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Review Article

Access to Public Health Services in South Africa's Rural Eastern Cape Province

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Abstract

Socio-economic issues, such as poverty levels and high levels of unemployment are among the impediments to accessing healthcare services which results in poor health outcomes. In rural areas, insufficient infrastructure and roads make it challenging to reach a health center. In some instances, primary health care services may not be provided in these regions, which often have fewer physicians, dentists, and specialists. The goal of this article was to examine the effects of government health expenditures, health insurance coverage, and the distribution of health facilities in rural areas of the Eastern Cape. Key lessons learned from other analogous rural communities were presented, along with recommendations for addressing the highlighted challenges.

Keywords: Eastern cape; Poverty; Primary health care; Rural communities; South Africa

Introduction

South Africa (SA) has poor health outcomes in rural and urban areas; even though it spends a lot more on health care than other middle-income and developing countries with better health outcomes. Although progress has been made in combating HIV and AIDS and increasing access to oncology and health services, there are regional disparities in South Africa's healthcare system. Undoubtedly, more could be done to enhance oncology and maternal health access. The World Health Organization talks about access to health care in terms of how much it costs, how many people it serves, and what services are available. The term "financial coverage" means that people are protected from the financial and socio-economic effects of getting health care. In rural areas, the number of people covered depends on how far they live from facilities [1,2]. The number of people covered by services depends on the quality of care provided at facilities and the set of services available at different levels of care. SA has built a much stronger social security system than other African countries. It includes grants for people with disabilities, people who need care, and people who are old. A lot of rural households depend on these transfers to stay alive. Some health services, like care for mothers and children and the distribution of antiretrovirals, are now free of charge. This is a big step toward making care easier to get. Even though PHC in the public sector is free, the case study shows that there are still big obstacles to getting care. Due to the costs, many families can't afford to use health care services. People who live in rural areas are affected more because they are less well-off [3,4]. When a family with few resources gets sick, it can have a terrible effect on the whole family that may be hard to recover from. Service coverage is important not only because of the facilities and services that are available, but also because of the quality of care that is given. The public health care system has certain ways of dealing with patients, which often keep stereotypes and assumptions alive. The healthcare system's focus on biomedicine doesn't deal with the social factors that lead to illness, and it also doesn't deal with cultural expectations, migration, or the social dynamics of changing cultures in a good way [4,5]. The case study shows how patients are expected to know how the healthcare system works, including the different levels of care and what they need to do to get care. Concerns have been raised about how well people in rural areas are cared for in public facilities. Recent community meetings about health care in rural areas showed that rural health care users are most worried about a lack of staff, bad attitudes among staff, long distances to health facilities and services, not enough medication, a lack of monitoring and evaluation, patient transportation, and a lack of ambulance services [5,6].

In most countries, inequitable access to healthcare services is a major contributor to health disparities, however many aspects of access remain poorly understood [7,8]. A lack of standardization in the definition and evaluation of access contributes to the lack of cognition. Citizens need to have unhindered and unrestricted access to a variety of health care services, including primary care, dental care, behavioral health, mental health and emergency care, and public health care such access to public health clinics [9,10]. Healthy People 2020 identified that access to healthcare is important amongst others for the following [11]:

- Status of citizens' overall physical, social, and mental health, as well as their overall wellbeing.
- Prioritise disease prevention.
- Early detection, diagnosis, and treatment of illness.
- Avoiding preventable long-term illnesses and deaths.

Rural residents in South Africa, like the Eastern Cape, struggle to access health care due to socio-economic reasons such high unemployment, lack of economic means to pay for treatments and supply for themselves, and lack of transportation to distant institutions [12,13].

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Background

The Eastern Cape Province is one of South Africa's nine provinces, with a population of 6.67 million people, or 11.1% of the country's total population, and ranks fourth among South African provinces [14]. When compared to the contributions made by other provinces, the Eastern Cape's share of the national GDP was 7.6%. In the fourth quarter of 2021, the provinces of Gauteng (35.6%), Kwazulu-Natal (16.3%), and the Western Cape (14.5%) made the greatest contributions to the national GDP [14,15]. There is a correlation between high unemployment rates and high poverty levels in impoverished communities, and such communities frequently have a scarcity of resources [16]. The Literature shows that poverty combined with poor public health conditions, overcrowded housing, and lack of accessible drinking water and sanitation make Africans most vulnerable to ill health [17-19]. The distribution of resources and the provision of medical care in South Africa vary from province to province and generally resources are skewed towards the private sector and urban areas [20].

Purpose

The purpose of this study was to compare the rural Eastern Cape Province to other provinces or national rates in terms of health care spending patterns, the availability and distribution of healthcare providers and facilities, and the impact of socio-economic factors like unemployment and poverty on these variables. We identify areas for reprioritization and offer suggestions on how to increase access to care.

Materials and Methods

This was the systematic review of the profile of the Eastern Cape Province and other countries, which also considered the following:

- Health financing
- Unemployment and Poverty lines
- Leading cause of death
- Maternal and Childcare service
- Mental health services
- Emergency medical services
- Heath facilities

Despite focusing on the Eastern Cape, the study compares to other provinces in South Africa. The comparison period also determines the review period.

Profile of the Eastern Cape

The province has six districts' municipalities and the two Metros (Metropolitan) areas and 20.8% and 18.1% of the people in the reside in the Oliver Tambo (OR) district and Nelson Mandela Metro and just over half, 53% of the overall population consists of females [21]. Male life expectancy at birth in 2021 was 59.3 years (58.7 years in 2021 for the EC), while female life expectancy was 64.6 years (65.0 years for the EC) [21-23]. The province has a high poverty rate, particularly in the districts of Alfred Nzo, Amathole, Chris Hani, Joe Gqabi, and OR Tambo (Figure 1) [24].

Financing healthcare in South Africa

The South African health system is a two-tiered system supported by public sector allocations of general tax money and private sector direct out-of-pocket charges and medical program contributions

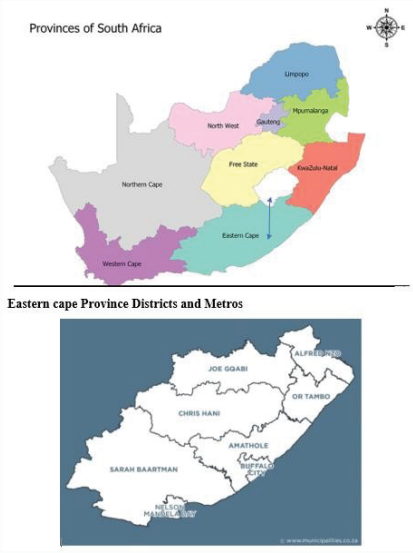

Figure 1: The Eastern Cape Province-South Africa [25,26].

[27]. Figure 2 demonstrates that 42% of expenditures in South Africa are incurred *via* Voluntary Health Insurance (VHI), but only 36% of these expenditures are made directly by individuals and businesses; the remainder is made up of government subsidies to VHI [28]. In 2019, health expenses in South Africa accounted for 9.1% of the Gross Domestic Product (GDP) [29].

Although South Africa's health expenditures as a percentage of GDP fluctuated substantially in early years, between 2000 and 2019 they tended to climb, reaching 9.1% [29]. In 2019, general government health expenditures paid 59% of current South African health bills. General government health expenditures as a percentage of South Africa's current health expenditures increased at an average annual rate of 2.67 percent between 2000 and 2019, from 36.6% to 58.2% [29]. In 2019, private health expenditures accounted for 40.1% of overall health expenditures in South Africa. The ratio of private health expenditures to total health expenditures in South Africa declined from 63% in 2000 to 41% in 2019 [29].

Medical schemes membership

The number of beneficiaries belonging to medical schemes has remained relatively constant over the past two decades, except for an upward trend that was observed between 2006 and 2012, which can largely be attributed to the introduction of the Government Employees Medical Scheme (GEMS), which provides medical coverage largely for state or government employees [30]. Figure 3 further depicts medical scheme membership from 2000 to 2021, a number of people covered by medical schemes were 8.6 million in 2012 and the figure grew to 8.9 million lives in 2021, which depicts a stagnant growth of 3% in almost a decade [30]. Relative to the population, medical schemes accounted for 16% in 2012, and this proportion reduced slightly to 15% in 2021, depicting that the balance of the population was reliant on the public sector [30,31].

Within-province analysis, which is also depicted in Figure 4, revealed that 27% of the population residing in Gauteng had private health insurance in 2006, but this declined to 22% in 2021 [30,31]. A similar trend is notable in the Western Cape Province, where 24% of the population residing in the Western Cape province had medical coverage in 2006, compared to the 19% reported in 2002 [30,31].

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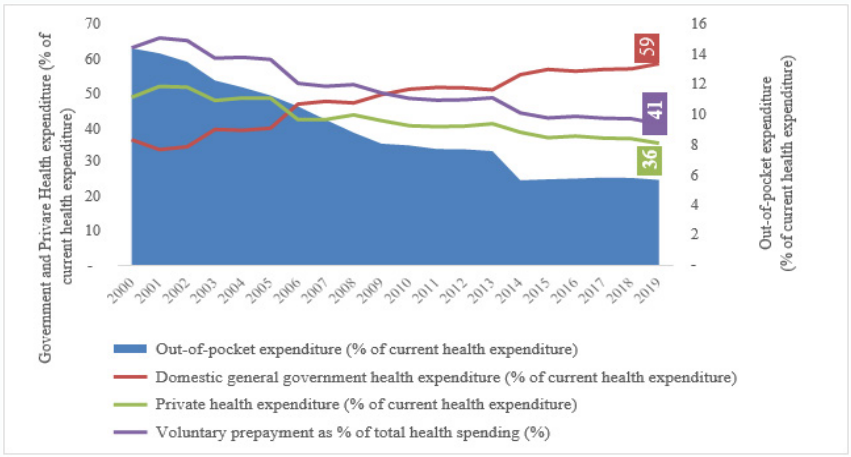

Figure 2: Healthcare financing in South Africa 2000-2019 [29].

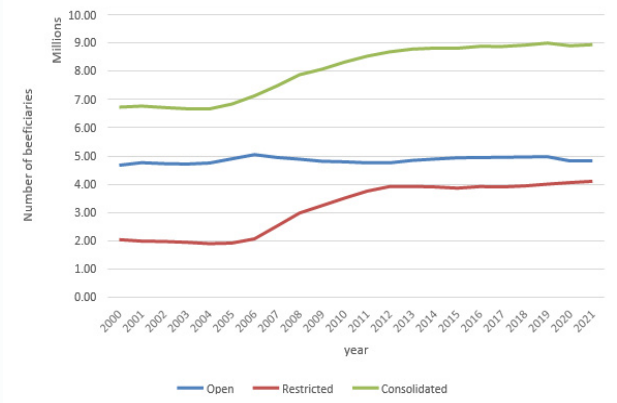

Figure 3: Medical schemes membership by sector [30].

Other provinces, such as the Eastern Cape, KwaZulu-Natal, Limpopo, the North West, the Free State, and the Northern Cape, experienced a minor increase in the number of covered lives between 2006 and 2022 in comparison to the province. Statistics, the 2009 General Household Survey (GHS) of South Africa, indicated that 90.0% of uninsured families lacked the means to pay for medical care [32]. Also, the country's high unemployment rate is viewed as a significant impediment to the use of medical schemes.

Poverty lines in the Eastern Cape

Numerous contributing factors are attributable to the poverty-stricken Eastern Cape population confront, notably in gaining access to inadequately resourced public healthcare facilities [13]. Nearly seventy percent of households in EC live in poverty and reside in rural areas, about double the national average of 37% [33]. Moreover, poverty lines vary greatly across ethnic groups, with African and Coloured populations being disproportionately affected [33]. As shown in Figure 5, provinces such as Limpopo and Eastern Cape have similar levels of poverty lines, with LP being somewhat higher than EC., with LP (67.5%), EC Cape (67.3%), and KwaZulu-Natal (60.7%) which has consistently been above 60% in both 2006 and 2014 as depicted in Figure 5 below [33].

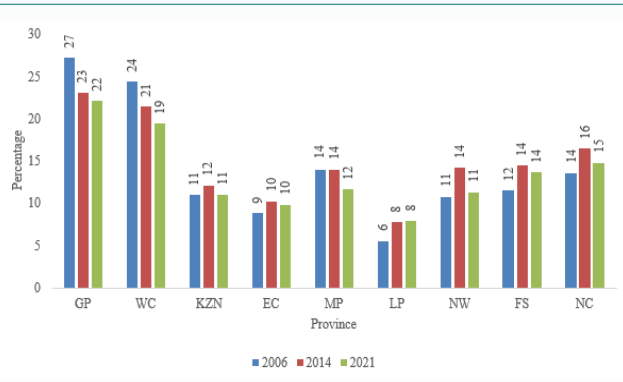

Figure 4: Distribution covered 3 lives by province [30,31].

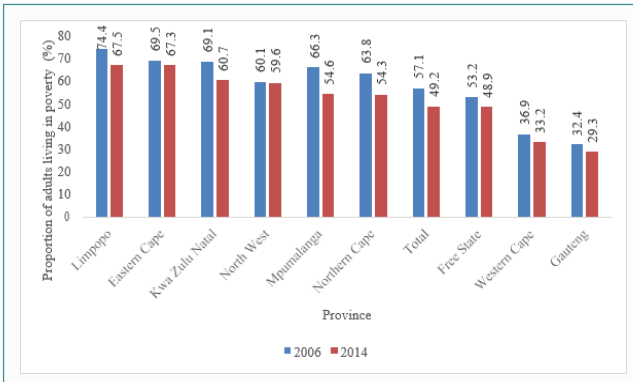

Figure 5: Proportion of adults living in poverty by province [33].

Unemployment rate

In the first quarter of 2022, the Eastern Cape Province in South Africa had the highest unemployment rate in the country, with 44% of the population unemployed [34]. This number is much higher than the national average of 34% and all other provinces' rates [34]. In rural regions such as Eastern Cape, KwaZulu-Natal, Mpumalanga, and Limpopo, the percentage of prolonged poverty is well above 50%. Except KwaZulu-Natal, Mpumalanga, Limpopo, and the North West province, all eight other provinces have an absorption rate above 40%, except the Eastern Cape Province, which has a rate of 29.2% (Figure 6) [34].

Effect of unemployment by demographic characteristics

The job market remains predominantly male-dominated and there is no indication that women's employment chances will improve

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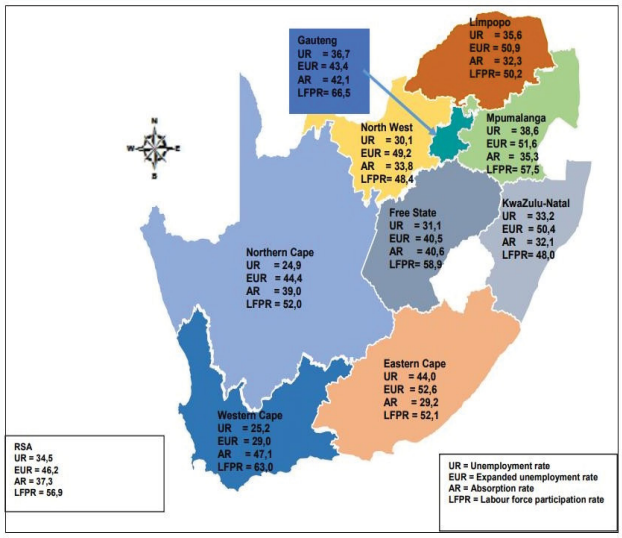

Figure 6: The unemployment rate in South Africa by province [34].

[34,35]. This trend is reversed in provinces such as the Eastern Cape; the unemployment rate for women is 35.5%, which is higher than the unemployment rate for men, which is 32.6%, representing a-2.9% gender difference [34-36]. In comparison, the unemployment rate for women is 48%, which is lower than the unemployment rate for men, which is 52%, representing a +4% gender disparity [35,36]. Furthermore, this phenomenon and its dynamics in EC are inconsistent with previous research in that women are more likely than men to be unemployed or underemployed [37]. In society, men are viewed as providers and family breadwinners, so their unemployment has a variety of negative consequences [38]. As many working-class men associate their image and self-esteem with their work ethic, unemployment carries a significant stigma [39,40].

Leading causes of death

On a global scale, ischemic heart disease is the leading cause of mortality, accounting for 16% of all deaths; however, this varies when comparing global, Africa, low-income countries, and South Africa [41,42]. In 2018, the leading top 3 underlying natural causes of mortality in South Africa were: tuberculosis, diabetes, and cerebrovascular illnesses [43]. When controlling for provincial data, the Eastern Cape Province recorded the highest proportion of tuberculosis-related mortality in South Africa, with 8.3% of deaths, followed by Mpumalanga, with 8.1% of deaths. The second highest underlying cause of death in Northern Cape and Limpopo was TB, accounting for 7.4% of fatalities in each province [43]. Notably, TB is ranked eighth among the leading causes of death in Africa and other low-income nations, as depicted in the Table 1 [44].

Health facilities in the Eastern Cape Province

South Africa is estimated to have between 1.7 to 2.3 beds per 1000 people, which is higher than the international benchmark for optimal beds per population is 1.5 per 1000 people [45,46]. Table 2 presents the number of district hospitals and the number of beds available.

The data depicts a shortage of beds in districts such as OR Tambo and Alfred Nzo, which are primarily rural, where the number of beds per 1000 population is less than 1 [47,48]. Amathole districts, Joe Gqabi, and Chris Hani seem to have adequate beds with a relative ratio >1 per 1000 people. Although the total number of hospital beds per 1,000 people conforms to international norms, the distribution of hospital beds among districts and treatment levels appears to be extremely lower in poverty struck areas.

Primary Heath Care (PHC) services

Many people need Primary Health Care (PHC) facilities and the unavailability of such amenities in rural-based communities might have a bad effect or effect on the national health system of any sort [13,49]. Most rural and impoverished residents lack competent primary care, which may solve most health issues, reducing downstream expenses [50,51]. Table 3 below the findings of s study conducted in South Africa and depicts a comparison analysis between the EC and RSA on the type of healthcare facility consulted first by the households when members fall ill or get injured [52]. The study revealed that most households first visit a public clinic, and the EC scored higher than the national response rate. This was more skewed at the national level, where 24.2% of respondents saw a private physician compared to 17.6% in the EC. Public hospital is the third point of contact. Regarding health-related services, 1.1% of households in EC compared to 0.7% of households in RSA consulted a Traditional. This study's findings highlighted the significance of maintaining adequate access to public facilities such as hospitals and clinics that provide primary health care.

Shortage of ambulance services and distance as a barrier to accessing healthcare

The Bill of rights and its pertinent sections provide for the rights of access to health care services, including reproductive health and emergency medical treatment [52]. Up to fifty percent of maternal deaths are related to the unavailability of emergency transport, according to Fawcus et al. [53]. Within communities, traditional birth attendants play a significant role in the care of women during pregnancy, birth, and puerperium [54]. Studies find that pregnant women relied on traditional delivery attendants who lacked the knowledge and tools to treat severe situations due to poor transport infrastructure [55-57]. In South Africa, EMS quality varies due to

Table 1: Top 10 Leading underlying causes of death.

	World	Africa	Low-income countries	South Africa
1	Ischemic heart disease	Neonatal conditions	Neonatal conditions	Tuberculosis
2	Stroke	Lower respiratory infections	Lower respiratory infections	Diabetes
3	Chronic obstructive pulmonary disease	Diarrheal diseases	Ischemic heart disease	Cerebrovascular diseases
4	Lower respiratory infections	HIV/AIDS	Stroke	Other forms of heart disease
5	Neonatal conditions	Ischemic heart disease	Diarrheal diseases	HIV/ AIDS
6	Trachea, bronchus, lung cancers	Stroke	Malaria	Hypertensive disease
7	Alzheimer's disease and other dementias	Malaria	Road injury	Influenza and Pneumonia
8	Diarrheal diseases	Tuberculosis	Tuberculosis	Ischemic heart diseases
9	Diabetes mellitus	Road injury	HIV/AIDS	Chronic lower respiratory diseases
10	Kidney disease	Cirrhosis of the liver	Cirrhosis of the liver	Malignant neoplasms of digestive organs

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Table 2: Number of district hospitals and beds in the Eastern Cape Province (2015).

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

Table 3: Percentage distribution of the type of healthcare facility consulted first by the households when members fall ill or get injured by province.

	EC	RSA	% Gap
Other	0.1	0.4	-0.75
Pharmacy	0.3	0.4	-0.25
Traditional healer	1.1	0.7	0.57
Private doctor	17.6	24.2	-0.27
Private nurse	0.5	1.3	-0.62
Private hospital	0.7	1.6	-0.56
Other public institutions	0.3	0.5	-0.4
Public hospital	4.8	6.1	-0.21
Public clinic	74.7	64.9	0.15

historical context and EMS resource constraints in rural areas are even more prevalent and these delays impact on poor health outcomes [58]. Studies find that the unavailability and delay of transportation is a leading cause of prenatal mortality (the death of a baby immediately before or after birth) [59-61]. Lack of ambulances for patient transfers and trauma incidents is serious problem in EC with 0.4 ambulances per 10,000 people compared to the national standard of 1 ambulance per 10,000 people [59,62,63]. The Table 4 depicts a significant shortage of emergency services in the public sector across provinces in South Africa other than the Northern Cape Province, which has an oversupply of 54%. The EC province has a shortage of 32%, while a province such as the North West has a significant shortage of 85% ambulances. The shortage in Limpopo, which has similar poverty lines as the EC, was 36%.

According to the information provided by the minister of health, as of December 2022, the number has climbed to 3,342 ambulances, and the deficit of 3,401 reflects a continuing worry on a national level. The national standard for ambulance availability is one operable ambulance per 10,000 persons. However, the EC is at 0.68:10,000 as of 2018, which is significantly lower than the set standard but higher than other provinces other than NC [31,64]. Only two of the eight districts, Joe Gqabi and Sarah Baartman, met the national average, as seen in the graph below. Rural districts such as Alfred Nzo and Or Tambo, as well as the two metropolitan areas, fell short of the benchmarks. Figure 7 illustrates the urgent need to seek alternative solutions to providing emergency medical services in rural based communities and at the national level.

Maternal and childcare services

There is progress with regard to maternal mortality, nationally, the ratio decreased from 105,9 deaths per 100 000 live births in 2019 to 88,0 in 2020, indicating that South Africa is experiencing a decrease in aternal Mortality in Facility Ratio (MMFR) [65]. The Eastern Cape and Northern Cape provinces showed an increase in MMFR between 2019 and 2020 [65]. All other provinces showed decreasing patterns, which is also reflected in the national pattern. In rural regions, driving long distances for care and other scenarios, such as giving birth in ambulances or forgoing prenatal and postpartum care, are prevalent

Table 4: Emergency services in the public sector- South Africa.

	Number of ambulances	Number of ideal ambulances	Shortage	% Gap/ Shortage
EC	447	653	206	32%
GP	726	1,472	746	51%
FS	191	295	104	35%
KZN	573	1,138	565	5%
LP	373	580	207	36%
MP	153	452	299	66%
NC	189	123	(66)	-54%
NW	61	398	337	85%
WC	264	662	398	6%
	2977	5,773	2796	48%

[66,67]. A study that explored perceptions, knowledge, and attitudes of women of reproductive age concerning maternal deaths in Qaukeni Sub-District, Eastern Cape Province, South Africa, found that [68]. The study found that Women do not attend antenatal care because of the long distances, absence of clinics, shortage of nurses and doctors; as a result, women deliver their babies at home [68].

Mental health services

The status of mental healthcare services in the Eastern Cape continues to present its own unique challenges [69]. Neither districts such as Joe Gqabi nor Alfred Nzo has a single bed for people with mental health conditions [69]. Furthermore, the table below shows that other districts, such as Buffalo City Metro and OR Tambo also have very few mental health beds relative to the population. The close proximity of the districts in issue suggests that there may be a greater number of patients requiring mental health care in the Chris Hani district than in the Sarah Baartman and Amathole areas, where the number of beds appears reasonable. The seven mental health facilities in the province only have a total of thirteen psychiatric nurses working for them. In the public institutions of the Eastern Cape, only two psychiatrists supporting these mental health facilities (Table 5) [70].

Implementation of an augmented non-governmental organization service

Even if health services are available in rural areas, these improvements and the ways to deal with problems like transportation costs and parents who aren't around for their children who live in rural areas all affect how many people use them. In rural areas of Africa, partnerships between the government and NGOs have worked well when both sides are committed to the process, and the partnership is made to fit the community's needs. There is evidence that these kinds of collaborative services make healthcare delivery and provision better [71-73]. This is especially true in places where there are both wars and extreme poverty and where public health services no longer reach rural and remote areas. In these places, only independent NGOs offer health services. In the South African province of the Eastern Cape,

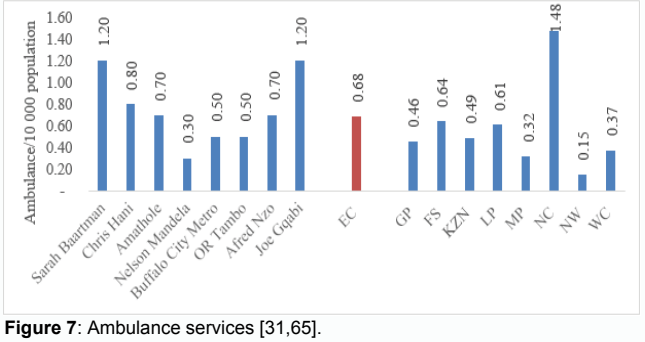

Figure 7: Ambulance services [31,65].

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NGOs and local governments have made partnerships to improve rural health care. A good example is a rural area around Mbashe and the King Sabatha Dalindyebo district of Mbashe in the rural Eastern Cape. An NGO called the Donald Woods Foundation (DWF) provides extra health services in these areas. This service is for people living in remote rural villages far from government health clinics. It includes assessment services, immediate treatment, and referrals to fixed government primary or secondary healthcare services for older people and children. The DWF mobile-tented clinical outreach service focuses on screening, referrals to other services, treatment of minor illnesses, and emergency medication. This service helps

the most overcrowded government primary health care clinics and serves some of the least accessible areas [72,73].

Key interventions and strategies to reduce access to health care in rural communities

The Table 6 shows some of the recommended solutions for addressing rural communication difficulties in gaining access to health care as a result of varied socio- economic conditions.

Discussion

Access barriers faced by many South Africans, in particular those residing in rural areas; require governments, policymakers and health care providers to enforce existing policies and regulations better. There is a need to engage local government and communities about service delivery and ensuring that infrastructure is in place. It should also go beyond just ensuring that the infrastructure is there, but the maintenance of such facilities, both the local government and the communities need to play a critical role in this regard. Despite the increase in population, not enough hospitals and beds have been built to meet the growing need. The survey also revealed insufficient mental health professionals, such as psychiatrists. Neither is the distribution of mental health facilities equal to the population per district or area. Even though this problem is not specific to the province, it is more pronounced there. In addressing access to care, governments need to avail transportation options in all communities taking into account the location and population in need for care.

This includes making sure that ambulance or emergency services are accessible. There are a number of initiatives that could potentially be explored in dealing with distance and transportation as a barrier to accessing health facilities. Some that have been studied in other countries include providing subsidies, ferry discounts or travel vouchers for patients that have to travel for medical care (BC Ministry

Table 5: Number of mental health beds per region in EC.

	Population	Number of Mental Health beds	Beds per population
Sarah Baartman	479,923	313	6.52
Chris Hani	840,055	440	5.24
Amathole	880,790	400	4.54
Nelson Mandela	1,263,051	198	1.57
Buffalo City Metro	834,997	50	0.6
OR Tambo	1,457,384	60	0.41
Afred Nzo	867,864	0	-
Joe Gqabi	372,912	0	-
Chris Hani, Buffalo City Metro, OR Tambo, Afred Nzo & Joe Gqabi	4,373,212	550	1.26
Buffalo City Metro, OR Tambo, Afred Nzo & Joe Gqabi	3,533,157	110	0.31
Sarah Baartman, Nelson Mandela	1,742,974	511	2.93

Table 6: Improving access to health services in rural communities.

Rural challenge	Intervention
Financial support and means to access services	In some rural communities, the unemployment rate is extremely high, and in districts with mountainous terrain, travel times to facilities and emergency services are lengthened. There should be financial support from local governments, local businesses, donors, grants, or other entities based on predetermined criteria.
Identification of rural areas with a high proportion of the elderly, people with disabilities, and people who have chronic conditions requiring multiple visits to outpatient healthcare facilities.	Targeted programs for vulnerable groups would require clearly defined programs between the department of social development, department of health, public works and others.
Transportation services to promote rural healthcare access	To reduce travel burdens in accessing healthcare, there should be transportation services which could include: • Using professional or volunteer drivers to transport patients to medical appointments. • Using a mobile clinic to bring healthcare services to patients in distant locations. • Sending Community Health Workers or Community Paramedics to patients' homes may reduce the frequency of journeys for medical care. • Provide transportation vouchers to the elderly and other qualifying citizens based on a set criterion.
Due to the lack of mental health providers in rural communities	The use of telehealth to deliver mental health services is increasing. Using telehealth delivery systems, mental health services can be provided in various rural settings, including rural clinics, schools, residential programs, long-term care facilities, and individual patient homes. Increased availability of broadband and internet connections should help telecommunications- related endeavours. This would also necessitate continued collaboration between the government, telecommunications firms, and the business sector.
Reproductive Health, Obstetrics, and Child Care and Maternal Health services	Women in rural-based communities lack access to screening services such as pap-smear tests and lack of access to other reproductive health services such as contraception, sexual and relationship history, Sexually Transmitted Infections (STIs) and other transmissible and obstetric services diseases. Access to labour and delivery, prenatal, and related services is also a concern. Services such as termination of pregnancies are virtually non-existent. One of the interventions considered in other countries is establishing mountainous, largely rural area network of maternity medical service providers. Maternal services satellite clinics could support this, and these initiatives are further supported by telehealth initiatives. Governments, corporations, and donors should support networks to ensure their sustainability.

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of Health, 2008). The expansion of access to high- quality primary care will make an enormous difference in health care outcomes in the so-called under-resourced areas. It is known that providing more resources to attract and retain healthcare professionals in rural areas is essential to improving access to healthcare in a rural area, for example, innovation proposal such as additional compensation for practising in rural-based communities is proposed (Kabene, 2006). Integrated programs with clearly defined plans amongst government departments such as health, transportation, social development, and public works are encouraged, and these programs should be continuously monitored and assessed against predetermined goals. It is also advocated that enough financing be channelled to Rural based villages as a model for cooperation between the government, donors, and corporate sectors.

Conclusion

Despite the challenges faced by underfunding the public health sector, which caters to a significant segment of the population, other factors, such as a lack of human resources and a lack of emergency medical services, hampers service delivery and access, hence contributing to poor health outcomes. Improving health outcomes requires adequate infrastructure, including roads, public health care facilities, and access to emergency transportation. Indeed, the Eastern Cape Province is one of the worst provinces in South Africa in terms of unemployment and poverty rates. Consequently, most residents cannot afford private health care, as many have no private health insurance or coverage. However, the government does provide free health services in public facilities. However, socio-economic factors such as unemployment, high levels of poverty, and the long distance to health facilities, mountainous terrains where residents live in remote, isolated areas remain challenging. This study proposes alternative community-specific interventions that can be used to increase access to health care.

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