured by participants. Homoeopathy was also perceived as a quick and effective treatment option, which was often able to assist when allopathic medicine could not. Furthermore, and most importantly; participants perceived that homoeopathic treatment outcomes provided valued health benefits which reportedly improved participant’s quality of life. By comparison, findings suggested that allopathic health outcomes were not perceived to be beneficial to the participant’s quality of life; as pill burden and side effects were found to overshadow the positive effects of the treatment. Perceived benefits and enhanced quality of life have previously been associated with the use of

homoeopathic treatment and were a definite determinant of homoeopathic healthcare utilisation within the community under study (Astin, 1998).

Study participants' satisfaction with service related outcomes was based on the perceived competency of the service in the following areas: efficiency, medical practice, quality of care and continuity of care.

Participants expressed satisfaction with all aspects of the homoeopathic service whilst showing dissatisfaction with areas of perceived incompetency in allopathic service provision. The perceived competency of a healthcare service is a direct determinant in healthcare utilisation (Mugisha *et al*, 2004). Findings show that the perceived competency of the homoeopathic service according to efficiency, medical practice, quality of care and continuity of care positively influenced healthcare utilisation and these factors contributed strongly to patient preference for a healthcare service. The impact of inadequacies in the public healthcare system and subsequent influence on participant perception and experience of allopathy in the study is largely unknown. However findings do indicate that participant perceptions and experiences of allopathic service related outcomes showed components which are likely to have arisen directly out of healthcare system inadequacies, for this reason it is difficult to distinguish how much of participant perception and experience with allopathic care relates directly to allopathy and how much is relative to the state of public healthcare.

5.5 THE ROLE OF TRUST IN HEALTHCARE UTILISATION

The study results illustrate the importance of trust in health seeking behaviour and healthcare utilisation. That is, participants voiced preference for provider care based on trust. Participants also identified key factors which impacted on the establishment of trust within a healthcare service.

Study results show that participant values, beliefs and expectations are an essential aspect to consider in the establishment of trust with a healthcare service. When healthcare services met the participant's values, beliefs and

expectations for healthcare they expressed trust and preference for the service. Participants in the study expressed that they trusted the provider and health outcomes related to homoeopathic treatment and linked their preference for and use of homoeopathic care primarily to feelings of trust. Conversely, allopathic healthcare inadequately met participant values, beliefs and expectations and was regarded with a lack of trust which negatively influenced perception of the service. While patient values, beliefs and expectations are known influences of healthcare utilisation (Astin, 1998), they are also fundamental to the establishment of trust within a healthcare service (Calnan & Sanford, 2004; Davies, 1999).

Study findings show that healthcare outcomes and provider care qualities were two main aspects in healthcare utilisation which influenced the development and establishment of trust within a healthcare service. Positive provider care qualities and service competency associated with the homoeopathic provider were identified as crucial aspects of care and positively influenced the establishment of trust in the homoeopathic provider. On the other hand, poor provider care qualities and a lack of service competence associated with allopathic providers was cause for distrust amongst study participants. Findings lend weight to the argument over the importance of interpersonal aspects of care and the value of trust in the doctor-patient relationship and subsequent demand for a healthcare service (Calnan & Sanford, 2004; Lings *et al*, 2003; Lise, Rosendal, Østergaard, 2015).

In addition to the influence of provider care qualities and service competency, the findings also suggest that trust is intimately related to the experience of healthcare outcomes associated with a healthcare service. That is, positive health outcomes associated with homoeopathic treatment were fundamental to participant trust with homoeopathy and the homoeopathic provider. Whilst current research recognises the influence of socio-economic, cultural and healthcare related factors on healthcare utilisation behaviour in plural healthcare systems

(Astin, 1998; Lings *et al*, 2003; Moshabela *et al*, 2012); study findings highlight that trust in the health outcomes related to the use of a healthcare service may be a fundamental determinant of healthcare behaviour and strong predictor of utilisation within plural healthcare systems (Lise, Rosendal, Østergaard, 2015).

The use of alternative healthcare resources, and in particular primary reliance on these alternative resources, have in past studies been strongly associated with patient distrust and dissatisfaction with orthodox allopathic healthcare (Astin, 1998). Study results show that distrust and dissatisfaction with orthodox allopathic care had a direct negative effect on the utilisation of allopathic services. However despite strong reliance on homoeopathy, findings suggest that participant distrust and dissatisfaction with orthodox allopathic care played a secondary role in its influence on the utilisation of homoeopathic services. Rather study results illustrate that the preference and use of homoeopathic services was primarily determined by the participants trust with the homoeopathic service rather than distrust of orthodox allopathic services.

The use of homoeopathy as an alternative healthcare resource in public healthcare; as an adjunct to orthodox allopathic healthcare and as a primary healthcare modality in its own right is shown to be considered as a significantly valuable resource by study participants, with demand for homoeopathic care being directly linked to trust (Lise, Rosendal, Østergaard, 2015).

5.5 CONCEPTUAL MODEL

The conceptual model developed in the study offers a qualitative description of interrelated factors that influence health seeking behaviour and healthcare utilisation of plural healthcare systems.

The proposed model in Figure 2 is based on the framework of the behavioural model of health service utilisation (Aday & Anderson, 2005) and incorporates adaptations based on the study findings and within the context of plural healthcare utilisation.

Components of the model were determined apriori (Aday & Anderson, 2005) and subsequently adapted drawing on themes which arose during data analysis. The following categories are included: i.) Environmental/Primary determinants ii.) Population characteristics iii.) Health behaviour and iv.) Health outcomes. The categories in the model are linked and the relationship between categories is indicated by arrows and feedback loops.

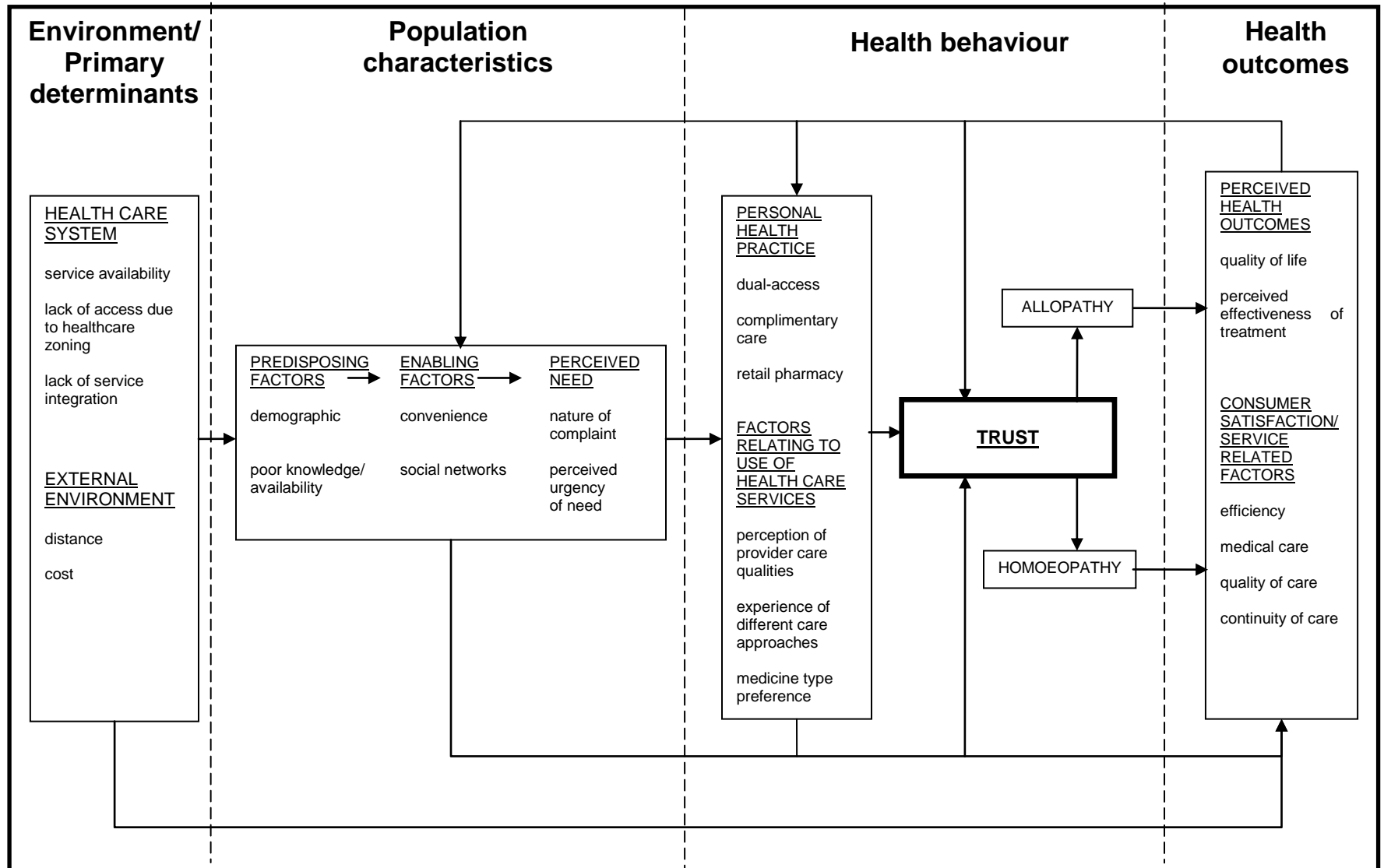


Figure 2: Conceptual model of healthcare utilisation behaviour for plural healthcare systems

The conceptual model is embedded within the greater contextual scheme of sociopolitical, economic and cultural determinants of public healthcare applicable to lower socio-economic populations in South Africa. Socio-economic constraints and socio-cultural norms, determined by the context in which the study is set, were found to be highly influential to healthcare seeking behaviour and utilisation. Inadequacies in current public healthcare systems of South Africa are identified as a significant contextual influence of participant perception and experience of allopathic care in the study (Benatar, 2013; Kautsky & Tollman 2004).

Healthcare utilisation and behaviour models are considered to provide a valuable framework for researchers in identifying variables, defining the relationship between these variables and evaluating factors related to the access and utilisation of healthcare services (Aday & Anderson, 2005). However, existing healthcare utilisation models have limited capacity to consider the role of alternative and traditional medicines and as such are limited in their ability to illustrate and predict healthcare utilisation of plural medical systems (Rebhan, n.d.). Based on the behavioural model of health service utilisation (Aday & Anderson, 2005), the above conceptual model addresses current limitations in healthcare utilisation models by offering adaptations which allow for the incorporation of features relevant to healthcare utilisation within plural healthcare systems.

The model maintains a linear relationship between four main components; i.) Environmental/primary determinants ii.) Population characteristics iii.) Health behaviour and iv.) Health outcomes. Illustrated as inter-leading and interrelated categories within the proposed mode, these components establish the platform for health seeking behaviour and healthcare utilisation relative to the context of the study.

Environmental/primary determinants are the first component of the model and are identified as direct causal factors of health seeking behaviour and healthcare utilisation (Rebhan, n.d.). This section is derived from context specific factor to healthcare utilisation and includes healthcare system factors and external environmental factors as identified by participants in the study. Study findings confirm that restrictions to healthcare access, as a result of socioeconomic and sociopolitical constraints directly impacted health seeking behaviour and healthcare utilisation (Ensor *et al*, 2004).

Population characteristics are determined as secondary causal factors behind health seeking behaviour and healthcare utilisation which were specific to the population under study. Population characteristics are derived from factors influencing healthcare utilisation. In keeping with the structure of the behavioural model of healthcare utilisation (Aday & Anderson, 2005), the study finds predisposing factors, enabling factors and perceived need as major components of population characteristics. Population characteristics show direct influence on health behaviour, trust and health outcomes.

Health behaviour reflects the theme of health beliefs and practices. Health behaviour is illustrated as a tertiary causal factor behind health seeking behaviour and healthcare utilisation. The model identifies determinants of health behaviour under personal health practices and factors relating to the use of a healthcare service.

Model adaptations depict a central, dependant variable of trust existing within the core of the health behaviour component of healthcare utilisation. The model establishes trust at the heart of the decision-making process in health seeking behaviour and healthcare utilisation, proposing that model components and feedback networks ultimately strengthened or weakened participant trust within a healthcare system, thereby influencing healthcare utilisation and future health seeking behaviour. Consequently, provider choice is depicted as a direct function of trust (Johnson *et al*, 2010; Lise, Rosendal, Østergaard, 2015).

The model illustrates that health outcomes are directly shaped by all preceding domains. Health outcomes are viewed as the final causal factor along the path of health seeking behaviour and healthcare utilisation and show direct recursive influence on population characteristics, health behaviour and trust; demonstrating the dynamic influence of experience on health seeking behaviour and healthcare utilisation.

Findings highlight the role of trust in shaping healthcare utilisation behaviour. Trust both determined and modified health seeking behaviour and healthcare utilisation of study participants. Findings draw attention to the importance of values and needs in attaining trust and support that trusted networks, in the context of healthcare providers, are more successful (Johnson *et al*, 2010, Lise, Rosendal, Østergaard, 2015). The results stress the importance of trust, along with patient values and needs as factors

for consideration in healthcare service provision strategies (Johnson *et al*, 2010; Lise, Rosendal, Østergaard, 2015).

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

The study findings offer a patient-based perspective of healthcare and insight into patient decision-making processes regarding healthcare choice within a plural and public healthcare setting in South Africa. In particular, the study sheds light on the patient's perspective of homoeopathy and establishes a view of the role which homoeopathy assumes as an alternative primary healthcare resource within the community of Kenneth Gardens. Findings describe that participant trust for services offered at the Kenneth Gardens Homoeopathy clinic positively influenced their use of the clinic as primary healthcare alternative. The study also highlights how patient perceptions and experiences of health care utilisation directly influence feelings of trust.

The study findings have been conceptualized in a proposed adapted conceptual model which identifies the relationships between factors influencing decision-making processes for health seeking behaviour and healthcare utilisation. The model depicts the flow of influential factors as they progress in health seeking behaviour and healthcare utilisation from environmental/primary determinants, to population specific determinants, to health behaviour related determinants and health outcomes related determinants. Adaptations within health behaviour identify a central dependant variable of trust as the final point in the decision-making process of healthcare utilisation for study participants. As reflected by study findings trust distinguished patient preference and use of a service; and patient trust with the homoeopathic service has been integral to patient use of the Kenneth Gardens Homoeopathic Clinic.

Recommendations

The relationship between the variables illustrated in the proposed adapted model need to be further tested using quantitative research methods. Quantitative research can generalise the findings beyond the Kenneth Gardens case study and provide valuable information which may be useful in understanding the role of homoeopathy in public healthcare in South Africa and in supporting future developments.

The study emphasizes the importance of the 'human' element when considering healthcare provision or when seeking to ensure healthcare utilisation. Findings lend

weight to the relevance of patient perception and experience in healthcare utilisation and move away from conventional quantitative measures which limit understanding of healthcare use to descriptions that are unable to fully consider the context of healthcare provision and patient need.

Trust in healthcare, and in particular with homoeopathy, is a subject which merits further exploration in relation to the healthcare approach and associated health benefits. Further qualitative research into the use of homoeopathic healthcare within the private sector of South Africa may be useful in establishing a contrasting perspective on trust, healthcare approach and associated health benefits of homoeopathy; and in determining whether or not these central components of healthcare seeking behaviour and healthcare utilisation with plural healthcare may be generalised across differing socio-economic and cultural context.

Study limitations

The study was set within the unique socio-cultural and economic context of the Kenneth Gardens community and therefore study findings are relative to the healthcare context of the Kenneth Gardens community and may not be generalised to the general public or other impoverished communities. In addition, the study sample consisted of patients who were current patients of KGHC and who had attended one or more follow-up consultations at the clinic. The study findings reflect respondent preference for homoeopathy due to the sample selection bias. Data does not reflect the opinions of patients who never opted to utilise homoeopathic services at the clinic or of those who did not return for further treatment after their initial consultation/treatment. The study sample consisted predominantly of elderly, retired black females who are not representative of the full spectrum of the general population in South Africa.

The context of public healthcare systems in South Africa must also be considered in relation to findings presented on allopathic healthcare in the study. The impact of challenges facing public healthcare, such as insufficient medical personal and demand on healthcare services are evident in participant perception and experience with allopathic providers and services and may have been a significant cause of bias/participant preference in study findings (Benatar 2013; Kautsky & Tollman, 2008).

Appendix A



INSTITUTIONAL RESEARCH ETHICS COMMITTEE (IREC) LETTER OF INFORMATION

Dear Participant

Thank you for taking the time to talk to us. This letter explains what the study is about and how to take part.

Title of the Research Study:

A study of the perceptions and experiences of patients receiving homoeopathic care in the context of primary healthcare services within the public sector.

Principal Investigator/s/researcher:

Researcher: Kirsty Love; B.Tech. Homoeopathy

Co-Investigator/s/supervisor/s:

Supervisor: Dr. Corné Hall; B.Sc.; M.Tech. Homoeopathy.

Brief Introduction and Purpose of the Study:

We are doing a study at the Kenneth Garden Community Clinic to find out what the patients think about homoeopathy and the healthcare at the clinic.

Outline of the Procedures:

The Researcher and a person who can speak isZulu and English will interview you in the gardens outside the Kenneth Gardens Community Clinic (Clinic venue). We would like to speak with you for about 20 minutes. We will ask you some questions to find out what you think about the Kenneth Gardens Clinic and homoeopathy.

If you want to take part in the study you must have gone to the Kenneth Gardens Clinic to see a homoeopathic doctor, two or more times. You need to be over 18 years of age or be the legal guardian of the person attending the clinic.

We will ask you if we can record what we talk about on an audiotape. We are only going to use the recordings for the study and afterwards they will be destroyed.

If you take part in the study you can still go to the clinic for treatment. We will not tell any of the people in the clinic what you have told us. If you do not want to take part in the study you do not have to. If you do not take part in this study you can still go to the clinic.

If you decide you want to take part in the study then we will give you a copy of this consent form to keep.

Appendix A (continued)

Risks or Discomforts to the Participant:

There are no risks that we know about. If you feel uncomfortable or do not like talking to us you can stop at any time. We will not tell anybody else anything you tell us. Only the researcher and her supervisors will be able to find out what you have told us.

Benefits:

You will not be given anything for taking part in the study. Results of this study might help the clinic organizers to make the clinic better in the future.

Reason/s why the Participant May Be Withdrawn from the Study:

The researcher may stop you from taking part in the study at any time if she believes it is in your best interest.

Remuneration:

You will not be paid to take part in this study.

Costs of the Study:

You don't need to pay anything if you are taking part in the study.

Confidentiality:

Your identity will be protected; we will not let anybody know who you are or what you have told us. We will put an anonymous number instead of your name on all copies of your interview. All of the interviews, documents and audio recordings will be kept safe by the researcher while we are doing the study and then they will be stored in a locked office of research study personnel at the Durban University of Technology, Homoeopathy department, and destroyed after 15 years. Only people involved in the research will be able to access this information.

Nothing you tell us will be shared with the people that work at the clinic, your family members or anyone else outside of this research project. We will not use your name when we write about what you have told us. We will make every effort to make sure that nobody will know what you have told us or who you are.

Research-related Injury:

It is safe to take part in this research.

Persons to Contact in the Event of Any Problems or Queries:

Please contact the researcher; Kirsty Love (cell. no. 079 635 2969), the supervisor; Dr. Corné.Hall (tel. no. 031 373 2514) or the Institutional Research Ethics administrator on 031 373 2900.

Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvctip@dut.ac.za.

Appendix B



IKOMIDI LEZOCWANINGO NEMIGOMO YESINGUNGO / INSTITUTIONAL RESEARCH ETHICS COMMITTEE (IREC) INCWADI YOLWAZI

Ngiyakubingelela

Ngiyabonga ukuthi uvume ukuba yingxenywe yalolucwaningo. Lencwadi ichaza kabanzi ngalolucwaningo nanokuthi imibono kanye nomlando wakho ubaluleke ngani.

Isihloko socwaningo:

Ucwaningo lwemibono kanye nemilando yeziguli ezithola usizo lokuhlengwa ngezehomoeopathy njengosizo ngqangi emphakathini.

Umcwaningi oqavile noma omkhulu:

Umcwaningi: Kirsty Love, B.Tech. Homoeopathy

Ababambisene nomcwaningi / Umhloli omkhulu wocwaningo:

Umhloli: Dkt. Corne Hall; B. Sc.; M. Tech. Homoeopathy

Isingeniso esifinqiwe kanye nenjongo yalolucwaningo:

ENingizimu Afrika, ihomoeopathy iyaziswa njengendlela esemthethwenin yokwelapha. Loluhla lokwelapha lulawulwa isigungu sesishayamthetho I "Allied Health Professions Council of South Africa". I homoeopathy ayisiyo ingxenywe yezokwelapha engaphansi kohla luka hulumeni. Bangingi odokotela abasebenzayo bezehomoeopathy lapha eNingizimu Afrika futhi imithi yezehomoeopathy iyatholakala emakhemisi, emafamasi kanye nasezitolo ezidayisa ezemvelo nezempilo. Ucwaningo luyatshengisa ukuthi ihomoeopathy iyindlela ebalulekile kakhulu yokwelapha izifo eziningi. Alukabikho ke ucwaningo uluhlola ukuthi ngabe iziguli zicabangani ngalendlela yokwelapha.

Thina ke senza ucwaningo kweziguli ezibonelwa emtholampilo womphakathi iKenneth Gardens. Isizathu salolucwaningo ukufunda kabanzi imibono noluvo lweziguli nangendlela eziphathwa nezilashwa ngayo kulomtholampilo. Futhi sifuna ukuthola ukuthi iziguli zicabangani ngalemithi nangohlengo ezilutholayo kulomtholampilo.

Uhlahlondlela:

Siyakucela ukuba ubeyingxenywe yalolucwaningo ngokuba uchithe nje imizuzwana engamashumi amabili noma engu 20 ubuzwa imibuzo ngalomtholampilo. Lokhukubuzwa kwalemibuzo kuyokwenzelwa engadini ngaphandle kwehholo lomphakathi lase Kenneth Gardens (okulapho lomtholampilo ukhona).

Appendix B (continued)

Ukuze ukwazi ukuzibandakanya kulolucwaningo kumele ube umuntu oseke wawuhambela okungenani kabili lomtholampilo wezehomoeopathy wase Kenneth Gardens. Futhi kumele ubengaphezulu kweminyaka engu 18 noma ubengumgadi noma umqaphi wontwana osemthethweni walowo mntwana ohambela lomtholampilo. Lolucwaningo luzokwenziwa umfundi owenza ucwaningo kanye notolika wakhe ozotolika IsiZulu asiyise esiNgisini.

Lolucwaningo luyothatha isimo sengxoxiswano, siyokhuluma ngemicabango yakho kanye nemibono yakho ngendlela ohlengwa ngayo kulomtholampilo wezehomoeopathy I Kenneth Gardens.

Ngemvume noma ngokugunyazwa nguwe siyocela ukuba siyirekhode lengxoxiswano yemibuzo nezimpendulo. Lawo marekhodi ayosetshenziselwa lolucwaningo kuphela.

Uma ukhethe ukuba yingxenye yalolucwaningo usangaqhubeka futhi uwuhambele lomtholampilo. Alukho ulwazi osinike lona oluyocothselelwa abakulomtholampilo. Futhi unalo ilungelo lokukhetha ukuba ungazibandakanyi kulolucwaningo lalomtholampilo, lokho ngeke kushintshe noma kuphazamise indlela yokuhlengwa noma ukwelashwa kwakho nabanye abahlali bakulendawo iKenneth Gardens.

Uma ngabe ukhetha ukuzibandakanya kulolucwaningo uyonikezwa ifomu elingufakazi neligunyaza ukuba uyavuma ukuba yingxenye yalolucwaningo oyoligcina ngakuwe.

Ingcuphephe nesihluku kulabo abazibandakanyayo:

Akukho ukuhlukumezeka ozokuthola ngokubayinxenye yalolucwaningo futhi ayikho ingcuphe nabungozi obaziwayo ngokuzibandakanya kulolucwaningo. Uma ngabe kukhona umbuzo onzima ukuphenduleka noma ungasazizwa kahle nokuqhubeka nalolucwaningo noma ukuphendula, siyobe (a) sesixoxisana ngalesosimo esivukayo, (b) sesithatha ikhefu, noma (c) sime siyeke. Uma ngabe ukhetha ukuyeka, singaqhubeka siqedele ngolunye usuku noma ungavele nje uzihoxise ekuzibandakanyeni kulolucwaningo.

Imininingwane yakho oyidalulayo kulengxoxiswano yemibuzo yocwaningo luvikelekile alunakudalulwa futhi yonke kuyokwenziwa yonke imizamo yokuthi uhlale nje wena uvikelekile kwizimpendulo zakho zingaziwa ngamunye umuntu ngaphandle komfundi owenza ucwaningo nomhloli wakhe.

Inzuzo:

Ayikho inzuzo nomklomelo oyowunikwa ngokuzibandakanya kwakho kulolucwaningo, kepha ulwazi olunikile lungasiza ukuthi sithuthukise ikweziguli ngokuzayo uma zivakashela lomumtholampilo

Izizathu ezingenza ukuba lowo ozibandakanyayo ahoxiswe kulolucwaningo:

Umfundi owenza ucwaningo angakumisa ekuqhubekeni nalolu cwano uma ebona ukuthi awukho esimweni esikahle nesigculisayo. Futhi nawe uqobo uvumelekile ukunqaba ukuqhubeka nokuba ekubeni yinxenye yalolucwaningo uma uzizwele ukuthi awusathandisi kahle noma umoya wakho awusavumi nomangasiphi isikhathi ngaphandle kokujeziswa.

Inkokhelo: Ayikho Inkokhelo etholwa yilowo ozibandakanyayo kulolucwaningo.

Izindleko zalolucwaningo: Akukho zindleko okulindeleke ukuba uzikhokhe ngokuzibandakanya kulolucwaningo.

Imfihlo: Siyacela ukuba ungadaluli noma ubhale igama lakho neminingwane yakho ephepheni lemibuzo. Imininingwane engase iveze noma idalule ubuwena ayidingeki kulolucwaningo. Kuyoba nezinombolo nje kuphela kuwo onke amapheshana emibuzo yakho yemibuzo yocwaningo ezosetshenziselwa ukuqhuba lolucwaningo ezingenandlela yokudalula lowo ophendulile ngendlela ethize. Amarekhodi alemniningwane nezimpendulo kuyogcinwa futhi aqaphelwe ngumfundi owenza ucwaningo ngesikhathi esnza ucwaningo, emveni kwalokho ayobe

Appendix B (continued)

esegcinwa isikhungo semfundo ephakeme i Durban University of Technology ngaphansi komnyango wezehomoeopathy.

Abantu abhekele lolucwaningo kuphela abayoba negunya lokufinyelela kuleminingwane yalolucwaningo. Imininingwane nezimpendulo osinika zona aziyikutshelwa absebenzi balomtholampilo, abomndeni wakho, noma ngabe ubani omunye ongaphandle kwalolucwaningo. Igama lakho angeke lisetshenziswe ngisho kwimibiko ebhaliwe nakwiziqeshana eziyimiphumela yalolucwaningo ezishicilelwa emaphepheni. Imizamo yonke iyokwenziwa ukuthi uvikeleke njalo ubuwena.

Ukulimala okunobudlelwano nalolucwaningo:

Kuphephile kakhulu ukuzibandakanya kulolucwaningo. Akukho ukulimala nabungozi okutholakala ngokuba ingxenye yalolucwaningo.

Abantu ongaxhumana nabo uma kwenzeka ubanezinkinga noma imibuzo mayelana nalolucwaningo:

Uyacelwa ukuba uxhumane nomfundi owenza ucwaningo Kirsty Love (ucingo: 079 635 2969)

Noma nomhloli omkhulu wocwaningo uDkt. Corne Hall (031-3732514)

Noma i-Institutional Research Ethics administrator on 031-373 2900.

Izikhazazo zingadluliselwa kwisekelamphathi wesikhungo se TIP, uProfF. Otieno kulenombolo 031-373 2382 noma dvctip@dut.ac.za.

Appendix C

Qualitative Interview Guide

Exploring patient perception: of provider care; of medicine/treatment.

1. Interview Pre-amble:

Hello, my name is Kirsty. I am conducting a study that is interested in hearing about patient experience and thoughts on the health service/care provided at the Kenneth Gardens Clinic by the student homoeopaths.

I have a series of general questions that I would like to ask you but your personal experiences and opinions are of most importance to me.

Our interview is not a formal interview it will be like a conversation.

Do you have any questions before we begin?

2. Demographic Information

1. Gender:

Male	Female
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2. Age:

18-25yrs	26-35yrs	36-45yrs	60-69yrs	46 and older
----------	----------	----------	----------	--------------

3. Ethnicity:

African	Caucasian	Coloured	Indian	Other
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4. Employment:

Employed	Unemployed
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5. Number of homoeopathic Consultations:

2	3	4	5	6	7	8	9	10	Specify	
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Appendix C (continued)

3. Interview:

1. Kenneth Gardens Clinic offers healthcare services in the form of nutrition, community nursing and Homoeopathy.
 - a. What healthcare services do you make use of at the Kenneth Gardens Clinic?
 - i. *Explore preferences and frequency of use, how each has benefited the patient.*
 - ii. *Explore motive for seeking homoeopathic services.*
 - b. Most patients coming to this clinic have never experienced Homoeopathy before. Have you had any experience with Homoeopathy before coming to this clinic? _____
 - i. *Explore previous experiences if any.*
 - c. Can you explain what you understood/thought about Homoeopathy before you came to the Homoeopathy clinic, and what you think about it now?
 - i. *Explore knowledge and understanding of homoeopathic care.*
2.
 - a. What have your family/friends and other people in the community told you about their experiences at the homoeopathy clinic?
 - b. What have your family and friends said when they have seen you taking homoeopathic medicines?
3. What other healthcare facilities did/do you still make use of and what are your reasons for deciding to go to there in particular?

Name: _____

- a. Can you tell me what your experience of this/these facilities are?

Probe: What are some of the barriers/difficulties experienced in accessing conventional/allopathic healthcare? What was it like going to these clinics? What was your doctor like? How did the doctor and medication help?

- i. *Explore barriers to accessing allopathic healthcare.*
- ii. *If none, explore use of traditional/other medicines.*
- iii. *Explore provider care in terms of the patients: feelings toward clinic; frequency of use; doctor-patient relationship; consultation.*
- iv. *Explore treatment/medicine in terms of: feeling towards medicine/treatment received; perceived benefit of the medicine/effect thereof.*

4. Kenneth Gardens Clinic offers the health care services of Student Homoeopathic Doctors. Can you please describe what your experience has been consulting with a Homoeopathic Doctor at this clinic?

Probe: What are some of the barriers/difficulties experienced in accessing homoeopathic healthcare? What was it like going to these clinics? What was your doctor like? How did the doctor and medication help? Is there any stigma related to this type of healthcare?

- i. *Explore barriers to accessing homoeopathic healthcare.*
- ii. *Explore aspects of provider care: feelings towards the clinic; frequency of use; doctor-patient relationship; consultation.*
- iii. *Explore perception of treatment/medicine: feeling towards medicine/treatment received; perceived benefit of medicine/effect thereof.*

5. Can you please explain to me, from your experience, what the similarities and differences are between a homoeopathic doctor and homoeopathic remedies like you have had at this clinic compared to Doctors/Nurses and medicines that you have encountered at other clinics?
 - i. *Explore perceived similarities in terms of comparative quality and satisfaction thereof.*

Appendix C (continued)

- ii. Explore perceived differences and associated advantage/disadvantage thereof.*
- iii. Explore preference and justification thereof.*

6.

- a. Can you please explain to me for which of your healthcare needs you seek homoeopathic care and for which you would/do seek conventional medical care (such as the care provided at government hospitals or clinics)?
 - i. Explore types of diseases for which homoeopathic care is sought and the perceived scope of treatment.*
 - ii. Explore what the participant regards to be examples of illness which are best suited to homoeopathic treatment and examples which are best suited to conventional medical treatment.*

- b. Has there ever been a time when you have gone to see a doctor from one type of clinic and then gone to see a doctor from another type of clinic for the same ailment?
 - i. Explore reasons, satisfaction with care and treatment.*

I have reached the end of my questions, thank you for taking the time to answer the questions. Is there anything you would like to ask me?

Appendix D

Uhlalondlela lohlu lwemibuzompendulo

Ukuhlola imibono yesiguli: Yabahlengimpilo: yemithi/ukwelashwa.

1. Isingeniso semimibuzo mpendulo:

Ngiyakubingelela, igama lami uKirsty. Ngenza ucwaningo olubhekelene nokuthola uvo noma imibono yeziguli ngempatho nangemicabango yeziguli ngosizo nokunakekelwa kwezempilo ngabafundi abenza ihomoeopathy okutholakala kulomtholampilo womphakathi i-Kenneth Gardens.

Nginohlu lwemibuzo ejwayelekile nje enginesifiso sokukubuzwa yona kepha imibono yakho kanye nesipiliyoni sakho yikhona okubalulekile kakhulu kimina. Imibuzompendulo lena akusiyo into yemiqhathango ejulile, kuzoba njengengxoxo nje.

Ingabe ikhona yini imibuzo onayo ngaphambi kokuba Siqale?

2. Imininingwane ngesimo sakho:

1. Ubulili:

Owesilisa	Owesifazane
-----------	-------------

2. Iminyaka yobudala:

18-25iminyaka	26-35iminyaka	36-45iminyaka	60-69iminyaka	46 nangaphezulu
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3. Ubuhlanga:

Nginsundu	Ngimhlophe/owebala	Ngiyilawu/ikhaladi	Ngiwumndiya	Olunye uhlanga
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4. Isimo sokuqashwa:

Ngqiqashiwe	Angiqashiwe
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5. Izikhathi osuhambele ngazo lomtholampilo:

2	3	4	5	6	7	8	9	10	Specify	
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Appendix D (continued)

Uhlalondlela lohlu lwemibuzompendulo luyaghubeka

3. Umbuzompendulo:

1. Umtholampilo wase Kenneth Gardens unikeza ezempilo njengendlela zokudla, ubuhlengikazi bomphakathi kanye nehomoeopathy.
 - a. Yimiphi imithombo yezempilo oyisebenzisayo kulomtholampilo i- Kenneth Gardens?
 - i. *Hlola ukuthi yimiphi imithombo eqokwa kakhulu, nesetshenziswa njalo, leyo mithombo isisize noma isihlomulise kanjani nakangakanani isiguli.*
 - ii. *Hlola injongo yokuba isiguli siqoke usizo lwehomoeopathy.*
 - b. Iziguli eziningi ezifika kulomtholampilo azikaze zilashwe ngendlela yehomoeopathy ngaphambilini. Ngabe wena usuke walashwa ngendlela yehomoeopathy ngaphambilini ungakawuhambeli lomtholampilo na? _____
 - i. *Hlola ikamva uma likhona.*
 - ii. *Ungachaza kabanzi ukuthi ulwazi obunalo/ nemicabango obunayo ngehomoepathy ibithini ngaphambi kokuhambela lomtholampilo we homoeopathy nokuthi isihluke kanjani noma isithini manje?*
 - iii. *Hlola ulwazi nokuqonda kohlengo lwezehomoeopathy.*
2.
 - a. Umndeni/nabangani bakho nabanye abantu nje emphakathini bakutsheleni ngemibono yabo nesipiliyoni sabo ngalomtholampilo wezehomoeopathy?
 - b. Umndeni nabangani bakho batheni uma sebekubona uthatha imithi yehomoeopathy?
3. Imiphi eminye imithombo yezohlengo oyisebenzisile nosayisebenzisa, nokuthi yiziphi Izizathu esenza ukuthi uyisebenzise ikhakhulukazi?
Igama: _____

- a. Ungangitshela ukuthi imibono yakho ngalomthombo noma imithombo ithini?

Qhwanda: Imiphi imingcele noma izingqinamba nobunzima obotholakalayo ekufinyeleleni ukuthola uhlanga olujwayelekile? Bekunjani ukuhambela lemitholampilo ejwayelekile? Ubenjani udokotela okubonile? Ukusize kanjani udokotela nemithi akunike yona?

- i. *Hlola imingcele nezingqinamba ekutholeni uhlanga olujwayelekile.*
 - ii. *Uma kungekho, Hlola ukusebenzisa amakhambi esintu neminye imithi.*
 - iii. *Hlola usizo abalunikwayo abahlengimpilo: ngokwemizwa noma imizwa yabo ngomtholampilo; ukuthi bawusebenzisa kangakanani, ubudlelwane iziguli ezinabo nodokotela; nangendlela ababonwa ngayo kulomtholampilo.*
 - iv. *Hlola indlela yokwelashwa/imithi ngokwemibono noluvo lweziguli: imibono mayelana nemithi nokwelashwa abakutholayo; imicabango ngenzuzo yemiphumela yemithi noma ukwelashwanangemithelela yaleyomithi.*
4. Umtholampilo i-Kenneth Gardens inosizo labafundi bezehomoeopathy nodokotela. Uyacelwa ukuba uchaze kabanzi imibono yakho mayelana ngokubonwa abafundi nodokotela bezehomoeopathy kulomtholampilo?

Appendix D (continued)

Qhwanda: Imiphi imingcele noma izingqinamba nobunzima obotholakalayo ekufinyeleleni ukuthola uhlenge olujwayelekile? Bekunjani ukuhambela lemitholampilo ejwayelekile? Ubenjani udokotela okubonile? Ukusize kanjani udokotela nemithi akunike yona? Ingabe ukhona yini umkhokha kwezehomoeopathy endleleni eyelapha ngayo?

- i. Hlola imingcele nezingqinamba ekuhambeleni loluhlenge lwezehomoeopathy.*
 - ii. Hlola usizo abalunikwayo abahlengimpilo: ngokwemizwa noma imizwa yabo ngomtholampilo; ukuthi bawusebenzisa kangakanani, ubudlelwane iziguli ezinabo nodokotela; nangendlela ababonwa ngayo kulomtholampilo.*
 - iii. Hlola indlela yokwelashwa/imithi ngokwemibono noluvo lweziguli: imibono mayelana nemithi nokwelashwa abakutholayo; imicabano ngenzuzo yemiphumela yemithi noma ukwelashwanangemithelela yaleyomithi.*
5. Ngiyakucela ukuba ungichazele kabanzi ngokwazi kwakho nje, ibuphi ubudlelwane nokufananayo kanye nokwehlukile endleleni odokotela bezehomoeopathy abalapha ngayo kanye nohlobo lwemithi yabo kulomtholampilo uma uqhathanisa nodokotela nabahlengikazi nemithi yabo osuke wakuthola kulomtholampilo?
 - i. Hlola imibono yeziguli ngokufanana umakuqhathaniswa nokugculiseka kwazo.*
 - ii. Hlola imibono yeziguli ngokuhlukahlukana kanye nenzuzo nokulahlekelwa okukhona.*
 - iii. Hlola abakukhethayo noma abakuncamelayo nezizathu zalokho. Explore preference and justification thereof.*
6.
 - a. Ngiyakucela ukuba ungichazele ukuthi yiziphi izidingo zempilo ezikwenza uqoke ukwelashwa ngendlela yezehomoeopathy nokuthi yiziphi ke ezikwenza uqoke ezinye izindlela zokwelapha ezihlukile (njengohlengo lwasemitholampilo kahulumeni)?
 - i. Hlola izinhlobo zezifo ezidingelwa ihomoeopathy kanye nobubanzi bezinto ezingalashwa ihomoeopathy.*
 - ii. Hlola ukuthi lona ozibandakanyayo uqonda ukuthi Imiphi imizekeliso yezifo ezilapheka kangcono ngendlela yezehomoeopathy kanye nalezo ezilapheka kangcono ngendlela ejwayelekile kweminye imitholampilo.*
 - b. Ingabe sesike sakhona isikhathi lapho uyewayobona udokotela kumtholampilo wabuye futhi ngaso lesosifo waphinde waya komunye Umtholampilo ohlukile?
 - i. Hlola Izizathu, ukugculiseka ngendlela yokuhlengwa nokwelashwa nemithi.*

Sengifike emaphethelweni emibuzo yami, Ngiyabonga kakhulu ukunginika lesisikhathi sokuphendula lemibuzo. Ingabe kukhona yini ongathanda ukungibuza khona?

Appendix E

23 June 2013

Dear Sir/Madam

Request for permission to conduct qualitative research at the Kenneth Gardens Community Clinic

As a Masters student of Homoeopathy at the Durban University of Technology, I am required to complete a partial dissertation in order to qualify. In compliance with this requirement I have proposed the following research topic:

A study of the perceptions and experiences of patients receiving homoeopathic care in the context of primary healthcare services within the public sector.

The study aims to establish a conceptual model from patient perception and experiences, which will help us to understand the relationship between homoeopathy and allopathy as primary healthcare modalities, and to identify discerning factors which influence patient choice and preference relating to their use of these modalities within the public sector.

In order to complete this research project it is required that we conduct in-depth, individual interviews with a small sample of patients (20-30 patients) who attend the Kenneth Gardens Clinic. All ethical considerations have been taken into account, and we have ensured that the interviewing procedure will neither interfere with the operation of the clinic nor inconvenience the participant. An isiZulu translator will be present for those who wish to participate in the study who are not English speaking.

It is my hope that the insights and knowledge gained from this research will be useful to the future development of the Kenneth Gardens Clinic, as well as the future development of homoeopathy within the public sector.

As such, I would like to request your permission to conduct the abovementioned research study at the Kenneth Gardens Clinic.

Should you have any queries or concerns regarding the research please contact me on 079 635 2969 or per e-mail kirstyjanelove@gmail.com.

Thank you for your time.

Yours Sincerely,

Kirsty Love

Appendix F



INSTITUTIONAL RESEARCH ETHICS COMMITTEE (IREC) CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, _____ (Kirsty Love), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant **Date** **Time** **Signature / Right Thumbprint**

I, _____ (Kirsty Love) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Full Name of Researcher **Date** **Signature**

Full Name of Witness (If applicable) **Date** **Signature**

Full Name of Legal Guardian (If applicable) **Date** **Signature**

Appendix G



IKOMIDI LEZOCWANINGO NEMIGOMO YESINGUNGO / INSTITUTIONAL RESEARCH ETHICS COMMITTEE (IREC) ISIVUMELWANO SOKUZIBANDAKANYA

Izitatimende zokuvuma ukuzibandakanya kulolucwaningo:

- Ngimilana ngiyavuma ukuthi ngazisiwe umcwaningi u, _____ (Kirsty Love), mayelana nohlobo, indlela, inzuzo kanye nencuphephe yalolucwaningo- inombolo ye Research Ethics Clearance: _____,
- Ngititholile, futhi ngiyifundile incwadi yokwazisa ngokuzibandakanya kulolucwaningo ngaba nokuqondisisa okuphelele mayelana nalolucwaningo.
- Nginakho ukuqonda ngemiphumela yalolucwaningo, ukubandakanya ubulili, iminyaka, unyaka wokuzalwa, ama-inishiyali ami nokudalulwa kwesigulo sami ukuthi kuyobe sekudidiyelwa ukwenza umbiko ngalolucwaningo.
- Ekwazini ngezidingo zalolucwaningo, ngiyanikeza igunya lokuba ulwazi ngami olutholakalyo ludidiyelwe bese luhlaziywa ngekhompuyutha nguye umcwaningi.
- Ngingahoxa ukuba ngizibandakanye kulolucwaningo noma inini, ngaphandle kokuba ngicwaswe kulolucwaningo.
- Sengibe nesikhathi nethuba elanele lokuba ngibuze imibuzo (futhi ngentando yami) ngizikhethele mina ukuba ngizibandakanye kulolucwaningo.
- Ngियाqonda ukuthi kusangatholakala ulwazi olubalulekile olusha oluphathelele nalolucwaningo, lolo lwazi ngiyokwazi ukuluthola uma ngiludinga.

**Igama eliphelele lalona
ozibandakanyayo**

Usuku

Isikhathi

**Uphawulokusayina/isithupha
sangasesandleni sokudla**

Mina, _____ (Kirsty Love) ngiyavuma ukuthi lona ongenhla ozibandakanya kucwaningo ngimazisile ngokuphelele mayelana nohlobo, indlela, inzuzo kanye nencuphephe yalolucwaningo.

Igama eliphelele lomcwaningi

Usuku

Uphawulokusayina

Appendix G (continued)

Igama eliphelele likafakazi
(Uma ekhona)

Usuku

Uphawu lokusayina

Igama eliphelele likamqaphi
Uma lidingeka

Usuku

Uphawu lokusayina

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