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**ACCESSIBILITY OF HEALTH INFORMATION PROVIDED BY THE CLINICS IN THE
CAPRICORN REGION IN THE LIMPOPO PROVINCE, SOUTH AFRICA**

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ABSTRACT

Health information is a weapon that provides people with much-needed knowledge about self-care management, especially in the rural areas, where only clinics are the key players in the provision and dissemination of such information. The purpose of the study was to investigate the accessibility of health information provided by the clinics in the rural areas of the Capricorn region of the Limpopo Province in South Africa. The study employed the qualitative research method. Face-to-face semi-structured interviews were conducted with the community members who visited the clinics at the time of the data collection. The negative attitude displayed by the healthcare practitioners and the lack of Information and Communications Technology (ICT) tools were found to be the major barriers to the dissemination of health information to the rural communities by the clinics in the Capricorn Region of the Limpopo Province in South Africa. The study recommends that staff be trained regarding the Batho Pele Principles relating to customer service. Moreover, the clinics need to fit into the Fourth Industrial Revolution, and to start using the necessary ICT tools for the dissemination of health information.

Keywords: information delivery systems, clinics, information dissemination, health information, rural communities, Limpopo Province

INTRODUCTION

Information is a valuable resource for health, social, political and economic development. In the health sector, information makes a significant contribution to good health, with it being considered as an important component of effective health systems. Therefore, securing universal access to quality health information is essential for the effective management of patients' health. Obtaining timeous information, packaged in the format preferred by the user, can have a profoundly positive impact on a person's health (Ntsala and Dikotla, 2019). In essence, a piece of health information can be either a lifesaver or a life taker, which means that health information can play a deciding role as to whether a person can live successfully with a certain disease and/or whether they will succumb to it at a relatively early stage. The United Nations 2030 Agenda for Sustainable Development recognises that the

accessibility of suitable health information is vital for the economic, political and social welfare of all communities.

In terms of the current Fourth Industrial Revolution (4IR), information is made widely and readily available through the use of information and communications technology (ICT). However, guaranteeing impartial access to health information and overcoming the nonuse of health information is a challenge (Kapadia-Kundu and Sullivan, 2011) in South Africa, as is it in many other developing countries as well. Godlee, Pakenham-Walsh, Ncayiyani, Cohen and Packer (2004) concur that the major problem is the inaccessibility of information, which impedes the provision of 'knowledge-based healthcare' in rural environments in developing countries. Having to pay to access such information also limits the extent of access obtained to information and knowledge in the rural areas. Pakenham-Walsh and Bukachi (2009) conclude that the lack of access to health information is evident across the entire health sector. The challenges concerned may be attributed to the fact that "information, education and communication health campaigns in Africa remain unfocussed and poorly funded; and are still subject to powerful but subtle morality and ideological battles" (Akukweas, 2004:1)

Despite the above-mentioned challenges, information must be accessible to, and usable and absorbed by, those receiving the information (Wagacha, 2007). In the above regard, ICT has served to enhance the accessibility and flow of information. The development of open-access publications has been aimed at striving to secure equal access to information for all. Moreover, wireless and mobile-based technology facilitates the dissemination of information in South Africa and other developing countries.

The ability to choose an information delivery system by means of which to disseminate health information does not necessarily mean that the system chosen will be effective for the dissemination of the information concerned. For instance, the use of television, the Internet and computers requires a proper infrastructure to be in place, including the supply of electricity and network connectivity. Accordingly, there are costs associated with using the various types of information delivery systems mentioned. As such, the health information

that is disseminated through the mass media might not be easily accessible to the rural communities involved, due to the high costs entailed. Most information delivery systems have been observed to suit, and to be appropriate for, the rich and educated, who mainly live in the urban areas, while neglecting the poor and illiterate, who mostly reside in the rural areas (Ilo & Adeyemi, 2010:2).

Context of the study

In South Africa, the Department of Health has established various clinics to render healthcare service delivery. Besides providing primary healthcare, the clinics play an important role in facilitating access to health information. The South African Department of Health uses mobile phones (in terms of the project called MomConnect), the social media, the mass communication media, like the radio and television, leaflets, brochures, billboards and the Internet (Republic of South Africa. Department of Health, 2019), as the information delivery systems for disseminating health information to South African citizens. Therefore, the health facilities concerned, including the clinics, use the aforesaid information delivery systems to interact, and to share health information, with their users. The clinics are allowed to employ only those media that are approved by the Department of Health, which implies that the use of such information delivery systems is centralised by the Department of Health. Accordingly, the current study focused on the functioning of clinics in the Capricorn District of the Limpopo Province, which is predominantly rural. In the South African rural setting, the traditional leaders, the churches and the ward councillors are the key informants for the community members.

PROBLEM STATEMENT

Having access to information is a distinct constitutional right in South Africa. Despite the right being enshrined, as such, in the Constitution, access to health information remains a challenge in South African clinics, due to various factors, including language barriers, the format of information sources, the attitudes of staff members, and diverse cultural factors (Dikotla, 2008). When patients are denied access to the health information held by the clinics, the consequences can be extremely serious, because their health might be at risk.

For instance, without health information, people might be unaware of the symptoms of COVID-19, and expose themselves and others, unwittingly, to the deadly virus. Consequently, several people could suffer serious complications and others could die, as a result of their lack of knowledge. To be precise, people are dying, due to a lack of healthcare knowledge (Chatterjee, Biswas, Datta and Sriganesh, 2012). Denying people access to information also marginalises their participation in the modern information era (Lor and Britz, 2007). As such, citizens might not be able to participate meaningfully in democratic governance. When health information is accessible, preventing and managing certain diseases is simplified. Therefore, ensuring that the health information that is held by clinics is accessible to all is of utmost importance. Presently, it is not clear whether the health information that is held by clinics in the Capricorn District of Limpopo Province in South Africa is accessible or usable. Therefore, additional research and development is required to establish the accessibility and usability of the information delivery systems that are used by clinics in the Limpopo Province to disseminate health information, which was the reason for the undertaking of this formal investigation.

Purpose of the study

The aim of the present study was to investigate the accessibility of the health information provided by the clinics that are situated in the Capricorn District in Limpopo Province of South Africa. The study was guided by the following objectives:

- to analyse the health information needs of patients in the rural communities of the Capricorn District in the Limpopo Province;
- to establish the channels used by the clinics in the Capricorn District in the Limpopo Province for disseminating health information;
- to evaluate the appropriateness of the health information delivery systems used by the clinics in the Capricorn District in the Limpopo Province; and
- to identify the factors hindering the accessibility of the health information provided by the clinics in the Capricorn District in the Limpopo Province.

LITERATURE REVIEW

The present section discusses the literature review undertaken for the current study. The review was guided by the objectives of the study.

Health information needs of community members

For effective public communication regarding diseases in the community, the health information needs of the local population must be adequately assessed. Such assessment should be aimed at enabling the wide dissemination of health information messages that are directed at preparing the public to be alert and to respond safely during outbreaks of disease. When health information needs are identified, tailored appropriate health information can be disseminated, so as to diminish the occurrence of outbreaks and the onset of widespread fear and panic (Odlum and Yoon, 2018).

The health information needs of the people are determined by the outbreaks of disease in their surroundings. A study by Odlum and Yoon (2018) used the content analysis of tweets to investigate the information needs that persisted throughout the global community during the 2014 to 2016 Ebola outbreak. The study revealed numerous health information needs, ranging from the need to know about the history and symptoms of Ebola to the need to know about the transmission mode involved, as well as about the statistical information pertaining to new infections and deaths. During the outbreaks of an epidemic or a pandemic, the public require immediately accessible health information. Wong, Harris, Staub and Bernhardt (2017) found that the tweets posted by the United States of America's local health departments focused on disseminating information about the symptoms and prevention of Ebola, and on dispelling the myths surrounding the disease, from September to November 2014.

Another factor that encourages people to seek health information is their health status. For example, patients will always require information about any illness from which they are suffering. Sharour, Malak, Subih and Salameh (2020) conducted a study focusing on the quality of life, and the care and information needs, of cancer patients. Such patients were

found to need information regarding their disease, medical testing, treatments, various places of care and how to cope with living with cancer. Common information needs that were identified in a study conducted by Clarke et al. (2016) included nutritional information in relation to an illness or medical condition, or relating to a new/experimental treatment that had recently become available, or information regarding prescriptions/drugs, exercise and physical activity, treatments, healthcare providers, the side-effects of drugs/treatments, or health promotion / lifestyle, among other issues. However, cases of unmet need exist that require suitable enlightenment that is tailored to the informational needs of the diversity of people found in the rural areas. Clignet, Houtjes, Van Straten, Cuijpers and Van Meijel (2019) expound on the fact that the unfulfilled needs of patients reduce their satisfaction levels, with health services while increasing their levels of anxiety and depression, which are linked to the emotional distress that affects their general health perceptions.

Mooko's (2005) investigation regarding the information needs and the information-seeking behaviour of women in three rural villages in Botswana discovered that the need for health-related information dominated their information needs. The study indicated that Botswanan women were interested, at the time of the study, in accessing information on how certain diseases were contracted and treated. A similar study by Benard and Chipungahelo (2019) surveyed the information needs and the information-seeking behaviour of rural women in the Morogoro Region, Tanzania. Women in the area surveyed articulated a number of health information needs regarding hypertension, malaria, family planning, pregnancy, HIV/AIDS and sexually transmitted disease. The information needs concerned might resonate with those experienced in the Capricorn District, which is primarily rural. The present study identified what was known and unknown about the health information needs of those living in the Capricorn District in the Limpopo Province, South Africa.

Information delivery systems appropriate for disseminating health information to rural residents

Of vital importance is the fact that clinics should supply their local communities with health information in the right format. Information needs pertaining to health information are spread across a number of fields, including law and medicine, with the information required being broadly sourced. The effectiveness of health information depends on the appropriateness of the information delivery systems that are used to reach the recipients involved. Fari and Omoniyi (2010:17) consider “mass media, especially radio and television, reinforced by interpersonal networks of teachers, parents and peer groups as the most feasible channels of disseminating health information”. Similarly, Nwagwu (2008) considers the following sources useful in terms of proving HIV/AIDS information to the communities concerned: the television; the radio; newspapers; pamphlets/magazines; clinical health workers; schools; community meetings; friends; relatives; political leaders; places of worship; the workplace; exhibitions; the cinema; and adult education programmes. A study conducted by Gombachika, Chirwa, Malata and Maluwa (2013) among couples living with HIV in rural southern Malawi found that the majority had sourced HIV/AIDS-related information through informal networking with others living with HIV, like peers and family members, in addition to the radio.

The role of clinics in disseminating health information involves various stakeholders. In South Africa, a number of agencies and several non-governmental organisations (NGOs) support the clinics in providing health information to those in need. The South African Broadcasting Corporation (SABC) is also playing an important role in broadcasting health programmes. Most importantly, the clinics employ home-based caregivers who are specifically used for visiting households to administer care and advice to those patients who are terminally ill (Coates, Richter and Caceres, 2008), while, simultaneously, providing health information.

Information and communication technology used by clinics to disseminate health information

The emergence of the Internet has allowed people to start accessing web-based health information (Fox and Duggan, 2013). Hence, Chikonzo (2008) has come to consider the Internet as a powerful tool for the providing of health information, including that relating to the COVID-19 pandemic. Currently, many healthcare institutions have come to use electronic healthcare (e-health) to facilitate the accessing of health information, through the use of telecommunications. Sharma and Kaur (2017:207) stipulate that “e-health has been applied by health practitioners to check and collect patient’s data instantly and to be notified when patient’s health exhibits critical signs”. Similarly, clinics can adopt the idea and use ICT to provide health information, particularly to the rural communities.

In South Africa, many healthcare institutions that have realised the value of social media are now using them for disseminating health information. Newbold and Campos (2011) concur that healthcare organisations use the social media for disease surveillance, in terms of conducting numerous searches regarding specific illnesses, and by involving communities in reporting the presence of the symptoms of disease or of communicable diseases, as well as by means of observing the occurrence of disease outbreaks, with the aid of technology.

With the outbreak of the COVID-19 pandemic, the social media has been found capable of helping the government, and health institutions in particular, with real-time communication, so as to: (1) trace and observe the outbreak of disease; (2) pinpoint misinformation regarding health; (3) isolate specific areas for intermediation efforts; and (4) monitor the attitude of the public towards such health issues as COVID-19. The social media can definitely play a central role in terms of disseminating health information throughout South Africa. McLeod (2017) has established that South African adults commonly use the Internet for communication and social networking purposes. The use of the social media in health institutions could prove to be outstandingly relevant and beneficial to both the health practitioners and the patients concerned, as well as to the consumers of health information. Sharma and Kaur (2017) established that patients’ preferences regarding where to obtain

health services tended to be greatly influenced by the presence of the social media at the hospitals involved.

Mayo Clinic (2020) an American non-profit academic medical center on its website at <http://www.mayoclinic.org> illustrates the success of the social media in disseminating health information relating to the healthcare sector. Although the Clinic has initiated using the social media to fight against illnesses and to promote health and healthcare, health institutions need to understand, and recognise, the socio-economic status of the communities that they serve, so as to be able to provide them with the appropriate health information, and thereby facilitate them gaining access to information.

The proliferation of the social media and of the Internet has resulted in the spread of health-related misinformation and disinformation, which makes it difficult to access and to evaluate quality health information. The situation is further exacerbated by people's general lack of understanding of the appropriate information retrieval and evaluation strategies, which tends to result in the proliferation of 'fake news'. Such 'news', according to Wardle and Derakhshan (2017), involves the spreading of false information, so as to cause harm. For instance, the COVID-19 epidemic has been portrayed either as consisting of biological warfare between the leading nations of the world, or as having been caused by the fifth generation of wireless communications technologies (5G), while the associated vaccine has been rumoured to have been tested in Africa, so as to depopulate the continent.

As a part of recent trends and developments, the use of mobile technologies is fast becoming a new way of providing unified care processes, with the understanding that the patient plays a key role in accessing supportive care (Sharma and Kaur, 2017). Health practitioners and information consumers now have an opportunity to download healthcare apps on their mobile devices, and to share health information in real time. South Africa has also seized the opportunity to use cell phones to disseminate health information, through the project called MomConnect, which uses cell phone-based technologies that are integrated into the maternal and child health services provided. According to the South

African Department of Health (2019), MomConnect facilitates interaction and information sharing across geographical boundaries, with little, or no, limitation (Mgudlwa and Iyamu, 2018). The use of MomConnect is a free-of-charge and voluntary project in which pregnant woman can participate if, and when, they wish to do so. The information made available through the project is provided in all of the 11 official languages of South Africa.

Factors hindering the dissemination of health information

The provision of health information is hampered by unparalleled impediments. Those living in the rural areas tend to experience various challenges, including inadequate healthcare facilities, poor road conditions and the inadequate provision of health information, all of which challenges affect the accessibility of the healthcare and health facilities concerned (Maphumulo and Bhengu, 2019). According to Bekalu and Eggermont (2014), the current methods that are used to disseminate HIV/AIDS information throughout the rural areas fail to capacitate the rural populace with health information, which puts rural populations at a disadvantage, relative to their urban counterparts. Their failure to do so could be due to the clinics not sufficiently considering the cultural, educational and social backgrounds of those living in the rural areas.

Some challenges that those living in the aforementioned areas tend to experience when they attempt to access information include illiteracy and not knowing where to access the appropriate information (Iloo and Adeyemi, 2010:3). In the absence of the right information, the public can be at an increased risk of being infected by disease. The lack of access to health information may create dangerous misconceptions among the rural communities. One misconception that has been expressed in recent times is that some racial groups cannot be infected with COVID-19. The attitudes of health practitioners influence the use of health services, including in relation to the provision of health information.

In regard to Malawi, the results of the study conducted by Nyasulu and Chawinga (2018) showed some challenges that were faced by health surveillance assistants in using ICT to disseminate health-related information. The challenges included the increased costs of ICT

gadgets, the poor supply of data, the paucity of ICT skills, and the lack of management support, in terms of organising ICT training.

Linguistic and cultural backgrounds can act as threats to health information access. Although South Africa has 11 official languages, much health information is only available in English, which is not the first language of most of the inhabitants of Limpopo Province. Additionally, language is inseparable from culture (Van den Berg, 2016:229). Whereas health information is produced by trained healthcare professionals, the recipients of the information concerned can hold different cultural views to describe and conceptualise diseases. For instance, in a study conducted by Mkabile and Swartz (2020), most of the participants in Khayelitsha, Cape Town, South Africa were found to experience difficulties and frustrations when accessing information, because some of it was in a language in which they were not fluent, or that they were not at ease speaking, such as English or Afrikaans.

METHODOLOGY

The current study used the qualitative research method to study the functioning of five clinics in the Capricorn District in the Limpopo Province of South Africa, with the target population for the study being the patients concerned. The clinics were selected, based on their proximity to the researcher and on their willingness to participate in the study, whereas the patients were selected, based on their availability at one of the clinics surveyed during the time of data collection, and their willingness to participate in the study. In all, 15 patients agreed to participate in the interviews. The patients were crucial participants in the study, in terms of the role that they played as the consumers of the health information provided by the clinics. The data involved was collected from the semi-structured interviews that were conducted with the patients concerned. The interviews that were conducted at the clinics were recorded by way of the note-taking recording method, with them being transcribed manually into a Word document for analysis. The data were then thematically analysed, based on the objectives of the study.

RESULTS AND DISCUSSION

This section presents the results of the current study. The results are reported under broad subheadings that address the objectives of the study.

Specific information required by patients from the clinic

The respondents were asked to indicate the specific information that they needed from the clinic. The results show that most of the respondents visited the clinic to collect their medication, or for purposes of immunisation or family planning. The above is evidenced by some of the responses made to the question concerned, which included the following:

“I am here to collect my chronic medication.”

“I brought [a] kid to be immunised.”

“I am here for prevention [i.e. family planning].”

“... I am not here for any information; all I need is flu medication ...”

The above finding denotes that those living in the Limpopo rural areas were found to have various information needs as regards managing their health. Although Ntsala and Dikotla (2019) note that the ability to provide timeous and right information to the right person at the right time has a positive influence on a person’s health, it was surprising to find that some of the respondents visited the clinic for specific health information. Their doing so can be seen in the light of Kapadia-Kundu and Sullivan’s (2011) assertion that trying to encourage people to utilise information effectively remains a serious challenge. All the patients at the clinics surveyed visited the clinics solely to consult the medical practitioners there for reasons related to their health.

Information and communication technologies used to disseminate health information

The respondents were then asked to outline the nature of the ICT used for interacting with the patients and for disseminating health information. Surprisingly, all of the respondents indicated that the clinics used no ICT tool whatsoever to disseminate health information. Such failure to use the appropriate ICT tools defied the existence of the South African Department of Health’s (2019) MomConnect system, which is meant to facilitate information

sharing across geographical boundaries, with little or no limitation (Mgudlwa and Iyamu, 2018). The failure, by the clinics and by those living in the rural areas, to use an information delivery system implies that such a system is inappropriate, and that it is not user-friendly for those living in the rural areas. Without the use of ICT tools, the accessibility of health information to the rural inhabitants is affected. In the current 4IR, people tend to rely on technology for many reasons, including to store and disseminate health information. The ICT infrastructure in the clinics was found to be inadequate. In most of the developing countries, like South Africa, inadequate funding tends to limit the establishment of an effective ICT infrastructure (Ugwoke, 2014).

Factors hindering the dissemination of health information

The respondents surveyed were asked to identify the challenges that they experienced when they accessed health information at the clinics. All the respondents indicated that they had experienced some challenges, ranging from the shortage of health promotional materials, the clinics' inadequate opening hours and their awkward geographic location, the language barriers encountered, and the negative attitudes of the nurses involved.

Shortage of health promotional materials

The Limpopo-based clinics were found to receive health promotional materials from their mother body, being the Department of Health, so that the dissemination of health information at the clinics was centralised. The centralisation of health information means that the development and dissemination of the health information used by the clinics falls under the control of the Department. However, the above does not mean that no effort is taken by the clinics. Rather, the clinics play a crucial role in providing health information to the patients, as they are the first line of contact with them. The current study found that the inadequate supply of promotional materials discouraged many of the respondents from seeking health information from the clinics concerned. Additionally, the materials that are made available at most South African clinics are largely print-based. A print format means that the system that is used to distribute such materials must be manual, which is expensive in terms of both time and money, with those concerned having to attend the clinics in person to access the available health information.

One respondent claimed that “*most [i.e. more] often than not, there are no materials, such as pamphlets, when you request them*”.

Another respondent said, “*I assume there is no health information in this [i.e. these] clinics, because I have never seen any booklet[s] or brochures in this clinic.*”

The above statements indicate that the access to health information in rural and urban settings is unequal (Godlee et al., 2004). Those who live in the rural areas seem to have less access to health information than do their counterparts living in the urban areas. Similarly, a UNAIDS Report (2013:3) reveals that “the ability to lay the foundation for an end to the AIDS epidemic in low- and middle-income countries continues to be undermined by a major resource gap”.

Clinics’ opening hours

Only one clinic, of those surveyed, was found to be open around the clock, while the other clinics were open for only eight-and-a-half hours a day, namely from 07h30 to 16h00 from Monday to Friday, whereas they were closed on the weekends. As a result, the majority of the respondents lamented the clinics’ limited opening hours. Such a limitation meant that there was no access to healthcare services, and to health information, beyond the clinic’s operating hours. Having only limited access to health information and services can put the health of the community members at risk. For instance, obtaining the right information about sugar diabetes can make a major difference between successfully living with the condition or succumbing to it, in the absence of the right information. Having access to a clinic is a determinant of good health. The relative inaccessibility of clinic services can increase the risk of HIV/AIDS infection, mortality and other health risks, including those resulting from misconceptions and myths about HIV/AIDS.

Geographic location of the clinics

The current study found that the unequal distribution of healthcare facilities, like clinics, is a critical barrier that requires to be overcome, so as to ensure effective access to basic health information. The above means that the geographic location of the clinics in the Limpopo Province hampers their reachability, with the respondents claiming that they had to travel long distances to access them. Such a situation was evidenced by the following statements made by two of the respondents:

“The clinic is far from where I stay, so I only come here when I really have a serious health problem.”

“Because I am not working, I do not have money to pay [for] the taxi to visit the clinic.”

The above results clearly show that the respondents' socio-economic status is a major contributing factor to hampering their accessing health information. In other words, those living in the rural areas have to pay to access such information. Costs in the above regard are in terms of money and/or the amount of time that is taken to travel long distances to reach a clinic.

Cultural and language barriers

In South Africa, cultures and traditions tend to differ across the country. Apart from the 11 official languages, many dialects are spoken in the various regions in the country. The language barriers existing across the provinces and districts can hamper the accessibility of the different information sources and programmes, in terms of the need to reach people with varying experiences and backgrounds. In the current study, the respondents reported that the health information resources offered by the South African Department of Health are provided in English. Only sometimes are such materials translated from English into the vernacular languages, so as to enhance the understanding of their readers. Some respondents stated that, even though most of the pamphlets and posters were written in English, the nurses used Sepedi to communicate with them, because the majority of those

living in Limpopo's Capricorn District speak Sepedi. Such a language accommodation maximises the chances of delivering useful HIV/AIDS information to the patients concerned.

Yet another cultural matter is that women tend to consider male healthcare workers to be unacceptable for dealing with certain issues, and vice versa (Schoeps, Gabrysch, Niamba, Sié and Becher, 2011:492). Moreover, Obermeyer (1999:153) notes that "in certain cultures, the use of biological or factual names for reproductive organs is sometimes prohibited or regarded as a taboo". Such cultural perceptions may distort the intended meaning of health information. Similarly, Dikotla (2008) found that nurses in the Limpopo-based clinics use two languages, namely Northern Sotho and English, to disseminate HIV/AIDS information, with English mainly being used when discussing issues pertaining to sex and the naming of the genitals. In South Africa, language has been identified as a health care barrier preventing patients from receiving quality health care service (Claasen, Jama, Manga, Lewis, and Hellenberg, 2017.). Ethnicity also affects the choosing of suitable health providers and the way in which the HIV/AIDS communication programme is accessed.

Attitude of healthcare practitioners

In South Africa, as in most sub-Saharan African countries, studies have revealed serious concerns regarding the poor relationship between health practitioners and patients, especially in terms of how health practitioners tend to interact and communicate with patients at the various health centres. Health workers, particularly nurses, have been found, sometimes, to neglect their patients or clients to a certain extent (Dapaah, 2016). The current study found that some of the healthcare practitioners surveyed tended to harbour negative attitudes that hindered the patient consumers of health information attempting to seek health-related information from the available clinics. Such negativity led to many patients experiencing healthcare practitioners as unfriendly, which made them feel unwelcome, resulting in their discontent with the service provided. Williams, Baker, Honig, Lee and Nowlan (1998) concur that many of the respondents in African countries are scared of consulting the appropriate medical authorities, due to the negative attitude of the nurses involved.

The statements made by those interviewed included the following:

- *“We are scared of visiting clinics, because when we go to [i.e. for a] test or [to] ask for information, [the] nurses would just look at you and tell you that if you want to [undergo a] test, it means you are having unprotected sex.”*
- *“Nobody cares about us; if you want to undergo a] test, you will be on [i.e. in] the queue for many hours without ... help”.*
- *“It looks like we are not a priority to [the] nurses.”*
- *“It breaks my heart to tell you that I have been here since 06h00, but I am still waiting ...”*
- *“I wish I can [i.e. that I could] afford private doctors, in order to avoid to be [i.e. being] ill-treated by these nurses.”*
- *“I promise you, these nurses have [an] attitude to[wards] us.”*

The above statements display the worrisome attitude adopted by some of the nurses at the Limpopo-based clinics. When they hold negative attitudes and beliefs regarding the provision of health information, the testing and counselling for HIV/AIDS, and the screening and wellness programmes, might be affected, resulting in the patients not receiving quality healthcare from the healthcare practitioners concerned (Mntlangula, Khuzwayo and Taylor, 2017). The findings of the present study are interesting to compare with those of a study conducted by Mntlangula et al. (2017), which found that, in eThekweni Municipality, South Africa, the nurses' attitudes, beliefs and perceptions regarding counselling for HIV/AIDS, tuberculosis and sexually transmitted infections were negative.

Fake news

The social media enable people to disseminate misleading health information, resulting in consumers failing to make important decisions regarding their health.

CONCLUSION AND RECOMMENDATIONS

The results obtained in the current study showed that the lives of those residing in rural areas were at risk, because they doubted the ability of their information sources to solve

their health-related problems, or to contribute meaningful input into their decision-making pertaining to their health. Therefore, it is imperative for the government to make the rural communities aware of the importance of health information for their continued good health. The increased use of health information should empower the consumers thereof to make informed health decisions, and to lead a healthy life.

The clinics in the rural areas are still lagging behind, as far as the use of ICT to disseminate health information is concerned. The government should consider permitting the clinics to create and use their own social media web pages, so to be able to disseminate health information and to encourage the patients, especially pregnant women, to use the MomConnect system. Non-use of the system would, otherwise, mean fruitless expenditure by the Department of Health.

The accessibility of health information is affected by various socio-economic factors. If the above-mentioned hindrances are not overcome, it would be difficult to achieve universal access to information, and the right to access information would continue to be violated in the rural communities. Without health information being disseminated timeously in the right format, those living in the rural communities are likely to remain vulnerable and susceptible to disease, as they are unlikely to be able to protect themselves from infection, or to take precautionary measures to influence government policies positively. The prevailing lack of health information fuels the social ills that are perpetuated by the myths, misconceptions and misinformation regarding certain health issues, like the COVID-19 pandemic.

As people still have to travel far before reaching the appropriate healthcare service, the recommendation is made that additional clinics should be built for the communities concerned. In accordance with the norms and standards of the healthcare service in South Africa, no patient should have to travel more than 25 km before reaching a health facility. To enhance the already existing community-based care facilities, mobile clinics should be introduced.

As far as language barriers are concerned, it is recommended that health workers should be trained in the medium of the vernacular language spoken in the area where the relevant health facility is located. Health practitioners who are conversant in the vernacular language of the patients are well-positioned to package and disseminate health information to meet the needs of their target audience (Ntsala and Dikotla, 2019). Accordingly, the above calls for the provision of language services, like translation and the interpretation of English information into information in the indigenous languages of the Limpopo Province. Cultural sensitivity and competence are also necessary for delivering the appropriate messages. Such a solution is recognised by francophones in Canada as being essential for providing suitable care for vulnerable populations (De Moissac and Bowen, 2019). The above was also seen in South Africa, in connection with communicating information about cholera, malaria, HIV/AIDS and, recently, the COVID-19 epidemic, with the relevant publications having been translated into the indigenous languages.

If the attitudes of health practitioners towards their patients or towards the consumers of health information are positive, the possibility is that those concerned are likely to be encouraged to seek out, and to use, health information. The recommendation is also made that the staff be trained regarding the Batho Pele Principles relating to customer service. Ilo and Adeyemi (2010:3, citing Ejeagwu, Nwafor-Orizu and Uhegbu, 2007) contend that “one of the best ways of disseminating health information to rural communities is to intensify the use of rural-based sources such as churches, age grades, women's associations, etc.”. Therefore, the clinics need to collaborate, and to work in partnership, with other stakeholders, including the tribal authorities, the ward councillors and the local churches and businesses. If there were to be buy-in from the stakeholders, the chances would be favourable that the currently prevailing misconceptions and misinformation would be dispelled. Finally, the current study concludes that the rural clinics should employ information delivery systems that are unique to, and appropriate for, the rural communities that they serve.

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