

Original Research Article

"I will die before God wants me to." Understanding factors that affect older adults' attendance of public healthcare rehabilitation services: An explorative study in Gauteng, South Africa

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ABSTRACT

Aim: Healthcare facilities are valued out-of-home places older adults' visit and a key constituent of Healthy Ageing. The study explored factors that affected older adults' rehabilitation attendance in Gauteng's public healthcare services, strategies to mitigate the barriers they confronted, and suggestions for improving their experiences.

Methods: An exploratory concurrent mixed methods design saw 84 multi-professional rehabilitation clinicians, working in public healthcare facilities, and interview with 393 community dwelling older adults in their rehabilitation practices. A semi-structured interview guide was used. Clinicians kept field notes and participated in discussion groups. Qualitative data were predominant and analysed through inductive content analysis. Quantitative data were analysed using descriptive statistics.

Results: Transport and fiscal poverty were predominant factors affecting older adult attendance of rehabilitation services in urban low-income communities. These affected compliance with attendance and effort exertion during rehabilitation. The perceptions and personal experiences of older adults when attending rehabilitation, along with their preference to attend out-of-home places that have multiple purposes and where they can be of use to their communities, were also factors that should be taken into consideration.

Conclusion: Older adults' living in South African urban areas, access to public healthcare is intrinsically tied to the communities that they live in. Factors outside of and inside healthcare affected their rehabilitation attendance. Cognisance of and insight into the complex and multifactorial nature of these factors is necessary for rehabilitation service providers to become part of strategies that address older adults' access to public healthcare rehabilitation. Actuating and strengthening resources within families and communities, fortifying the dignity of older service users, and incorporating the principles of community-oriented rehabilitation services are suggested as starting points.

Implications for rehabilitation: This article provides evidence towards understanding, insight, and knowledge of the realities that South African urban older adults, from low-resourced communities, face to get to rehabilitation. Attending rehabilitation appointments is affected by multiple factors such as transport poverty, limited funds, crime, public humiliation, personal health, and experiences at medical facilities. These findings

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contribute to the WHO's Decade of Healthy Ageing agenda and could be taken into consideration by national and local rehabilitation service providers and related stakeholders.

Limitations: Due to the uniqueness of South African settings and the use of a convenience sample, external validity is limited. The authors suggest that the results be seen as transferable only to other urbanised areas within South Africa. Interviews were held with older adults who arrived at healthcare facilities. The views and realities of those that cannot make it to healthcare facilities might add additional evidence to the problem investigated. Within South Africa (Ramafikeng & Marshall, 2023), and in other African countries (Kori-Siakpere et al., 2024), differences in age, language, education, and ethnicity affect communication and interaction. In this study, there were differences in age, language, education, and ethnicity between clinicians and the older adults they were interviewing. During discussion groups after the interviews, clinicians reported experiencing these differences as a barrier when conducting the interviews. This could have affected the quality and content of the interviews.

Keywords: patient-centeredness, rehabilitation experience, community-oriented rehabilitation, healthy ageing, functional ability, good health and wellbeing

INTRODUCTION

South Africa faces imminent healthcare reform, most prominently with the rollout of the National Health System (NHS) (National Department of Health, 2017). This is in line with the principles of universal health coverage (UHC) (World Health Organization, 2018) and the Healthy Ageing model (WHO, 2019) endorsed by the World Health Organisation (WHO). In their editorial, Evans et al. (2013) expanded on the ideals of UHC to include universal access and argue that UHC is not possible without universal access. Applying the principles of universal access to healthcare, they reason that access to healthcare includes the availability, quality, and location of health services. An editorial by Cornielje (2022) applies this to rehabilitation and calls for the *emancipation* of policy makers from their lack of insight and understanding of the realities and experiences of rehabilitation service users.

There is ample evidence that shows attending healthcare was a valued out-of-home place for older adults (Naidoo & Van Wyk, 2019) and that there were multiple and complex factors that affected their ability to do so (Margot-Cattin et al., 2019). An urban data framework for assessing equity in Canadian cities (Mayaud et al., 2019) showed that people living in low-income neighbourhoods were more likely to be excluded from healthcare compared to their counterparts in high-income neighbourhoods. In Uganda, a qualitative study (N=41) (Tuller et al., 2010) found that lack of money for transportation was a key factor in missed medical appointments as participants struggled to afford transport costs in addition to basic necessities such as food, housing, and school fees. A literature review of barriers to healthcare for persons with disabilities in developing countries (Baart & Taaka, 2017) reiterates this, indicating barriers both outside and inside/within healthcare systems. Focusing on access to rehabilitation for persons with disabilities in low and middle-income countries, a systematic review (Bright et al., 2018) showed that access to rehabilitation is complex. Describing factors that affected non-attendance of rehabilitation appointments, a South African retrospective, cross-sectional study (De Klerk et al., 2019) calls for further context-specific research to address the complexity of rehabilitation attendance. A South African case study (Ned et al., 2017) concluded that

rehabilitation service providers need to understand the daily struggles and barriers faced by persons with disabilities.

Although older adults are often seen as a group with special needs and frequent users of rehabilitation services, their experiences cannot be directly equated with those of persons with disabilities. Focus groups conducted with South African urban community-dwelling older adults (N=64) showed that older adults' complex health needs cannot be adequately addressed by a process-driven approach to care (Kelly et al., 2019). A South African qualitative explorative study (N=28) showed that older adults using community public health centers were distressed by long waiting times, felt they were looked upon as diseases to be treated, and that health providers lacked compassion (Naidoo & Van Wyk, 2019). A population-based survey (N=2352) explored older adults' opinions of South African healthcare responsiveness and identified prompt attention, autonomy, communication, and access to care as priority areas that needed improvement (Peltzer & Phaswana-Mafuya, 2012). This article explores factors that affected older adults' attendance at rehabilitation in Gauteng's public healthcare services, strategies used to mitigate the barriers they confronted, and suggestions made for improving their experiences.

METHODS

Research Context

The research project was undertaken in Gauteng, South Africa's most urbanised and densely populated province. The sites for data collection were public healthcare facilities that offered rehabilitation services. These were in urban areas, townships, and informal settlements where most inhabitants do not have health insurance and thus utilise public health care services. The research took place at eight such facilities. The decision to recruit older adults at these venues was made as they were strategically situated and offered proficient access to the research population.

Research Team

The research team comprised the authors. All rehabilitation clinicians working in public healthcare in Gauteng Province's Department of Health (N=193) were invited to volunteer for the study. They were contacted electronically, and further awareness of the research was created through presentations at public healthcare forums. In addition, those who volunteered were encouraged to alert and invite colleagues. Volunteering rehabilitation clinicians (N=125) attended an orientation and training workshop held at their places of work. At these sessions, they were provided with research kits, oriented in terms of the ethical and methodological principles of the research, and familiarised with the interview form. The principles and practice of semi-structured interviewing, keeping of field notes, professional reflection, debriefing, and taking part in audiotaped group discussions were reviewed. The first author kept regular contact with participating rehabilitation clinicians, thus coordinating data collection throughout the research process.

Research Design, Recruitment, and Sampling

A mixed-methods study using a concurrent embedded research design was conducted. Rehabilitation clinicians recruited older adult participants when they visited public healthcare rehabilitation facilities as outpatients. Only community-dwelling adults over the age of 65, who lived in low-resource urban communities and utilised public healthcare clinics that have established rehabilitation services, were recruited. Such participants came to the healthcare facilities accompanied or unaccompanied, and they gave verbal consent to be interviewed. Each rehabilitation clinician was asked to recruit as many participants as possible; the numbers they recruited ranged from one to 12, with a median of five participants per rehabilitation clinician, thus producing a convenience

sample of 393 older adults. One interview was done per older adult, and this took place in rehabilitation treatment areas.

Data Collection

Data collection involved data source triangulation to increase the scientific rigour of the study. The interview guide was developed by the authors and piloted in February 2019. The pilot was done with a church group of older adults in Johannesburg CBD who fitted the research sample criteria. The focus was to have a culturally sensitive method of data collection for the multi-ethnic participant sample, acknowledging the importance of oral traditions in an African context (Tuwe, 2016). It captured both qualitative and quantitative data. The interviews with the older adults were done between 1 June and 14 September 2018.

Interviews were conducted by rehabilitation clinicians using a 27-item semi-structured interview guide. The interviews were captured in handwriting on paper-based interview guides, as clinicians did not have equal access to other forms of data capturing. Rehabilitation clinicians also kept field notes during and directly after the interviews, to capture insights and reflections they deemed noteworthy as prompted by the interview guide. Concluding the data collection stage, participating rehabilitation clinicians took part in audiotaped group discussions facilitated by the principal researcher and explored thoughts and insights gained to complement and enrich the findings.

The first part of the interview guide captured bio- and demographical information: Participants' age, gender, citizenship, the location of their traditional or ancestral home, the languages they spoke, the type of house they lived in, including the number of rooms and the number of occupants, the amenities they had access to, and whether they were homeowners. Participants were asked about their health. They were asked to name health conditions they experienced (open question) and the extent to which these impacted their ability to leave the place where they stay. Participants rated their functional abilities on a 3-point scale in the domains of mobility, personal care, domestic activities, pain/discomfort, and anxiety/depression. Their socio-economic situation was captured by asking about their highest level of education, working status, the type of income received (salary, pension, other), and how many people they supported with their income.

The second part of the interview guide focused on meaningful out-of-home activities and places. Participants named the places they go to, how they get there, how often they go, and why it is important to them. They were asked if there were places they found difficult or were unable to go to, and to explain the reasons for and repercussions of this. The third part of the interview guide captured information on participants' community mobility needs and realities. They were asked to give suggestions on what would improve their access to valued out-of-home places and community mobility.

Older adults were not remunerated and incurred no cost as they were interviewed at the healthcare facilities that they visited for scheduled rehabilitation services. Concluding the data collection stage, the principal researcher held one-hour debriefings and audiotaped discussion groups at clinicians' places of work in October and November 2018. In 2019, results were analysed, summarised, and disseminated to all participating rehabilitation clinicians and to rehabilitation services management in the head office of Gauteng Health. This was done in the form of emails and oral presentations at staff meetings and stakeholder forums. A report was sent to the Gauteng province's Head of Government Office.

Data Analysis

The qualitative data collection approach was exploratory and descriptive, with quantitative data complementing and confirming the qualitative findings. Descriptive statistics were used for analysis of quantitative data, and inductive content analysis for

qualitative data. The first author analysed the data, and with all authors present, census meetings were held to discuss the final outcome.

Data analysis saw interviews, field notes, and transcribed audio recordings, captured on Microsoft Excel and Word. A fully integrated approach (Cresswell, 2013) was used in the analysis of results, which meant that qualitative and quantitative data were integrated at the data collection, data analysis, and interpretation stages. Data analysis and interpretation were not linear. Descriptive quantitative analysis was done of biographical data. Inductive content analysis was done to identify categories. Thematic analysis of barriers that affected participants' attendance was done. Quantitative data were analysed using descriptive statistics. The qualitative data were imported into WeftQDA (qualitative data analysis software) and analysed through inductive content analysis.

Trustworthiness and Rigor

Face validity was addressed by designing a questionnaire specifically for the research population and context using the researchers' experience of older adults with limited income. A pilot study improved the content validity of the interview guide. This took the form of the *think-aloud method* (Charters, 2003) with four community-dwelling urban older adults who were members of a church in a low socio-economic area of Gauteng. Items shown to be misunderstood were modified in and the interview guide was shortened. Inter-rater reliability was addressed when the principal researcher provided the same training on data collection techniques to all rehabilitation clinicians. The main strategies for establishing the trustworthiness of qualitative data involved drawing on a variety of data sources (Enworo, 2023).

Ethical Considerations

Formal ethical approval was obtained from Stellenbosch University's Human Research Ethics Committee (Ref No N18/01/003) and the Gauteng Healthcare's Research Committee (DRC Ref 2018-03-008), prior to registration on the South African National Health Research Database (GP201802 022). Volunteering rehabilitation clinicians provided written consent after orientation to the research and had had the opportunity to question and confirm their understanding of their role in the research. Rehabilitation clinicians introduced the research verbally to older adults and informed them of their right to decline participation or withdraw with no consequences to their right to healthcare services; in addition, they were supplied with an information sheet of the research to take home. Informed consent was negotiated before data collection commenced. The rehabilitation clinicians numbered the interview sheets, and no demographics that could lead to the identification of the older adults were captured. Confidentiality of older adults and clinicians' contributions was maintained throughout the study.

RESULTS

Of the 193 total population rehabilitation clinicians in Gauteng's public Healthcare in 2018, 65% (n=125) volunteered and were trained and equipped, and 67% (n=84) of the volunteers complied with all aspects of the project by conducting interviews with older adults, keeping field notes, and taking part in debriefing and discussion groups. The reason for attrition provided was predominantly work pressure. The professional breakdown of the 84 clinicians was 45 Occupational Therapists and Technicians, 25 Physiotherapists and Assistants, and 11 dually practicing audiologists and speech-language therapists.

Demographic Information of the interviewed Older Adults

Table 1 shows a bio- and demographic profile of the 393 older adults who were interviewed. Most participants were female and lived with immediate or extended family, in brick houses with indoor access to electricity and water. Despite basic levels of

education, the majority were polyglots, with English the most spoken language, followed by two indigenous languages, Zulu and Afrikaans. Most of South Africa's official languages were spoken in addition to languages spoken in neighbouring countries, signifying the cultural diversity often found in urban areas. Those who qualified were financially dependent on the non-contributory governmental old age pension and living on the equivalent of 4 US dollars a day, which they shared with an average of two family members and/or friends.

Table 1: Bio- and demographic profiles of interviewed older adults

Profile of Interviewed Older Adults	
Gender	73% females (n=290) 27% males (n=103)
Age	The average age was 72 years old (Range 65 – 98)
Language proficiency	87% of participants were bilingual, and 60% multilingual English (n=252) was the most spoken language, followed by Zulu (n=196) and Afrikaans (n=196) Most of the official SA languages were recorded to be spoken, as well as other African languages and Portuguese
Place of Abode and Living condition	87% (n=341) of the older adults were staying in 4-room brick houses. 93% (n=366) reported having access to all amenities (indoor water and electricity) Only 4% (n=16) were staying alone. The average number of people sharing their places of abode with them was four.
Highest levels of education	41% had high school training 41% primary school 7% had a tertiary education 11% had never been to school
Income	93% receive the non-contributory government old age pension of R 1 780.00 per month or R 1 800 for those older than 75 years. The remaining 7% did not qualify for this old age pension due to being foreign nationals or still being in active employment.
The most frequently reported work the older adults did prior to retirement	Domestic workers, working in factories as manual labourers/machine operators, and in various forms of nursing and caregiving.

Qualitative data obtained from rehabilitation clinicians elaborated on and added contextual detail. They highlighted that older adults were contributing towards the income of extended family and doing so to their detriment. It was not uncommon for older adults to forfeit meals to ensure the availability of food for school-going children. Many participants walked long distances to access healthcare facilities to save transport money, which was spent on groceries for the family instead.

It upsets me how the gogo's would rather use their money for their children than take care of themselves or come to the clinic. (Field notes)

She had been in [the clinic] since early this morning, and by the time she came to me, she was hungry and tired, so I shared my lunch with her. (Group discussion)

Rehabilitation clinicians also mentioned practices that showed gender discrepancy in the use of available resources.

The Mkulus¹ have more freedom with their money and can use their pension for themselves, but the Gogos² They are expected to feed the family with their pensions. (Group discussion)

The 393 older adults who were interviewed named 1118 meaningful out-of-home places that they valued visiting. Places of worship (268, 24%) were most valued, with healthcare facilities the second most reported place they valued to go to (247, 22.1%). These were mostly visited monthly (201/246, 82%) or weekly (38/246, 15%). Participants reported visiting medical facilities:

"To get my medicine"

"Because the doctor says I must go."

or because

"I have to go to know about my sickness".

Six participants visited medical facilities for the health needs of family members:

"I have to take my grandchild (who is disabled) to see the therapists for his exercise," and "My wife is in a wheelchair, so I must push her to see the nurses."

Personal Health Factors and how these affected the ability and motivation to leave home and or use transport

When participants were asked to rate their health in general, 27% reported good health, 56% average health, and 17% poor health. When participants rated the degree to which their health had an impact on their ability to leave their homes, 58% reported no impact; however, for 42% ill-health had a constant or occasional impact. Table 2 shows the prevalence of health conditions and the effect this had on participants leaving their homes.

Table 2: Impact of personal health condition on leaving home

Health conditions reported by this population and its impact on leaving home	Qualitative data descriptors
Hypertension 74% (n=290) 45% (n=133) reported this to have an impact	Dizziness, Tiredness, Headaches. <i>If I have headaches, I cannot trust it to go out because I fear getting a stroke out there.</i>
Arthritis 36% (n=141) 73% (n=103) reported it to have an impact	Chronic pain affects motivation to leave home, modes of transport, and increases pain levels. <i>Our roads are too broken and the taxis too bumpy, so I feel the pain in my joints when we use the taxi.</i> Endurance. This affects the ability to walk. <i>I walk and stop and walk and stop.</i> Weather. <i>If it is cold or wet, my bones cannot move.</i> Joint deformities affecting mobility and functional ability. Slowness, stiffness, and joint pain affecting the ability to queue, sit or stand for long periods.
11% (n=45) had pulmonary and/or cardiac conditions 78% (n=35) reported it had an impact	Low endurance and fatigue. <i>I have to stop and rest for my chest, even if it is raining or there are tsotsis standing around.</i> Breathlessness or asthma. <i>My breathing is too hard, so in the taxi, people do not like to sit next to me because they can hear I am sick.</i>

¹ Grandfathers

² Grandmothers

9% (n=36) had had CVAs that resulted in some form of hemiparesis 78% (n=28) reported it had an impact	Mobilising/walking restrictions, especially over uneven terrain. <i>I cannot walk off the sidewalk without falling, and the ground is too rough with the loose stones.</i> Difficulty getting into and out of transport, and walking aids are cumbersome and difficult to take onto public transport.
7% (n=29) had conditions that affected their eyesight 66% (n=19) reported it having an impact	Night blindness. <i>I cannot see so I cannot be careful if someone comes to talk to me like I cannot watch him if he is taking my things from my bag.</i> Reduced peripheral vision. <i>I can only see parts of what I used to see so I need to plan where I walk and turn-turn-turn my head to watch for things on the roads.</i>
5% (n=21) had orthopaedic problems such as amputations, hip fractures, joint replacements 95% (N=20) reported it to have an impact	Pain and low endurance affect the ability to stand in queues or to walk for longer distances. <i>Even with the new hip, I cannot walk for long or stand and wait for the taxi.</i> Fear of falling due to uneven, inaccessible sidewalks and difficulty getting into transport or uneven ground surfaces. <i>I fell and broke my hand, and now I fear falling too much.</i>
4% (n=18) had speech and/or hearing difficulties 33% (n=6) reported it had an impact	Hearing loss affects safety. <i>I cannot hear if the taxi driver tells us something, and then I miss my drop off, and they get very cross. He says I am stealing his money.</i> Safety. <i>I cannot hear the running of the nyaope boys before they grab me, so (snatch her bag).</i> Other. <i>In taxis, you can always find loud talking and music, and it makes it difficult for me to hear.</i>
4% (n=18) had mood disorders such as anxiety or depression 78% (n=14) reported that it had an impact	Fear of the unpredictability of using taxis, crime, and close contact with strangers was reported to affect their ability to leave their homes. <i>Someone must always be with me when I go out.</i>

Health factors that were visible, such as limping or the use of assistive devices, increased participants' vulnerability during attendance at public healthcare facilities because of increased exposure to petty crime, mostly in the form of *snatch-and-grab* incidents. When public bathroom facilities were absent, limited, or poorly maintained, participants with poor bladder or bowel control were badly affected. They explained how disposable adult nappies were not affordable, forcing them to use towels or cloths, which do not prevent smells and leaks. Slowness of movement and poor endurance affected participants' efficiency when walking or boarding public transport; they reported a lack of compassion and understanding from commuters and drivers towards impairment or disability. Using assistive devices and mobility aids was problematic in crowded spaces and/or when using mini-bus taxis³ and buses, especially during peak hours when the demand for access to transport was high. The type of mobility aids used by participants was bilateral elbow crutches (n = 67), walking canes/sticks (n = 36), wheelchairs (n = 31), and walkers (n = 15). A fear of falling was reported, especially related to poorly maintained or absent sidewalks or when moving in and around crowded areas. Standing and sitting tolerance posed problems when having to stand in queues when waiting for transport to arrive, and due to the small, confined spaces inside the taxis.

³ The most common type of taxi in all South African cities is a 10 to 14-seater mini-bus, which is used to operate an unscheduled transport service for reward, mostly to or from a taxi rank.

Modes of mobility and transport used to visit healthcare facilities

Walking was reported by 89% of older adults to be their main mode of mobilisation in the community and was predominantly used daily and more often at the end of the month when their funds were depleted. The mean duration for walking was 35 minutes (range 5 – 60 minutes). Older adults walked to clinics and community centers in their neighborhoods and to public transport pick-up/drop-off points. Conversely, older adults recognised the health value of exercise obtained from walking; this view was reportedly promoted by rehabilitation clinicians who encouraged them to walk.

'She likes walking and finds it helps with the management of her pain.' [Field note]

Rehabilitation clinicians reported that the weather affected attendance and highlighted financial and transport poverty as the predominant reasons why older adults walked.

'They walk but not by choice – if only they had more choices.' [Debriefing and Discussion]

The second most frequently used mode of transport was the mini-bus taxi, and this was reported to be readily available. They were used to get to health facilities that were not within walking distance when the weather was cold or wet, if there was not enough daylight left, and if the area that had to be moved through was unsafe due to criminal activity. In close-knit communities, taxi drivers were reported to take care of older adults. There were, however, also problems associated with using mini-bus taxis related to poor road-worthiness of vehicles, reckless driving, and risk-taking behaviour of drivers. Multiple transfers⁴ were confusing. The opening and closing of the sliding door posed problems for some of the older adults who have reduced strength or problems with handgrip. They also reported crime, such as *pick-pocketing* and *snatch-and-grab* incidents at taxi ranks. Driver and commuter behaviour towards participants who were slow or used assistive devices was considered rude and humiliating.

They can shout at you whoza whoza goggo you are making us all late. [Interview data]

Having access to or hiring a private motor vehicle was the third most frequently reported mode of transport. It was used when walking was not possible and public transport was not available; mostly the case for visits to tertiary and quaternary hospitals.

My daughter has a car, and it is good for us to ask her to take us to the hospital when we have to see the big doctors (specialists). [Interview data]

Most participants (66%) had never driven or owned a motor vehicle. Of those who could drive, only 11% were still driving. Rehabilitation clinicians further explained that it was common to find their patients having to rent a car, especially if they had a disability and/or were using wheelchairs, because none of the other modes of transport could fit a wheelchair or walking frame. This was reported to be the most expensive form of transport, and thus used only as a last resort.

Other modes of transport, such as buses and trains, were available in Gauteng, but those that operated in low-income communities were not accessible, and their routes focused on working commuters. None of the older adults reported using them to get to healthcare facilities. Clinicians highlighted the difficulties participants had in boarding a bus with walking aids, emphasising that it was impossible to do so with a wheelchair. Tuk-Tuks⁵ were available in two of Gauteng's five districts, and none of them used them to get to healthcare facilities. Two participants (n = 2), both male, reported using bicycles daily and reported going *everywhere* on them, including using them to get to their local clinic. These two older adults considered cycling to be an affordable transport mode that kept them healthy and allowed them freedom of movement.

⁴ Multiple transfers involve having to use several taxis, or more than one mode of transport to reach a destination.

⁵ Tuk-tuks are three-wheeled motorised rickshaws operated for reward

Clinicians shared observations that showed coping strategies being used by participants to enable their access to health facilities. Participants often planned and waited for each other to walk together. In close-knit communities with strong leadership, older adults were collectively cared for. A clinician explained that in such communities, an older adult was everybody's grandmother (Group Discussion). Mental stoicism was also found amongst the participants; exploring the impact of barriers preventing attendance of rehabilitation appointments, a participant answered:

If I have to go, I have to go. If I don't go, I will die before God wants me to (Interview)

Experience at medical facilities

Healthcare facilities had developed 'reputations' in the communities they served, and participants' responses supporting this ranged from positive accounts of supportive and well-run services to complaints. Long waiting periods for the attention of healthcare professionals were reported as problematic by clinicians and participants. One participant said that she prefers paying extra to go to the hospital, which was further away from her than going to her local clinic, because she felt the clinic did not help her as they ran out of her tablets, and the queues were too long. Older adults told of being scolded by healthcare practitioners, and one participant said:

You have to be careful when you go (to the clinic) because the nurse will fight with you because you come on a different day. (Interview)

Discussion with participating clinicians supported this and showed that they were aware of attitudes that negatively affected older adults' rehabilitation attendance. One example was of colleagues who would send a patient home if they were late for an appointment, telling them to make another appointment. This was also reported by an older adult who said that:

If I see that I will be late, I will go home because the doctors⁶ will tell me to come next time. (Interview data)

Lack of resources, such as splinting material and problems with the referral system between institutions, was also reported by clinicians.

We refer patients to other hospitals if we do not have the resources, so they have to travel again, and in fact, any referral is a problem. (Group discussion)

Strategies to address barriers that affect access to rehabilitation

Clinicians suggested designated transport to fetch older adults and persons with disabilities from their homes and bring them to rehabilitation services. They felt this would address the out-of-pocket cost of healthcare for older adults and would address confusion related to patients turning up for services that were cancelled or moved. Some community health centres had such vehicles available, and these would drive through the community, picking up older adults for groups in the centre. Clinicians also mentioned interviews with clients who lived in old age homes and had access to transportation provided by the facilities in which they lived.

There are people who come and fetch him and drop him off, which is a big difference cause of not having to walk and not having no cost of transport. (Field notes)

DISCUSSION

Healthy Ageing is the process of developing and maintaining the functional ability that enables wellbeing in older age (WHO, 2019). Access to and attending rehabilitation is imperative towards such a goal. In this research, factors that affected older adults' attendance of rehabilitation in Gauteng's public healthcare services, the strategies they used

⁶ Older adults collegially refer to everyone who is not a nurse as 'doctor' as it is difficult for them to distinguish between healthcare professionals.

to mitigate the barriers they confronted, and suggestions made for improving their experiences were explored. Combining the skills and points of view of different rehabilitation clinicians strengthened the results of this project, and this was seen especially in the discussion groups and suggestions made by rehabilitation clinicians to enable greater access to their services for older adults.

The benefits of urban living were seen in the demographics of the older adults interviewed: the collective age of older adult participants was higher than the South African life expectancy, and living amenities and healthcare facilities were within walking distance from them. Factors associated with the African philosophy of Ubuntu were offered as positive factors that were used as strategies to overcome barriers, but this philosophy also posed restrictive factors, such as the sharing of resources that equalize the well-being of a whole community. This is confirmed by other South African studies (Grut et al., 2012) that found that the health-related choices and decisions made by people with limited resources were shaped by complex barriers that prevented them from accessing health care services even when the services are available. This study recommends that health care provision to people who live in resource-poor settings should consider both individuals' needs and the availability of resources within the family group.

Bringing healthcare closer to the users of these services is an essential part of the NHI, and most of the participants in this study reported living within walking distance from a healthcare facility. The challenge lies in the offering of rehabilitation services at the primary healthcare level and in creating contextually relevant evidence to support the policies that must decide who offers what rehabilitation services and at which levels of healthcare. For policies to be effective and efficient, sound relevant evidence is needed, and preferably evidence that emerged from the context in which the policy is to be implemented. Financial poverty, not only of the older adults themselves, but also of their families and communities, coupled with transport poverty, was the main factor affecting the older adults' attendance at public healthcare rehabilitation services. There were indications that women were disproportionately affected compared to their male counterparts.

Globally, these factors have been well documented. In Thailand, mobility, poverty, and long waiting queues for healthcare services were a problem (Meemon & Paek, 2019). Du et al. (2020) investigated how older adults in a Chinese city commute to healthcare activities and found walking to be the main mode of mobility, and required a companion to accompany them. In Australia, older adults were found to be more likely to rely on public transport to access healthcare services (Patel et al., 2019), and a study in Brazil showed that populations in socio-demographically disadvantaged tracts have poorer public transportation links, resulting in barriers to equitable healthcare access (Yuen et al., 2018). There are also suggestions made to address health care access problems. A study done in Ireland showed that for older adults who do not have access to health insurance, the availability of healthcare within walking distance exerted a positive and significant effect on the utilisation of such services (Mohan et al., 2019). Choi and Dinitto (2016) propose increasing walkability, public and paratransit transportation designated for older adults, and increasing the practice of informal caregivers' transportation. The results from this study are thus not unique in the global context and the goals for universal health coverage and healthy ageing.

Suggestions made by clinicians and older adults, and strategies that are already employed by the older adults to address factors that affect their attendance of rehabilitation services, resonate with those of Grut et al (Grut et al., 2012). They suggest bringing healthcare to the users, strengthening accessibility of transport that brings users to healthcare facilities and using resources available within families and at community levels to address healthcare equity. Most of the older adults who participated in this study lived within families, and this meant that by extension, they shared in the well-being or

misfortune of the family. In poor families, they share their pensions, and this meant they had to walk to or forfeit food when going to or attending rehabilitation. In more affluent families, if someone had a private car, they were taken to and brought back from rehabilitation appointments. The lot of older adults is thus intrinsically linked to the community they live in.

Factors associated with normal ageing, for example, being slow or the use of an assistive device, affected older adults' access to healthcare facilities. However, these were exacerbated by the attitudes of transport operators and fellow commuters, a problem that has been well documented in international literature (Vaucher et al., 2018). More should be done to educate communities. We argue for a strong focus on shifting attitudinal barriers because negative attitudes seemed to contribute more to older adults' experience of vulnerability than their physical frailty did, shown by juxtaposing the experiences of older adults with physical impairments in supportive environments with those in which they are scolded, humiliated, or mistreated.

Improving transport to and from clinics was the most discussed suggestion to improve older adults' attendance at rehabilitation services. They suggested transport that operated on routes closer to their homes and the clinics. They also asked for better infrastructure on the route to clinics and specified sidewalks, walking rails, public toilets, shelters against the rain and sun, benches to rest on, and safe waiting areas in front of clinics. Asking a family member, friend, or neighbour to accompany them was a common strategy amongst the older adults. They explained it to be a culturally acceptable practice that was widely used and not only for the attendance to healthcare facilities. In exchange for the assistance and protections afforded by the accompanying person, it was expected of the older adult to pay for any transportation costs and, if the visit took the whole day, to provide them with lunch.

CONCLUSIONS

Politicians judge best when they listen to their people and learn from science. In traditional Africa, the phrase 'the elders have spoken' is the introduction to a finalisation of a matter. This article foregrounded the voices of older adults to allow them access to rehabilitation and healthy ageing.

The following strategies, emanating from this research, are proposed:

- Campaigns with a focus on healthy ageing in place, specifically facilitating supportive attitudes of transport operators and fellow commuters, are needed.
- Rehabilitation must be decentralised. To do this will require more evidence of the rehabilitation needs of older adults in SA and convincing leaders at all levels of buy-in. The concept of community-oriented rehabilitation is not a new concept (Wade, 2003) and is closely related to the principles of community-oriented primary care (COPC), a geo-graphically-based comprehensive approach to health care service delivery that starts with individuals and families in their homes (Marcus 2015).
- Rehabilitation service providers need cognisance of and insight into the complex and multifactorial nature of factors that affect attendance of their services. Rehabilitation clinicians have to take cognisance of the fact that they are not treating pathologies and conditions but older adults with valuable experience, and by extension, the families and communities from which they come.
- Older adults' living in South African urban areas, access to public healthcare is intrinsically tied to the communities that they live in. Actuating and strengthening resources within families and communities, fortifying the dignity of older service users, and incorporating the principles of community-oriented rehabilitation services are suggested as starting points.

Declaration of Interest

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article. This research did not receive any grant or funding. Data supporting the findings can be accessed by contacting the corresponding author.

Data Availability Statement

Data that support the findings of this study are available on reasonable request from the corresponding author. Data are not publicly available due to the format in which it was captured.

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