

HEALTH SEEKING EXPERIENCES AND BEHAVIOURS OF HOMELESS PEOPLE IN DURBAN, SOUTH AFRICA

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ABSTRACT

This study aimed to describe health seeking behaviours and experiences of homeless people in order to provide improved healthcare services to homeless people. A qualitative design was adopted and semi structured interviews with homeless people and healthcare workers were conducted. Through a thematic analysis major themes, related to unique health seeking behaviours amongst homeless people, were identified. The definition of health, as understood by homeless people, their health seeking behaviours as influenced by social issues, and access to healthcare services were addressed. Although the homeless participants were physically able to access healthcare facilities, they reported mixed experiences about the services received.

International conventions dictate the social responsibility of providing healthcare to homeless people. However, homeless people themselves have recommendations for policy makers, healthcare service providers and researchers. Their participation in planning and implementing health services for homeless people might enhance the services rendered to homeless people.

Keywords: access to healthcare, health seeking behaviour; healthcare in South Africa, homeless people's healthcare experiences

INTRODUCTION AND BACKGROUND INFORMATION

Health seeking behaviour is defined as behaviour a person displays in a conscious effort to promote own optimum wellness, or seek medical treatment for an ailment/illness and rehabilitation (Gabrysch & Campbell, 2009). The state of homelessness has a significant influence on the health of homeless people. Inadequate shelter, poor access to food, susceptibility to communicable diseases, vulnerability to violence and injuries, contribute to higher rates of morbidity and premature mortality. These factors

lower life expectancy amongst homeless people (Wright & Tompkins, 2006:287). Homelessness has been identified as a dual-edged sword, as health problems may contribute to homelessness, whilst homelessness may cause and exacerbate health problems (McMurray-Avila, 2001:11).

Despite substantial international evidence, homeless people experience problems to obtain adequate healthcare (Hwang, Tolomiczenko, Kouyoumdjian & Garner, 2005:314; Manfellotto, 2002:76; National Health Care for the Homeless Council, 2008:3; Riley, Harding, Underwood & Carter, 2003:474; Wright & Tompkins, 2006:286). The “inverse care law” proposed by Tudor Hart (1965, cited in Riley et al., 2003:473), stating that the availability of healthcare varies inversely with the population’s health needs, is applicable to the provision and utilisation of health services for homeless people. Provision of healthcare to homeless people is promulgated in the declaration of human rights (WHO, 2008:1) which states that: “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family”.

If homeless people access available healthcare services, they might receive poor care and have unpleasant experiences. The World Health Report (WHO, 2000:ix) identifies inequalities in relation to healthcare availability for homeless people indicating that they are treated with less respect, having access to a more circumscribed choice of health providers, offered poorer quality amenities and receive less prompt attention. Seager and Tamasane (2008:11) reported that homeless people suffered from verbal abuse when accessing health services. Similarly Martins (2008:427) maintained that homeless people might be treated with disrespect when accessing healthcare services.

The barriers encountered by homeless people to access healthcare include lack of finances, cultural barriers due to marginalisation, and barriers due to a lack of comprehensive healthcare provision (Wright & Tompkins, 2005:4). These barriers could result in a delay in deciding to seek healthcare, a delay in reaching a healthcare facility and/or a delay in receiving adequate healthcare. Homelessness is a broad and complex topic. In the South African context, homelessness results from severe socio-economic conditions, including general poverty, rural to urban migration and inadequate provision of housing. It is in this context that homeless people seek access to healthcare (HSRC, 2010).

THEORETICAL FOUNDATION

The study used an adaptation of the Three Delays Model (Thaddeus & Maine, 1994) that identifies three phases of accessing quality care. Phase I refers to the process of seeking care, phase II to the process of accessing care and phase III to the quality of care received. Factors facilitating and hindering access to quality healthcare by homeless people might be identified in each phase (Gabrysch & Campbell, 2009).

RESEARCH PURPOSE AND OBJECTIVES

The purpose underpinning this study sought to describe the health seeking experiences and behaviours of homeless people in South Central Durban. The objectives included the description of healthcare needs, description of experiences related to health seeking behaviours, description of factors facilitating and hindering access to healthcare and recommendations regarding healthcare services for homeless people.

RESEARCH DESIGN AND METHODOLOGY

Semi-structured interviews were conducted with 12 homeless people and with six healthcare workers. The choice of a qualitative methodology was prompted by the need to understand health seeking behaviours both from the perspective of homeless people as well as from that of healthcare workers in governmental and non-governmental healthcare services in Durban.

Purposive heterogeneous sampling was used: key informant interviews were held with both homeless people and healthcare workers. This heterogeneous sampling enabled the researcher to elicit similarities and differences from the two groups (Ulin, Robinsin, Tolley & McNeill, 2002:60). After 12 interviews with homeless people and six interviews with healthcare workers, data collection was stopped based on the principles of saturation and redundancy. New participants were approached until data saturation had been reached, because “no new data or new inputs were obtained” (De Vos, Strydom, Fouche & Delpont, 2005:329).

Research setting

The study setting was an urban area in South Central Durban, in the KwaZulu-Natal province of South Africa.

Sample

Twelve homeless participants, six males and six females were interviewed. Six healthcare workers were interviewed, all women, two registered doctors and four registered nurses. Three healthcare workers were from government services and three healthcare workers were from non-government services. For gathering data from homeless people, homeless people were approached from the soup kitchen queue at a church and from a hostel run by the local municipality. At the hostel, snowball sampling was used to identify further participants. For gathering data from healthcare workers all the clinics in the study location were included in the study. From each clinic (three municipal and three non-government organisation-based clinics) one healthcare worker was interviewed.

Data collection

Interview guides for both types of respondents were developed by the researcher. The interview guides for the healthcare workers were developed in English, whilst the interview guides for homeless people were developed in both English and isiZulu. The guides for homeless people were first developed in English, then translated into “street” isiZulu then rechecked by a third person, thereby enhancing the reliability of the translation. A research assistant, who was a first language isiZulu speaker, was trained and employed to conduct interviews. All interviews were audio-taped.

Homeless people were asked reasons for coming to Durban; where they resided in Durban; normal daily activities; meaning of health; where healthcare is accessed, which healthcare services have been utilised, distance traveled to the healthcare services, cost of travel, services received at the clinic, health seeking behaviours and experiences of accessing healthcare, and suggestions for improving healthcare provision to homeless people.

Healthcare workers were asked about their perceptions of the healthcare needs and healthcare seeking behaviours of homeless people; where homeless people accessed healthcare; factors and barriers encountered in accessing healthcare; and suggestions for improving the provision of healthcare services to homeless people.

The interviews were conducted by the research assistant which ranged from 30-40 minutes per participant. All participants agreed to be audio-taped. After each interview the researcher and assistant met and compiled field notes.

Data analysis

Interviews were transcribed verbatim. Interviews in isiZulu were translated by the research assistant. All data (interviews, field notes and memos) were collated to form a data base. After reading and re-reading the data, a thematic analysis approach was implemented to identify patterns/categories of themes and sub themes, which represented the “central core of the data collected” (Patton, 2002:453). To identify major themes, a deductive approach was used to analyse the data according to pre-determined categories, suggested by the research questions and research objectives. An inductive approach was implemented to identify sub-themes. Findings from the data were reported in narrative format.

Trustworthiness

In this study trustworthiness, member checks, analyst triangulation, reflexivity and clear exposition of all study decisions were used to enhance rigour. Data were collected by

compiling transcribed verbatim interviews and field notes. Details were provided about the data collected, thus allowing thick descriptions.

For trustworthiness of data interpretation member checking was done with healthcare workers. The researcher was unable to trace the homeless participants to query whether the transcripts were true reflections of the information they had provided.

An independent researcher analysed selected transcripts and compared the coding of emerging categories and sub categories with those of the researcher and research assistant. Differences were discussed and resolved.

Reflexivity was implemented through keeping a reflective diary throughout the fieldwork process. As the first author had volunteered at a healthcare service for homeless people for many years, she was sympathetic to the healthcare needs of homeless people. The reflective diary assisted her to 'bracket' her own experiences and beliefs, thus formally acknowledging and assessing her own subjective experiences and their potential influences on the study.

In order to ensure dependability, the researchers meticulously represented, explained and logically motivated all steps and study decisions (Engelbrecht, 2005).

All data collected were stored in a safe place together with decisions about coding thus providing evidence of research findings (audit trail).

ETHICAL CONSIDERATIONS

Prior to the commencement of data collection, ethical clearance was obtained from the Biomedical Research Ethics Committee at the University of KwaZulu-Natal (reference no.H083/06). Permission to conduct the study was obtained from the governmental and non-governmental healthcare services. Informed consent was obtained from each participant prior to the interview. The majority of the homeless people in South Central Durban are isiZulu speaking. Consequently an isiZulu research assistant conducted the semi-structured interviews and the translation thereof. All participants agreed to allow the interviews to be audio recorded. The tapes and transcribed data were kept in a locked-up cupboard to which the researcher had sole access.

RESEARCH FINDINGS

Biographic information

Twelve homeless participants, six males and six females participated in the study. Three came from rural areas in the Eastern Cape, six came from rural KwaZulu-Natal, one from Mpumalanga and two came from Durban. Participants' reported periods of homelessness ranged from six months to three years to *"all my life"*. With regard to their reasons for migrating to Durban, nine participants responded that they came to Durban to seek employment, while one responded *"because of HIV positive, to get better care."*

Perceived health status

When asked about their health problems, all homeless participants in the study stated their basic needs such as food for survival, ablution facilities and shelter. *"We use the toilets at the train station....we sometimes get chased away by the cleaners"*. This finding was corroborated by healthcare workers who emphasised the urgent need of providing hygiene facilities, showers and toilets for homeless people.

As a result of lack of sheltered accommodation, homeless people are at risk of physical and sexual abuse. One participant described the threat of abuse from young boys and taxi drivers *"I don't want to fight because I am old...I'm not of their age...they must go to their own age group"*. Ways of attempting to protect themselves include *"we don't sleep in one place"* and *"I always wear a tight legging in case of gang rape, the leggings protect me at night"*. The homeless participant elaborated that *"we live together, there are many people...we protect each other"*. A further example of the threat to safety was when one participant was hesitant to sign informed consent for the study, as *"my name would be forwarded to SAPS (South African Police Services)"*. One participant summed up the vulnerability felt *"the only thing that we are scared of, are people rather than animals...sangomas (diviners) want body parts to make "muti" (traditional medicine)"*.

With regard to perceptions of their own state of health, responses were mixed. Some homeless respondents perceived themselves as being healthy and others were reportedly unhealthy. The main reasons for not being healthy included not having a permanent job, resulting in an inability to buy food, as stated by the participants:

"... one must have a steady job, as I am unable to work, life is difficult for me, one must have money for things for food and healthcare".

Homeless participants reported suffering from minor ailments, communicable and non-communicable diseases and trauma.

“I have a sore on my leg...it is not getting better...I think it is because of the tight shoes I am wearing”.

“For my legs...I have these sores because I have not been looking well after myself properly”.

“I’m not well...I am HIV positive”.

“I was beaten with a crate”.

Healthcare workers reported that homeless clients presented with ailments ranging from minor to major

“A lot of them tend to come when they are late in their illnesses...they are actually very sick...and sick for quite some time”.

Processes used to access healthcare

Factors facilitating access to healthcare identified by both homeless persons and healthcare workers included: incentives to seek care, financial costs, quality of care and accessibility of healthcare facilities. Two faith-based organisations stated that a soup kitchen was run in conjunction with the healthcare facility. Food was an incentive for homeless clients to seek healthcare, as explained by one person:

“...is that there is a feeding scheme that’s run here everyday”.

The cost of travelling to the facility and the cost of paying for services at the facility were influenced the accessibility of healthcare facilities for homeless persons. Healthcare workers in health services provided by faith-based organisations postulated that homeless people access their clinics as

“the main thing is that we are free... they get a meal a day...medication is for free... some of the homeless live around here so they just walk”.

Hostel residents said that they were given letters confirming that they were residents, which facilitated access to government healthcare facilities. Access to healthcare facilities was also influenced by the geographically location of the facilities. Homeless respondents described the distance to travel to clinics to be “near” and that the time taken to travel was 20-30 minutes. One healthcare worker described the location of the clinic as “situated right in the centre of all the taxis and transport...everything is close by”.

An additional factor facilitating access to healthcare facilities is the quality of care that homeless people received. Homeless participants gave positive responses concerning the services that they received from both clinics and government hospitals:

“I found it very good...I have always had good attention”.

Healthcare workers felt that the better health resources available in the urban areas facilitated access *“sometimes people come from the rural areas, when they come with long term sicknesses hoping to get better assistance from the urban clinic”.*

Factors identified as hindering access to care included long waiting times at healthcare facilities, lack of money to travel to another healthcare facility for referral for antiretroviral treatment (ART), clients not having the required identification documents and not having fixed addresses. Non possession of an identification document also poses problems when obtaining grants and pensions and registration for ART programme. Two healthcare workers elaborated as follows:

“... identification, permanent address and a friend to go with them...As clients are sleeping under the bushes... they do not have a permanent address”.

“... this is a great problem for us referring for ART, the clients have to produce an identification document and they have to have a permanent address”.

Factors hindering access to healthcare services identified by both homeless persons and healthcare workers were the range of services offered, such as not providing ARVs, problems encountered at healthcare facilities, problems with money and identification documentation and discrimination. Homeless participants lamented the long waiting time at healthcare facilities

“I find I have to wait, wait, sometimes the whole day”.

“I have to wait. I know that they are very busy here. I sit and wait”.

One healthcare worker raised the issue of healthcare for non-South African citizens, by stating:

“... if they are from another country, they are not considered South African citizens, so they are chased away”.

Compliance with care schedules was reported to be problematic. Healthcare workers gave the following reasons for non compliance by homeless people: stopping medication when symptoms improved, medication stolen, no money to pay for transport to

healthcare facilities and no fixed address. In anticipating non compliance one healthcare worker explained

“... one opts for injection rather than tablets...they (homeless people) do default”.

Quality of care received at the healthcare facility

Homeless participants provided positive and negative responses concerning the service that they had received from both faith-based organisations and government services.

“At the hospital they wanted R20...but I didn't have...they said I must pay next time”.

Lack of medication hinders access of healthcare by homeless people, as described by homeless participants:

“Sometimes if I go there they do not give me tablets...they say that they are finished”.

Discrimination makes healthcare services inaccessible to some homeless people. This was stated by homeless participants who described staff as being unfriendly.

“Just depends on the staff that you have...because a lot of the time people don't want to go to other facilities because the staff are unfriendly, and the staff don't provide an atmosphere that is non-discriminating”.

DISCUSSION

The findings present the experiences and health seeking behaviours of homeless people, as described by homeless people and healthcare workers. Experiences with regards to the process of seeking care (phase 1 in the model reviewed by Gabrysch & Campbell, 2009) demonstrate how homeless people exercise self-care, care for each other, and how homeless people decide to seek care from a health facility, whether governmental or non-governmental. Furthermore, homeless people showed a holistic understanding of health, by associating health needs with other basic needs such as food, shelter, ablution facilities and safety and security. Concerning safety and security needs, the findings show how homeless people form social, protective networks as described by Smith (2008:89), through the development of ‘street families’, to protect themselves and each other. Concerning their health needs, homeless people show that they are acutely aware of their compromised health status, which in some instances, has prompted migration to Durban from a rural area in order to increase access to better healthcare. However, despite this awareness, homeless people are still reported by healthcare workers to seek healthcare in advanced stages of disease. This may result from the low priority assigned to healthcare and low expectations of their health. While fear of stigmatisation has been associated with a reluctance to seek healthcare (Thaddeus & Maine, 1994) homeless

people participating in this study were frank about their health status and their ailments, including living with HIV.

Experiences with regards to the process of accessing healthcare (phase 2 in the model reviewed by Gabrysch & Campbell (2009) depicted relatively easy access to healthcare pertaining to location, physical accessibility, transportation and cost. Furthermore the findings demonstrated that there was a good referral network connecting the different levels of care, meeting homeless persons' healthcare needs. This finding was in contrast to the findings reported by Riley et al. (2003:475) who described several barriers experienced by homeless people in accessing primary healthcare facilities, leading to their inappropriate use of emergency healthcare services. The free healthcare policy introduced in South Africa in 1994 for women, children and indigent, and other vulnerable groups, might have facilitated the accessibility to healthcare facilities, even for homeless people (Chetty, 2007). However, even within a context of free and relatively easily accessible healthcare, linking healthcare services to the provision of other needs (such as food in the form of a soup kitchen) provided additional motivation for homeless people to access healthcare services.

Experiences with regard to quality of care (phase 3 in the model reviewed by Gabrysch & Campbell, 2009) reported that homeless people experienced a lack of medication, lack of identification, a lack of fixed permanent addresses and discrimination towards homeless people. Homeless participants stated that they had received good services from healthcare facilities. These findings concur with those of Gabrysch and Campbell, (2009:14) that the quality of care is an important consideration in the decision to seek care. Long waiting times and the lack of medication were problems voiced by homeless participants. Whilst lack of medication is a general factor affecting public sector clients, not only homeless people, vulnerable groups might suffer most. Gabrysch and Campbell (2009:14) reiterated that delays in receiving adequate treatment at a healthcare facility could delay the client's recovery. The findings demonstrate administrative barriers to receiving quality care, such as lack of appropriate documentation. Due to the migratory nature of homeless people, it is problematic to register them at specific healthcare services (Riley et al., 2003:475). Some discrimination was experienced by homeless people at healthcare services, which could be a factor preventing them from seeking healthcare.

CONCLUSIONS

The findings of this study highlighted experiences and health seeking behaviours of homeless people. International conventions dictate the social responsibility of providing healthcare to homeless people. Homeless people themselves have a number of recommendations for policy makers, healthcare service providers and researchers.

Their participation in planning and implementing health services for homeless people could enhance the quality of healthcare services rendered to homeless persons.

RECOMMENDATIONS

Homeless persons and healthcare workers recommended that there should be additional facilities where homeless persons can access South African identification (ID) documents. With such documentation homeless people can apply for grants and pensions. Homeless participants from the hostel requested a permanent healthcare facility/ healthcare worker to be situated at the hostel.

Healthcare workers gave numerous recommendations: a database should be established and maintained with names, numbers, diagnoses and sleeping addresses of the homeless persons. With this database the extent of homelessness could be established and plans formulated to provide promotive, preventive, curative and rehabilitative healthcare services for homeless people. Healthcare for homeless people is primarily curative. Attention also needs to be focused on promotive, preventative and rehabilitative healthcare. Provision of ART for homeless people needs to be addressed as homeless persons do not have fixed places of shelter, a requirement for going onto the ART programme. Education classes, enabling homeless people to finish their basic education, would empower homeless people to become economically viable, gain dignity and self esteem and improve their health status. The social networks formed among homeless people should be used to encourage them to help design and implement strategies to improve their living conditions, health status and general well-being.

LIMITATIONS

Homeless persons might be suspicious of any persons trying to ask them questions. In order to persuade the homeless persons to answer questions, both trust and confidentiality were essential. The researcher employed an assistant who could develop rapport with participants without making the participants feel intimidated or victimised. For this study homeless participants identified their place of 'residence' as being in the suburbs of South Central Durban. However homeless people are known to be migratory and sleep anywhere considered as being safe and dry. In the translation of the questionnaire for homeless participants from English into isiZulu, and in the translation of verbal responses of homeless participants from isiZulu into English, some loss of meaning might have occurred.

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