

RESEARCH REPORT

**FACTORS CONTRIBUTING TO HEALTH SEEKING BEHAVIOUR OF PATIENTS AT
SISTER MASHITENG CLINIC, NKANGALA DISTRICT OF STEVE TSHWETE LOCAL
MUNICIPALITY, MPUMALANGA PROVINCE**

By

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DISSERTATION

Submitted in fulfilment of the requirements for the degree of Masters' in Nursing

MASTER OF NURSING SCIENCE

in the

FACULTY OF HEALTH SCIENCES

(School of Health Care Sciences)

at the

UNIVERSITY OF LIMPOPO

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2019

DECLARATION

I, **Nonhlanhla Maseko**, declare that the research reported in this thesis “**Factors contributing to health seeking behaviour of patients at Sister Mashiteng Clinic, Nkangala District of Steve Tshwete Local Municipality, Mpumalanga Province**” is my original work.

This dissertation hereby submitted to the University of Limpopo for the degree of Master of Nursing Sciences (MNurs) has not been submitted for a degree at any other university or institution; it is my own work in design and execution, and all material contained herein has been duly acknowledged.

Signature

Maseko, Nonhlanhla.

Date

DEDICATION

This study is dedicated to my mother, Nancy Ntselane Moshoeu, my father Richard Sunboy Maseko and my daughter, Ayanda Excellent Mlambo.

ACKNOWLEDGEMENTS

My special acknowledgement to the following individuals; without their love, support and patience, I would not have been able to complete this study:

- Almighty God for making this research project possible and for protecting me throughout this journey.
- My Supervisor, Mrs MA Bopape, for guiding and encouraging me through the journey of my research project.
- My Co-supervisor, Professor TM Mothiba, for her guidance, encouragement and support.
- To my one and only daughter, Ayanda Excellent Mlambo, for her support and love.
- To my mom and dad, Mrs Nancy Ntselane Moshoeu Maseko and Mr Richard Maseko, for their support and words of encouragement.
- To My uncle, Calvin Maseko, for his support and words that keeps me motivated and pushing very hard.
- Mr Gabriel Mthobi Gladile for his support and for being my mentor throughout this research project.
- The participants who took their precious time to participate in this study and allowed me to interview them, thank you so much.
- The Department of Health in the Mpumalanga Province, for granting me permission to conduct the study.
- The Director Primary Health Care of Nkangala District, Dr C Nelson, for granting me the opportunity to conduct interviews in the facility.
- Thank you, my colleagues; a special thanks to my Operational Manager, Miss Mariam Mahlangu and my clinical supervisor, Mrs Poppi Mahlangu, for the support and words of encouragement.
- To my siblings, Goodness Maseko, Sifiso Maseko and Karabo Maseko for love and support.

ABSTRACT

Introduction: Health seeking behaviours are explained as a dynamic interaction of cognitive, behavioural and effective elements, focusing on the attitudes and beliefs of individuals preceded by a decision-making process that is governed by individual or community norms within the primary health level context to explain and predict health behaviours.

Aim: The purpose of this study was to describe factors contributing to health seeking behaviour of patients at Sister Mashiteng Clinic, Nkangala District of Steve Tshwete Local Municipality, Mpumalanga Province.

Methodology: A qualitative, explorative, descriptive and contextual research design was followed in this study. A non-probability purposive sampling was used to select 15 patients who voluntarily agreed to participate in this study. The researcher conducted semi-structured, one-on-one interviews which were tape recorded and transcribed. Data collection was done and analysed using the Tesch's inductive, descriptive coding technique.

Results: Four themes emerged, namely, explanations related to the factors contributing to health seeking behaviour; reasons towards missing scheduled appointments behaviours; views about health seeking behaviours related to services provided at the clinics; related/existing health beliefs amongst patients. To ensure the trustworthiness of the research data, Lincoln and Guba's framework, as outlined by Polit and Beck (2010), was adhered to throughout the study.

Conclusion: Findings of the study revealed that the factors contributing to health seeking behaviour in Steve Tshwete clinics are behaviours that were linked to prescribed treatment, test and treat during consultation in the clinic, socio-economic background, behaviours of missing scheduled appointments or treatment, health seeking behaviour due to avoidance of running out of treatment, lack of reliable transport blamed for health seeking, patients trust of private doctors and family influence.

Keywords: Patients, Behaviours, Defaulters, lost to follow up, Religious beliefs, Health seeking behaviours.

DEFINITION OF CONCEPTS

HEALTH

The World Health Organisation (WHO) defined health “as a state of complete physical, mental and social well-being in the absence of any disease or impairment which allows the individual to adequately cope with all demands of daily life (WHO, 2011). In this study health is the ability to survive from any disease, being free from illness spiritually, physically, mentally, thus meeting the goals for survival.

BEHAVIOUR

Cao (2010) defines behaviour as the range of actions and mannerisms made by individuals, organisms, systems and or artificial entities in conjunction with themselves or their environment, which includes the other systems or organisms around as well as the (inanimate) physical environment. In this study, behaviour is any actions taken by patients when seeking health outside health facilities.

FACTORS

Factors mean circumstances, facts or influences that contribute to the results (Murray, 2015). In this study, the factors are circumstances that contribute to health seeking behaviour.

SEEKING

Seeking means an attempt to find something or desire to obtain or achieve something and or to push towards a goal (Murray, 2015). In this study, seeking is any alternative action taken by patients to find help with their health and wellbeing.

PATIENTS

A patient, as defined by South African Nursing Council, is an individual who is under the care of a health care practitioner and entitled to receive the service in accordance with the condition (Act 33 of 2005). In this study, a patient is any individual who has health problems and who is ill, undergoing treatment for a disease and requested to be evaluated by any health care professional.

HEALTH SEEKING BEHAVIOUR-

as a sequence of remedial actions that individuals undertake to rectify perceived ill-health before and after consulting health practitioners at health care facilities.

LIST OF ABBREVIATIONS

ANC	Ante Natal Care
ARV	Anti-Retroviral Therapy
ATM	Alternative Traditional Medicine
CD	Communicable Diseases
CEO	Chief Executive Officer
CHC	Community Health Centre
CHW	Community Health Worker
HIV	Human Immune Virus
HSB	Health Seeking Behaviour
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organisations
PHC	Primary Health Care
SES:	Socio Economic Status
TB	Tuberculosis
THP	Traditional Health Practitioner
TREC	Turfloop Research Committee
UNAIDS	Joint United Nations Programmed on HIV/Acquired Immune Deficiency Syndrome
UTT	Universal Test and Treat
WHO	World Health Organization
WOBOT	Ward Based Outreach Team

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Health-seeking behaviours have been defined as a sequence of remedial actions that individuals undertake to rectify perceived ill-health before and after consulting health practitioners at health care facilities. Health-seeking behaviours can be described as the time difference between the onset of illness and contact a healthcare professional (Longbing, 2010). The health-seeking behaviour of a community determines how health services are used by patients. Factors that determine health-seeking behaviour and the utilisation of a health care system may be socio-economic, due to educational levels, cultural belief and practices (Musoke, Boynton, Butler & Musoke, 2014).

About 7 million children worldwide, under the age of 5 years, died in 2011. More than half of these deaths were due to preventable conditions like pneumonia, diarrhoea and birth asphyxia where access to health care facilities was possible, but patients sought help outside of health facilities and only presented themselves to the health facilities when their conditions were in a deteriorating state; this delay led to a number of deaths (Webair & Bin-Gouth, 2013). According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) (2008), there are an estimated 33 million people living with HIV globally, with over 5700 persons dying from AIDS every day. The estimated number of deaths due to AIDS in 2007 was 2.0 million annually worldwide, due to a high rate of health-seeking behaviours resulting in delays to seek treatment.

In developing countries, such as Uganda, illiteracy, poverty, underfunding of the health sector, inadequate water and poor sanitation facilities had a big impact on health-seeking behaviour, and cultural prescriptions are also a barrier to the provision of health services. These challenges affect the health-seeking practices of communities (Musoke et al., 2014). According to Kaiser (2014), rural residents often experience barriers to healthcare facilities that limit their ability to get the care they need. Furthermore, they begin health-seeking behaviours in places that are conveniently available to them.

According to the World Health Organisation (WHO, 2011), traditional medicine in China accounts for around 40% of all health care delivered and more than 90% of general

hospitals have units for traditional medicine. In the United States, about 38% of adults and 12% of children use some form of traditional medicine to maintain their health (Ribnicky, Pouley, Schmidt, Cefalu & Raskin, 2008). In India, 70% of the population depend on traditional medicine to help meet their health care needs and health-seeking behaviour is not limited to health care facilities. In Africa, up to 90% seek health from traditional healers and prophets (WHO, 2011).

In South Africa, patients discontinue treatment and others are lost to follow up due to health-seeking behaviour that puts them at high risk of their illnesses lapsing into deteriorating states and deaths because of HIV/AIDS-related conditions, (Macpherson, Moshabela, Martinson & Pronyk, 2009). According to Van der Hoeven, Kruger and Greeff (2012), South Africa is currently experiencing a burden of diseases which results from health-seeking behaviours. These burden diseases refer to an increased burden of chronic diseases, a rise of infectious diseases associated with HIV/AIDS and health-seeking behaviours. Treatment interruptions have been found to increase the risk of opportunistic infection and death with viral load increase and associated CD4 decline, most pronounced in the first two months (Kranzer, Lewis, Ford, Zeinecker, Orrell, Lawn & Wood, 2010).

In Mpumalanga, some prophets and pastors encourage their sick congregants to stop taking their medication and trust that God will heal them. Patients who were HIV positive or who had chronic illnesses such as diabetes mellitus, hypertension, TB, etcetera reportedly stopped their treatment and despite all the health education given by their healthcare providers about the importance of adhering to treatment, they defaulted, all in the name of faith (Maseko, 2017).

Nowadays, the concept of health-seeking behaviour has become a tool for understanding how people engage with the health care systems in their respective socio-cultural, economic and demographic circumstances. All these behaviours can be classified at various institutional levels: family, community and health care services (Shaikh, 2008).

1.2 PROBLEM STATEMENT

There seems to be an increased number of patients reporting at Sister Mashiteng Clinic with complications due to health-seeking behaviours. Behaviours such as missed

appointments contributed to complications of diseases. Some patients come with their illness in a deteriorating state because they have defaulted on their treatment. The clinic statistics in 2016 revealed that 40% defaulted; in 2017, 45 %; in 2018, already 55% of patients have defaulted on treatment. The subjective data collected from those patients by the nurses indicated that patients had stopped treatment because they were seeking health from Traditional Health Practitioners prophets, friends and family members so that they could be given herbal products or spiritual healing. The collected data showed that some patients' knowledge and beliefs about specific treatments had influenced their willingness to comply with treatment.

Non-attendance of patients to the primary health care facilities as scheduled appointments has been highlighted as one of the most factor contributing to health-seeking behaviour. Health seeking behaviours of patients in communities has become a major contribution to complications of diseases and death

1.3 AIM OF THE STUDY

The aim of the study was to determine the factors contributing to the health-seeking behaviour of patients at Sister Mashiteng Clinic, Nkangala District under Steve Tshwete Local Municipality.

1.4 RESEARCH QUESTIONS

The research question which guided the researcher throughout the study was:
What are the factors contributing to health-seeking behaviour of patients at Sister Mashiteng Clinic, Nkangala District under Steve Tshwete Local Municipality?

1.5 OBJECTIVE OF THE STUDY

The objectives of this study were to:
Explore and describe the factors contributing to health-seeking behaviour of patients in primary health care facilities in the Nkangala District under Steve Tshwete Local Municipality.

1.6 RESEARCH METHODOLOGY

In this study, a qualitative explorative, descriptive, contextual design was used with the aim of exploring and describing factors contributing to health-seeking behaviour of patients at Sister Mashiteng Clinic of Steve Tshwete local municipality.

A population is the entire group of persons or objects that are of interest to the researcher; in other words, it is the group that meets the criteria that the researcher is interested in studying (Brink et al., 2012). In this study, the population was all patients with behaviours of missing scheduled appointments with the total number of 130 defaulters. These patients were traced telephonically, and some came with health problems for consultation at the clinics. This study only focused on patients who attended the Sister Mashiteng Clinic.

Sampling is a subset of the population that is selected to represent the population (Brink et al., 2012). According to (Christensen, Johnson, & Turner. 2011) Sampling is a selection process whereby a smaller representative part of a larger group is selected for research purposes. In this study, the researcher used non-probability purposive sampling; it was based on the judgement of the researcher regarding participants who were knowledgeable about the factors contributing to the health-seeking behaviour of patients who had defaulted treatment. The researcher sampled 20 patients and end with 15 patient's due data saturation reached.

Trustworthiness deals with the quality of data collection, analysis, interpretation and presentation by the researcher (Taylor, 2013). Fenton and Mazulewicz (2008) define trustworthiness as supporting the argument that the study findings are worth paying attention to. The researcher proved that the information provided was true and not manipulated, so they should be deemed trustworthy. Strategies used to ensure the trustworthiness of the research were credibility, transferability, dependability and confirmability. These strategies are discussed in detail in Chapter 3.

Permission to conduct the study was obtained from the Department of Health Mpumalanga Province and Chief Executive Officer (CEO), the Supervisors and the Operational Managers at Sister Mashiteng Clinic in the Nkangala District. The researcher obtained ethical approval from the University of Limpopo Turfloop Research and Ethics Committee (TREC/375/2017: PG). Permission was obtained from all participants and

their informed consent was obtained prior to each interview. The participants were ensured that their names would not be reflected in the study. Privacy, confidentiality and fairness were maintained throughout the study and participants were also informed that they could withdraw their participation from the study at any time.

1.7 STRUCTURE OF THE DISSERTATION

The study report on the factors contributing to the health-seeking behaviour of patients at Sister Mashiteng Clinic of Steve Tshwete Local Municipality, Mpumalanga Province, consists of the following chapters:

Chapter 1

Overview of the study

Chapter 2

Review of relevant literature and theoretical framework

Chapter 3

Research methodology

Chapter 4

Data analysis, presentation and description of the research findings.

Chapter 5

Summary, conclusions, recommendations and limitations of the study.

1.8 CONCLUSION

This chapter provided an overview of the study. The study was introduced and background information about factors contributing to the health-seeking behaviour of patients was presented from a global context to the primary health care facility context in the Mpumalanga Province. The research problem and the theoretical background were described. The aim, research questions, and the objectives of the study were outlined.

Chapter 2 will provide the literature review and theoretical framework Chapter 3 will present the research methodology, and Chapter 4 presents the discussion of results, literature control and adaptation strategies, whereas Chapter 5 will provide the summary, limitations and recommendations.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

This chapter will be focusing on studies that were already done about factors contributing to health-seeking behaviour. The aim is to check what other researchers have found regarding the problem being studied. The literature review was conducted on journals, books, newspapers, articles and online media reports. The chapter also presents theoretical framework which aligns with the research topic that is about health-seeking behaviours of patients.

2.1.1 ACCESSIBILITY OF HEALTH CARE FACILITIES AND AVAILABILITY OF SKILLED WORKFORCE

Depending on the area a person lives in, access to healthcare services is critical for rural residents. Ideally, residents should be able to conveniently and confidently use services such as primary health care facilities, but they are limited due to workforce shortage, and other factors. Rural residents often experience barriers to healthcare that limit their ability to get the care they need. They then begin health-seeking behaviours that are inappropriate for their wellbeing (Kaiser, 2014). The availability of skilled health care providers particularly midwives, nurses and doctors are critical in assuring high-quality service delivery: a population large burden of ill-health where the workforce is insufficient, limits and delay patients accessing health care facilities for their illnesses and thus lead them into health-seeking behaviours (Gerein, Green & Pearson, 2013).

A study conducted by Appiah-Denkyira, Herbst, Soucat, Lemiere and Saleh (2013) revealed that a delay in receiving adequate care and availability of human and material resources both became influencing factors to patients' health-seeking behaviour within communities at health care facilities. The patients' health care seeking behaviours were associated with staff shortages of nurses working in the health care facilities, together with unavailability of treatments. According to Appiah-Denkyira, Herbst, Soucat, Lemiere and Saleh (2013), a lack of human resource for health prevents health service being accessed by those mandated to receive it. The participants reported that they seek

services elsewhere since the community health care facilities only had one or two nurses attending to all their clients.

A study conducted by Ononokpono and Odimegwu, (2014) about determinants of maternal health care utilization in Nigeria revealed that access to a primary health care facility is projected as a basic social right. Dissatisfaction with primary care services in either sector leads many people to health care shops or to jump to higher-level hospitals for primary care, leading to considerable inefficiency and loss of control over efficacy and quality of services. In developing countries, including Pakistan, the effect of distance on service use becomes stronger when combined with the dearth of transportation and poor roads, which contribute towards increased costs of visits (Shaikh & Hatcher, 2004) cited in Ononokpono and Odimegwu, (2014)

Non-availability of transport, physical distance to the facility and time taken to reach the facility undoubtedly influence the health-seeking behaviour and health services' utilisation. The distance separating patients and clients from the nearest health facility has been remarked as an important barrier to use, particularly in rural areas. The long-distance has even been a disincentive to seeking care, especially in the case of women who would need somebody to accompany them to the facility (Shaikh & Hatcher, 2004). As a result, the factor of distance impacts strongly.

Other factors such as the availability of transport, the total cost of one round trip and women's restricted mobility also impact on visits to health care facilities. Resources and equipment, namely, the availability of human and material resources, are a marker of health care access to and utilisation of ANC services to health care and emergency services. The current study findings revealed that pregnant women had limited access to health care and emergency services. (Shaikh & Hatcher, 2004) cited in Ononokpono and Odimegwu, (2014)

A study conducted by (Selke, Kimaiyo, Sidle, Vedanthan, Tierney, Shen, Denski, Katschke & Wools-Kaloustian, 2010) nurse participants confirmed that having just two health posts and one mobile clinic in the area were contributory factors responsible for

the limited access to health care by pregnant women. The pregnant women participants stated that residing in this rural community was a major contributory factor when requiring access to health care and emergency services. The factors that influenced access to health care and emergency services were inaccessibility to health care due to the clinic's operation times and operation days; transport unavailability and other financial issues, the number of clients accepted per clinic session and the provision of services per clinic session. (Selke, et al. 2010).

Levesque, Harris, and Russell (2013) define health care access as access to a service, a provider or health care facility, whereby there is an opportunity for health care customers to use suitable services relating to their health needs. The participants from both phases of this research study agreed that the health care facilities in the community were inaccessible due to the clinic's operational times and operational days, which became major contributory factors to the under-utilisation of ANC services. The pregnant women concurred that the major contributory factor became a deciding factor in the delay to reach care, thus leading to utilisation of ANC services elsewhere outside the community.

Arthur (2012) proposed that in the most remote rural areas disparities in health care still exist and are due to the inaccessibility and unavailability of health facilities, human resources, and poor road infrastructure to facilitate utilisation of ANC. Wabiri et al. (2013) concurred with the above author when stating that in KZN pregnant women concentrated in the urban formal areas have better access to health care, compared with 23.8% of the poor living in rural informal tribal areas with limited access. These authors agree that deficiencies in access to and utilisation of maternal health services and poorly skilled health care providers make a critical contribution to maternal health outcomes; the findings of the current study concur with these authors.

The factors that influenced limited access to health care were therefore inaccessible health care due to clinic operational times and days; the number of clients accepted at the health posts; the provision of more than one service for one day; and transport and financial issues. These factors brought about an under-utilisation of ANC services within

this rural community. In relation to the Constitution of the Republic of South Africa, the rural community of KwaMkhizwana has a fundamental right to access health care services. Chapter 2 Section 27(1a) of the Constitution of the Republic of South Africa, (1996) affirms that everyone has the right to access to health care services, including reproductive health care. Pregnant women in this rural community, therefore, needed to benefit fully from this constitutional right by obtaining accessible health care and emergency services.

2.1.2 HEALTH KNOWLEDGE AND HEALTH SEEKING BEHAVIOURS

The individual's ability to understand and act on health information by itself contributes to health-seeking behaviours. Health knowledge is one of the significant factors determining the health-seeking pathways taken. Focusing on the influence of health knowledge, Howell et al. (2008) conducted a study among patients diagnosed with lymphoma in West Yorkshire, examining their beliefs and actions about health-seeking behaviour. They found that a lack of knowledge and the interpretation of symptoms as not being serious had led to delays in patients seeking health care.

According to Mbonu et al. (2009), knowledge about HIV, which includes knowledge about one's HIV status, modes of HIV transmission and effective treatment, is important for people living with HIV if they are to obtain adequate care. Morrison, Banushi, Sarnquist, Gashi, Osterberg, Maldonado and Harxhi (2011) conducted a study in Albania assessing the barriers to the care of HIV-positive patients. They found that a lack of knowledge of HIV medical care is associated with the existence of barriers to care. Patients do not know where they can find medical help for HIV/AIDS. A study by Chomat et al. (2009) found that patients generally have little knowledge of the available treatments for HIV, despite their good knowledge of HIV transmission and prevention.

Studies have indicated that a lack of knowledge is a barrier to care not only for patients. Morrison et al. (2011) found that medical providers' lack of knowledge is also associated with barriers to care. Chomat, Wilson, Wanke, Selvakumar, John and Isaac (2009), states that most Indian medicine providers reported dangerous misconceptions about HIV

transmission, diagnosis and treatment. Van Schalkwyk, Maree and Wright (2008) in their study among women with advanced cervical cancer also found that a lack of knowledge and awareness among health-care professionals can result in a low suspicion of cancer and misdiagnosis.

2.1.3 FACTORS INFLUENCING HEALTH-SEEKING BEHAVIOURS

According to the WHO (2011), Socio-Economic Status (SES) influences health-seeking behaviour by the distribution of power and knowledge of health that leads to patients being unsatisfied with their health care provider”, which in turns leads to them stopping seeking treatment.

The economic polarisation within the society and lack of social security make the poor more vulnerable. In terms of affordability and choice of health provider, poverty not only excludes people from the benefits of a health care system but also restricts them from participating in decisions that affect their health. This results in greater health inequalities.

Less possession of household items, cattle, agricultural land and type of residence signify not only the socio-economic status of a person but also give a picture of the person’s livelihood within a family. In most of the developing countries of the South Asian region, it has been observed that the magnitude of household out-of-pocket expenditure on health is at times as high as 80% being spent of the total amount spent on health care per annum.

Factors such as cultural values and gender roles are significant in influencing the decision-making process associated with health-seeking behaviour (O’Neil, 2012). Cultural beliefs and practices often lead to self-care, home remedies and consultation with traditional healers in rural communities and the giving of advice by the elderly in houses also being very instrumental; these factors result in the delay of treatment-seeking (Shaikh, 2008).

Asian-American cultures suggest that seeking help from health care professionals or seeking financial aid from the government to pursue treatment would be exposing the problem beyond their family network, which is considered shameful and could pose a

threat to the status or reputation of the family. Consequently, Asian-American people tend to turn to family members before pursuing external help, thereby delaying the act of seeking professional health care (Martucci & Gulanick, 2012).

In Pietermaritzburg, the capital of KwaZulu-Natal, patients seek health from different posters and pamphlets advertising herbal products and services that are distributed to people. There are, however, some potentially dangerous and harmful services that are also advertised, such as abortions, a cure for HIV/AIDS. Such services have led to a negative stigma that is now being associated with traditional medicine in KwaZulu-Natal. Such intentions are not to heal, but rather to destroy and take advantage of the ignorance of unsuspecting, desperate patients in urban communities (Ndhlala, Stafford, Finnie & Van Staden, 2011).

2.1.4 IMPLICATIONS (SUGGESTIONS AND INVOLVEMENT) ON THE HEALTHCARE SYSTEM AND ITS APPROACH TO THE HEALTH CARE SECTOR

(Masters, 2015) It is important for health care professionals to understand the different factors that affect an individual's decision to seek healthcare treatments. This is to promote good health-seeking behaviours, instead of providing options that patients might not feel comfortable with because of social norms or values. If healthcare providers can have knowledge about cultural beliefs and gender roles in terms of health-seeking behaviour, it could help improve their professional-patient relationships. Despite decades of research and public education campaigns aimed at decreasing patient delay times, most patients still do not seek treatment in a timely manner, therefore benefits of early treatment must be promoted to decrease patient delay (Moser, Kimble, Alberts, Alonzo, Croft, Dracup, Evenson, Hand, Kothari & Mensah, 2006.cited by Tsegaye, Abiy, Mesele and Tadesse (2016).

2.1.5 PREGNANCY AND HEALTH SEEKING BEHAVIOUR

Research in Australia shows that vitamins/herbs are the most popular Complementary and Alternative Medicine (CAM) used by pregnant women. Many herbalists believe that herbs are often better, cheaper and healthier than their medical counterparts, however, many medical professionals do not recommend herbal remedies for pregnant women since their safety has not been established through extensive research, unlike

prescription drugs (Mollart, Adams, & Foureur, 2016). According to the WHO (2011) estimates for 2015, 138 women per 100 000 live births in South Africa died due to pregnancy-related reasons, however, many women went to the clinic too late due to their health-seeking behaviour and choices, some due to how the public health system operates.

2.1.6 PAST PREGNANCY EXPERIENCE

Participants revealed that experience was a contributing factor to health-seeking behaviours. Studies revealed that previous experiences in the local health care facilities, previous pregnancy outcomes and the attitude of staff towards pregnant women are amongst the factors that impact on the choice to utilise health care facilities or not. A study in Zimbabwe concurred with these findings in that barrier to first ANC services were the negative attitudes displayed by the service providers (Gore, Muza, & Mukanangana, 2014). These study findings were further supported by Kurtz, Draper and Silverman (2016). who argued that a bad experience with the health care system can have an influence on a patient's decision of when and where to seek care.

The current study participants reported several social and cultural issues influencing pregnant women's decisions to seek and reach health care facilities. Amongst these factors were traditional and cultural norms and beliefs regarding ANC (Corrigan, Druss & Perlick, 2014). Amongst these factors were traditional and cultural norms and beliefs regarding ANC attendance; client's awareness regarding the importance of ANC; peer and community influence regarding ANC attendance; approval of pregnancy by parents and the community's understanding of social and cultural issues, which were necessary in the recognition of health-seeking behaviours of the population or communities. This was supported by the findings of a Chinese study by Lee et al. (2009) which revealed that antenatal taboos generally exist and still are practised by pregnant women.

The fears of the women participants in the study were based on being bewitched, rather than not practising certain cultural taboos as indicated in the Chinese study. In the current study, social and cultural issues influenced an individual's decision towards accessing

health care. This reflects that there is a need for women's awareness-raising so as to inform their decision-making regarding their pregnancy, maternal and child health. Lee et al. (2009)

As posited by Agus, Horiuchi and Porter (2012), an understanding of the obstacles within the local culture is vital to improving women's awareness about their pregnancy. As most women participants believe that pregnancy must be kept a secret until it is visible and apparent, this may have serious implications for the early identification of problems during ANC, and this is because women may delay seeking health care until later when pregnancy is recognised.

2.1.7 GENDER AND AGE

According to Victoor, Delno and Friele, (2012), age and gender are found to be determinants of treatment choice. Studies have indicated that there are differences in gendered patterns of health-seeking behaviours. According to Schmitt, Nyla, Branscombe, Postmes, and Amber (2014) cited by Kraemer (2000), men are slower to notice signs of illness and when they do, they are less likely to consult their doctors. This implies that men have limited contacts with physicians and health-care services (Schmitt et.al 2014). According to Pearson and Makadzange (2008), dominant gender norms of resilience and self-reliance, shyness and embarrassment delay men's treatment-seeking. Pearson and Makadzange (2008) found that once the symptoms of illness have been recognised, some men will proceed directly to accessing treatment, particularly if they have previously experienced similar symptoms. On the other hand, other men in the same situation may spend time seeking information and advice, but not progress further if the symptoms diminish. However, on contradiction to the findings of these studies, Victoor et al. (2012) find that the likelihood of men accessing any type of health care or qualified allopathic care is greater than of women doing the same. In supporting Victoor statement, (Richie, 2018) indicate that inequality in access is associated with the finding that women must overcome more obstacles than men to reach treatment.

In the context of age differences in health-seeking behaviour, Victoor et al. (2012) find no difference in health-seeking between the elderly and younger adults. He finds self-

treatment to be the most common choice of treatment for most illnesses, irrespective of the age group (Victoor et al., 2012). Most adults who are ill seeking treatment from western medical providers, visiting either a public clinic or a private doctor. Afolabi, Daropale, Irinoye and Adegoke (2013) cited by Jain et al. (2006), find that most adolescents and young, unmarried females first discuss their health problem with their mothers or elder sisters.

2.1.8 QUALITY, SAFETY AND SCIENTIFIC EVIDENCE

There is little data on the composition and quality of most herbal medicines not only due to lack of adequate policies or government requirements but also due to lack of adequate or accepted research methodology for evaluating traditional medicines (WHO, 2011). In addition, there is very little research overall herbal mixtures of natural chemicals. To isolate each ingredient from each herb would be immensely time-consuming at high cost making it not cost-effective for manufactures (WHO, 2011).

More conclusive evidence on the relative risks of herbal medicine versus synthetic drugs is scarce. The potential benefits of herbal medicines could lie in their high acceptance by patients, efficacy, relative safety, and relatively low costs. Patients worldwide seem to have adopted herbal medicines in a major way (Ernest, 2008).

2.1.9 STIGMA AND HEALTH SEEKING BEHAVIOUR

Goffman (2013) describes stigma or social devaluation “as a mark of social disgrace” often leading see others as untrustworthy, incompetent, or tainted. Gender, race, social status, mental and physical health are topics vulnerable to stigma. It is important to note that some cultures or individuals feel that seeking treatment is a shameful thing because it’s akin to announcing to the public that you have an illness. Therefore, education is needed to break this negative stigma to decrease factors contributing to health-seeking behaviours. Within the context of mental health, public stigma is characterised by the general population endorsing beliefs that devalue people with mental illness leading to health-seeking behaviours which leads to complications (Lau, Picco, Pang, Jeyaguranathan, Satghare, Chong, & Subramaniam, 2017).

People living with HIV are also faced with the related stigma of living with the disease. Such stigma may hinder the treatment and care of people living with HIV. However, a study by Gosling (cited in Mbonu et al., 2009) indicates that a person who is able to overcome stigma and shame is consequently able to seek appropriate treatment by publicly stating his or her HIV-positive status, whereas, according to the study of Morrison et al. (2011) the majority of patients indicate that a major barrier they faced in seeking care is that they do not want others to know that they are HIV-positive.

Mbonu et al. (2009) indicated that people living with HIV make different healthcare-seeking choices due to stigma, and this may lead to under utilisations of healthcare institutions. Chuma and Maina, (2012) indicated that people living with HIV utilise several strategies for accessing care without incurring negative repercussions, and this includes concealing their HIV status if possible and seeking health care outside of their own community so as to protect their anonymity. Mohammadpour et al. (2009) found that participants fear to disclose their statuses to others because of fear of rejection, fear of being blamed, misjudged and labelled and that their participants did not believe that their statuses would be kept confidential.

2.1.10 FALSE PROPHECY AS A CONTRIBUTING FACTOR TO HEALTH SEEKING BEHAVIOURS.

According to Revesai (2019) A 27 years old foreign national, has been looking for a baby and a job for six years in Johannesburg. She claims she was recruited by Lukau's Alleluia Ministries International to give false testimony and was promised a job and to be healed. She went to church on a Sunday, where she was brought forward to the altar where her "testimony" of being healed of HIV after three years was announced in dramatic fashion in front of the whole congregation. Ricky (2019).

Rape and fraud scandals have prompted calls in South Africa, there have been several high profiles cases recently involving disgraced pastors. Victims of alleged sexual abuse have detailed their experiences to BBC and criticised the invulnerability of so-called men of God who used their position of authority as a cover of abuse. Mtshibile (2019).

According to Alleyn (2019), South Africans buy “holy oil” guaranteed to cure all manner of diseases (especially HIV) and even their children, are argued to drink petrol to attain God’s protection against poison.

Health seeking behaviours have made patients participate in activities seemingly inimical to their wellbeing. These patients blindly trust some pastors, preposterous claims of miracles, such as raising the dead and deliverance from evil. These are dangerous untruths and give to fear and superstition.

South Africans have had tragic experiences of false prophets who misled their followers to believe in the superiority of the white race, which resulted in appalling discrimination against other racial and cultural groups. Alleyn (2019).

According to Ricky (2019) in Johannesburg - An episode of SABC 1’s investigative show on Cutting Edge has brought the topic of false prophets, suspicious miracles and everything. There are a number of health-seeking behaviour practices that were exposed. Cutting Edge spoke to the employer of Elliot Moyo, the man "resurrected" inside the coffin by Lukau. His employer says that Moyo has done similar stunts with other churches before. Show producers visited the township where Moyo lives and spoke to angry community members who dismissed the "miracle" as a farce. One neighbour describes how they were told about Lukau's church and how they recruit actors to perform or testify about "miracles". Another alleges that Moyo's wife recruits' people. Foreign nationals were specifically chosen because they are not easily traceable and venerable. Ricky (2019)

2.2 THEORETICAL FRAMEWORK

The Health belief theory is applied in relation to the problem studied

The theory is an organised, coherent, and systematic articulation of sets of statements related to significant questions in a discipline that are communicated in a meaningful whole (Masters, 2015). A theoretical framework is a structure that can hold or support a theory of a research study. The theoretical framework introduces and describes the theory that explains why the research problem under a study exists (Swanson, 2013).

The Health Belief Theory (HBT) is commonly used in health education and health promotion (Masters, 2015). It was developed in the 1950s to explain why medical screening programmes offered by the U.S public health service, particularly for tuberculosis, were not very successful. This theory postulates that health-seeking behaviours are influenced by a person's perception of a threat posed by a health problem and the value associated with actions aimed at reducing the threat.

The HBT has been successfully applied to predict health behaviours across several diseases and conditions among patients. Purcell, Moran, Fromer, Ruderfer, Solovieff, Roussos, O'dushlaine, Chambert, Bergen, Kähler, and Duncan (2014). Specifically, the model has been applied to help increase adherence to treatment for chronic disease management, both communicable diseases, such as HIV, TB, STIs, and non-communicable diseases like hypertension, diabetes mellitus, mental health etcetera. Despite the Health-Based Model (HBM) being primarily a behaviour change model, in this study the HBM is applied to explain the factors contributing to the health-seeking behaviour of patients.

In this study, different components of the theory are applied separately to examine individuals' own risk assessment, decision-making processes, and continuity of medication use. Risk perceptions were examined by assessing the individuals' perceived susceptibility and perceived severity of the diseases. Decision-making processes were assessed through exploring the perceived barriers and perceived benefits of adopting specific health-seeking behaviours including medication use.

The following schematic representation of Health Belief Theory shows the components of the model as adapted in the study (see Figure 2. 2.1).

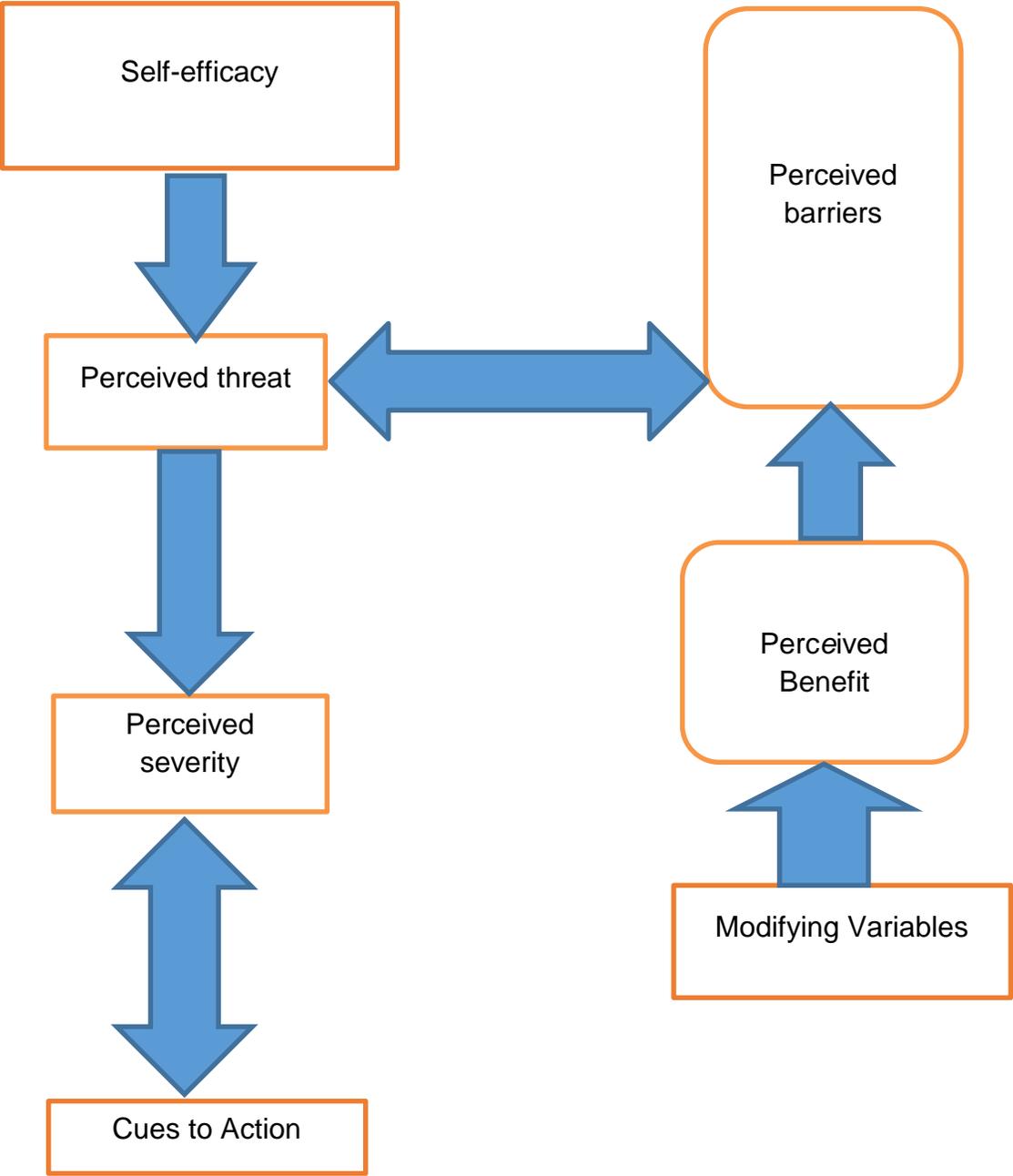


Figure 2.2.1 Schematic representation of the Health Belief Theory

2.3 Theoretical Constructs

The following four perceptions serve as the main constructs of the model: perceived threat, perceived susceptibility, perceived benefits and perceived barriers. Each of these perceptions, individually or in combination, have been used to explain health-seeking behaviours of patients. More recently, other constructs have been added to HBM, thus the model has expanded to include: cues of action self-efficacy and motivating factors.

2.3.1 Perceived threat

The perceived threat is one of the influential factors that motivate people to practise healthier behaviours (Green & Murphy, 2014). It refers to individuals' own beliefs regarding the risk of contracting an illness; the greater the perceived susceptibility, the greater the likelihood of engaging in behaviours to decrease the susceptibility. For example, participants in this study, that is, patients perceived themselves to be susceptible to death caused by chronic diseases like HIV, TB, HPT, DM etcetera if not adhering to treatment. They then made the decision to seek help and continue with care because they were feeling threatened by the consequences of the diseases, or maybe threatened by the death of someone known with the same disease. The greater the perceived susceptibility, the more likely health-seeking decisions were made. In this study, it was clear that the consequences of disease caused anxiety to the patients.

2.3.2 Perceived severity

When patients recognise personal susceptibility, action will not occur unless the individual perceives the severity to be high enough to have serious organic or social complications. These involve the beliefs that the patient holds concerning the factors contributing to the disease (Green & Murphy, 2014).

In this study, most patients presented themselves to health care facilities to seek health care when the symptoms were progressively worse. Findings revealed that participants started by treating themselves with home remedies, followed by traditional healer's remedies. The health care facility was the last alternative when the symptoms were progressively worse. Most patients who engaged themselves in health-seeking behaviours presented themselves at the facility when they were very weak, unable to

walk, and when they were an emergency and required immediate referral to the tertiary level. For example, un-booked fully dilated pregnant woman with unknown HIV status, hypertension, not on treatment and asthmatic, would present themselves for treatment. The construct of perceived severity comes from the beliefs a person holds about difficulties a disease would create or effects it would have in his/her life in general. Another example would be if a patient is known to be hypertensive and not adhering to treatment, then suddenly that patient sees someone who has developed a stroke, with body stiffness and in a wheelchair due to the stroke resulting from non-adherence to hypertension treatment, this will influence the patient's perception of the seriousness of the disease and often changes their behaviour.

2.3.3 Perceived benefits

The patient's beliefs that the given treatment will cure the illness or help prevent it (Green & Murphy, 2014) is a perceived benefit. Perceived benefit signifies an individual's own judgment on the advantages of adopting and continuing with the proposed actions to reduce the severity or consequences of the illness.

In this context, patients who default on treatment need to feel that the benefits of seeking and continuing with care are greater than if they did not; they need to feel certain that adopting health-seeking practices will have favourable outcomes. Patients who have decided to seek health care at health care facilities, that also believe that treatment is effective and is reducing the threat, will change their behaviour. This includes the satisfaction of patient in health services and plays a good role in good health-seeking behaviour.

In this study, participants adopted healthy behaviour with the belief that the new behaviour would decrease their chances of developing a disease.

The perceived benefit factor emphasises that patient's satisfaction plays an important role in health-seeking practices (Rahman et al., 2011). Corno (2011) finds that previous health outcomes play a crucial role in shifting individual preferences to care.

2.3.4 Perceived Barrier

These are problems experienced by patients in accessing health care (Green & Murphy, 2014). This refers to an individual's evaluation as to what would stop him/her from adopting the new behaviour. If people perceived obstacles to adherence of chronic treatment (for example, where the proposed treatments were perceived as inappropriate for treating the specific disease or were perceived to be costly), it was less likely that a decision for continuing with care would be made.

In this study, there were barriers to care experienced by patients which led to non-adherence. Participants indicated factors contributed to health-seeking behaviours such as long waiting time; according to some participants, long waiting time resulted in barriers to care because they had to wake up at 4 am to book a place in a queue or to stand in a queue so that they would be attended in time. Some reflected that they had waited patiently in long queues but were sometimes sent home without having been attended to because all the Steve Tshwete clinics close at 16h00. Religious beliefs about certain diseases were also barriers to care because participants delayed seeking adequate care due to religious beliefs that participants held about a certain disease. Patients often experience barriers to healthcare that limit their ability to get the care they need. They begin to seek health from other sources which are conveniently available to them, such as the traditional healers, prophets and family advice.

2.3.5 Self-efficacy

Self-efficacy was not in the original Health Belief Model. The concept was derived from Bandura's Social Learning Theory to encompass individuals' own belief regarding their capability to practise the suggested health behaviour successfully. Self-efficacy is the individual's perceptions and beliefs about handling his or her illness (Green & Murphy, 2014). In this study, self-efficacy was the belief that made patients decide whether their illness required treatment from health facilities or from spiritual, religious leaders, or from an educational level of thinking about certain diseases. Participants in this study believed that traditional medicine cleanses the bloodstream and boosts the immune system. Some participants believed that if a client is sick, he/she should be treated at home, then if that treatment fails, that is the time for the client to seek health in health care facilities, the

early prevention is required to avoid health-seeking behaviours and to promote early treatment seeking.

Traditional healers were believed to be able to successfully treat bewitchment (perceived effectiveness), which was important as the illnesses were perceived to be the result of bewitchment (Plummer, Mshana, Wamoyi, Shigongo, Hayers, Ross & Wight, 2006).

According to this model, health-seeking behaviour is based on the cognitive perception of the person who seeks help. People's health beliefs strongly influence their health and illness behaviour. Such beliefs influence whether people treat themselves or consult with health-care providers. In the study conducted in South Africa among children's caregivers, Spark-du Preez, Griffiths and Cameron (2005) indicate that beliefs, as determined by religion, background and the influence of an older relative, are important for deciding whether a child should be or not be given traditional medicine.

Wasti, Simkhada, Randall, Freeman and Van (2012) cited by Plummer et al. (2006) conducted a study examining general illness, sexually transmitted infection and HIV/AIDS health-seeking behaviour in Tanzania. They found that treatments were pluralistic and opportunistic, usually beginning with home remedies, followed by visits to traditional healers and/or health facilities. However, traditional healers were preferred to health facilities because of the subjects' perceptions of the cause, nature and severity of the illness, as well as the perceived benefits of accessibility, trust, and familiarity Wasti et al. (2012) further indicates that most of the individuals stopped attending health facilities because they came to believe that they could not treat witchcraft-induced illnesses (a perceived barrier).

2.3.6 Cues to Action

This is the other concept that was later added to the model and it has been widely observed as an important aspect triggering people's health-seeking behaviour and medication use. In this study, cues to action related to information and ideas about non-adherence to treatment and the sources thereof, whether internal (symptoms, past experiences) or external (health care workers, friends, relatives, mass media), which

influence their health-seeking behaviour and continuity with care. Cues to action are not directly linked to perceived threats, because individuals must first have perceived susceptibility, perceived severity and a higher perceived threat; then, when they develop pain or illness symptoms (cues to action), it prompts their perceived threat to trigger their decision-making processes and they thus become more likely to take action in terms of health-seeking and continuing with care. On the other hand, symptoms (cues to action) directly trigger individuals' self-efficacy, which also triggers decisions for actions.

For example, an individual must feel s/he is at high risk for contracting HIV (perceived susceptibility) and believe that HIV can be severe (perceived severity) and lead to death (perceived threat). When this person experiences HIV symptoms (cues to action), these symptoms prompt the perceived threat (that is, thinking, "I may die"), and this triggers the decision-making processes by increasing her/his likelihood of taking actions to reduce/alleviate the symptoms. On the other hand, illness symptoms (cues to action) prompt individuals' evaluation of their ability to take actions successfully (self-efficacy) and this, in turn, shapes the decision-making process by inducing health-seeking behaviour to offset the symptoms.

2.3.7 Modifying variable

The four major constructs of perception are modified by other variables such as culture, educational level, past health care experience, skills and motivation or rewards. These are individual experiences that influence personal perceptions, for example, participants in this study who were diagnosed with chronic diseases like HIV positive with signs and symptoms and were successfully treated and had diminished the signs and symptoms, s/he might have heightened perceptions and be more conscious of condom use because of past experience. Conversely, this experience could diminish the person's perceptions of the seriousness of HIV symptoms if symptoms were easily treated and cured.

The Health Belief Model addresses the relationship between a person's belief and behaviours, it provides a way to understand how clients will behave in relation to their health and how they will comply with their health care therapies.

2.4 CONCLUSION

This chapter outlined the reviewed literature about the health-seeking behaviours of patients and the theoretical framework in supporting that. The aim of the literature review was to check what other researchers have found regarding the problem being studied. The literature review was conducted using journals, books, articles and online media reports. In the context of this study, the theory states that health-seeking behaviours were influenced by a person's perception of a threat being posed by a health problem and the value associated with actions aimed at reducing the threat.; the next chapter will be focusing on research methodology.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

A qualitative research approach was followed in this study with the aim of determining the factors that contribute to health-seeking behaviour at Sister Mashiteng Clinic of Steve Tshwete Local Municipality in Mpumalanga Province. Sharan (2009) defined a qualitative research approach as an umbrella term encompassing an array of interpretive techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain or occurring phenomena in the social world. The researcher wanted to attain a dense description and excellence of study without any deficiencies. It is for this reason that a qualitative, explorative, descriptive and contextual research method was used in this study to explore and describe the factors contributing to the health-seeking behaviour of patients.

LoBiondo-Wood and Haber (2015) hold that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people brings to them. In this study, the researcher employed a qualitative research approach by going to the clinic, Sister Mashiteng Clinic, where participants attend every day. This helped the researcher to get a deeper understanding of factors contributing to the health-seeking behaviours of patients.

Du Plooy and Adan (2010) state that a qualitative approach is appropriate when researchers intend examining the properties, values, needs or characteristics that distinguish individuals, groups, organisations, communities, events, settings or messages. In this study, the researcher employed a qualitative research approach to get a deeper understanding of the factors contributing to patients' health-seeking behaviours. This assisted the researcher to understand and interpret the impact of cultural values on health-seeking behaviours at Sister Mashiteng Clinic.

3.2 STUDY SITE

The study was conducted at Sister Mashiteng Clinic, under a clinical setting in a primary health care facility in the Nkangala District under the Steve Tshwete Local Municipality

which is situated in the Thembisa Section of Mpumalanga Province, 3 km away from the town of Middleburg.

3.3 RESEARCH DESIGN

The research design is the plan for gathering data in a research study (Brink et al, 2012). In this study, the research design that was used was an explorative, descriptive, contextual design of the qualitative research method. The designs are explained as follows:

3.3.1 Exploratory design

An exploratory research design was used to establish the facts by gathering new data to determine whether there are new patterns in the data and to gain new insights into the phenomena (Mouton, 2010). In this study, it was used to gain new insights about the factors contributing to health-seeking behaviours. The central question was as follows; please share with me what brings you to the clinic today? Furthermore, the researcher asked probing questions to explore the factors contributing to health-seeking behaviours. To answer these central research questions, the researcher employed semi-structured interviews to achieve the intended objective of the study.

3.3.2 Descriptive design

Brink et al. (2012) attest that descriptive designs are used to describe the variables to answer the research question. In this study, the researcher held a semi-structured interview with participants to give them an opportunity to describe the factors contributing to health-seeking behaviours of theirs. This assisted the researcher to get accurate information about effects faced by patients who seek health from other sources, outside of the health facilities.

3.3.3 Contextual design

In this design, the researcher aims to understand the phenomenon which are studied as described by the participants in their lived world (Brink et al., 2012). In this study, the researcher visited the patients at Sister Mashiteng Clinic in the Nkangala District of the

Mpumalanga Province to prove, through semi-structured interviews, whether the factors which the participants had mentioned were true or not.

3.4 POPULATION AND SAMPLING

A population is the entire group of persons or objects that are of interest to the researcher; in other words, it is the group that meets the criteria that the researcher is interested in studying (Brink et al., 2012). In this study, the population was all patients with behaviours of missing scheduled appointments with the total number of 130 defaulters. These patients were traced telephonically, and some came with health problems for consultation at the clinics. This study only focused on patients who attended the Sister Mashiteng Clinic.

Sampling is a subset of the population that is selected to represent the population (Brink et al., 2012). According to (Christensen, Johnson, & Turner. 2011) Sampling is a selection process whereby a smaller representative part of a larger group is selected for research purposes. In this study, the researcher used non-probability purposive sampling; it was based on the judgement of the researcher regarding participants who were knowledgeable about the factors contributing to the health-seeking behaviour of patients who had defaulted treatment. The researcher aimed to recruit 20 patients from the clinic, but the exact number determined by data saturation was 15.

3.4.1 Inclusion criteria

Inclusion criteria refer to the characteristics that prospective subjects have to be included in the study (Brink et al., 2012). Participants that were included in the sample were selected because they had met specific criteria.

The selected participants needed to meet the following criteria to be part of the sample:

- All patients with behaviours of missing scheduled appointments of treatment from two weeks and above, who were traced telephonically.
- Patients aged 18 to 65 years and been on treatment for more than a year because they are knowledgeable about the factors contributing to health-seeking behaviours.

3.4.2 Exclusion criteria

- All patients who were complying with treatment
- All patients who were newly diagnosed of about less than 11 months on treatment and younger than 18 years old of age were excluded because the researcher was interested in describing the factors that contribute to health-seeking behaviours from participants who have more knowledge about their condition.

3.5 DATA COLLECTION

Data collection is the process of gathering information that describes some information from which conclusions can be drawn during the research project (Brink et al., 2012). The researcher used semi-structured interviews to collect qualitative data from the participants. Semi-structured interviews include a certain number of questions that can also entail additional probes (Brink et al., 2012). The semi-structured interview was conducted in the clinic's private rooms, each patient was interviewed until data saturation was reached. Follow-up questions were made in the interview to get more clarity on factors contributing to health-seeking behaviour. To collect more data, the researcher used an interview guide with a voice recorder to supplement information collected through the interview, which was also accompanied by field notes.

The central question was as follows: "Please share with me what brings you to the clinic today?". The researcher expanded on any question to draw in-depth information from the participants' responses. The researcher was able to ask follow-up questions added to the standard questions when an unexpected or interesting answer was provided as guided by Mitchell and Jolley (2013). This allowed the researcher to get clarity on any statement that was not clearly understood. An example of a probing question that was asked was: "What was the main reason for you to miss your scheduled appointments?" A voice recorder was used to record the interview and its use was explained to the participants. The duration of the interviews ranged between 30 and 45 minutes. Field notes were taken together with the recording in order to enable coding. Open-ended questions were provided on an interview guide to steer the participants' responses and data were collected until saturation was reached (Botma et al., 2010).

The advantages of the interviews were as follows:

- The researcher met with the participants and was able to observe the reactions and the emotions of the participants.
- It was easy to make follow-ups; statements that were not understandable were readily clarified.
- Sometimes the researcher would observe that the participants were disinclined to give full detailed information but probed more until that information was provided.
- Participants expressed their views without limitation. Participants also had a chance of asking for clarity when they did not understand.
- The researcher was able to go back to the participants when clarity was needed from their side.

Disadvantage of interviews

- The disadvantage of interviews was that sometimes participants were held up at the agreed-upon time for interviews and the sessions then had to be postponed. This impacted on time management.

3.5.1 Preparation Phase

The researcher followed the preparatory phase of data collection as outlined by Hennink, Hutter and Bailey (2011). The researcher physically contacted the Chief Executive Officer (CEO) of Sister Mashiteng Clinic to build rapport and to explain the participants' involvement in the study. The CEO then granted the researcher an opportunity to take the matter to the involved Clinical Supervisor and clinical OPM.

The planned dates and periods of data collection were highlighted. The researcher briefly explained the aim, objectives and the significance of the study to the Operational Manager and Clinical Supervisor and provided them with the approval letters from Turf Loop Research Ethics Committee (TREC/375/2017: PG) and the Department of Health's Provincial Office. Permission was therefore granted by the CEO of the Nkangala District. The patients allowed the researcher to continue with the preparations for the interview sessions that were to follow the preparation phase. The researcher identified potential participants and contacted them in the health care facility.

3.5.1.1 Information Session

The information session was conducted a few days before the day of discussion with the participants in the semi-structured interviews and on the days that the interviews took place. The researcher outlined issues related to what would be expected of the participants during the interviews, explained the aim, objectives and significance of the study together with the central question to be asked as well as the questions in the interview guide, during the information session. The period for interviews was confirmed by the researcher with the manager of the clinic.

The researcher explained the informed consent forms to all participants who agreed to participate in the study. The use of a voice recorder and its purpose were also outlined. The participants were assured of their privacy and the confidentiality of their information. The researcher also explained to the participants that they could withdraw from the study at any time if they wished to do so without being victimized, but the information they would have given until the time of withdrawal could be utilised for the study's purpose.

3.5.2 Interview Phase

3.5.2.1 Conducting the Semi-Structured Interview

At the beginning of each interview session, the researcher greeted the participant with a warm welcome. The researcher started by introducing herself to the participant and assured the participant that the permission to conduct the interview session had been granted by the involved personnel and showed them all the letters which had been granted as evidence. The aim, objectives and significance of the study were explained again, the participant's anonymity was assured, as names were not used - but numbers instead - and the data recording process was explained. The confidentiality of the information was also explained to participants. The interview sessions commenced after the participants had signed informed consent forms.

The researcher collected data through semi-structured interviews which were used to describe factors contributing to health-seeking behaviours of patients and with the aid of voice recorder and field notes to remember the answers during data analysis and not to lose meaning when translating English to Siswati. Polit and Beck (2010) describe semi-structured interviews as open-ended interviews during which the researcher is guided by a list of certain topics to address.

The interviews were conducted in English and Siswati some participant would mix these two languages, but they were understood clearly. In the interview guide translation of English to Siswati questions were used to ask the participants who don't understand English during interview sessions conducted. See Annexure B1.

The research environment comprised a well-ventilated venue which was quiet, relaxed and disallowed any disruptions. In line with de Vos et al. (2012), the setting for the interview provided privacy, was comfortable and in a non-threatening environment which is easily accessible. No barriers were encountered during the interviews—the participants were able to describe factors contributing to health-seeking behaviours. The researcher avoided personal questions as they would have occasioned discomfort to the participants and therefore could have hindered the yielding of more data (Hennink et al., 2011).

The researcher was able to gather more information from the semi-structured interviews on factors contributing to health-seeking behaviours. All the interview sessions were recorded with the voice recorder. The researcher also took field notes to complement the recordings since the voice recorder could not record the non-verbal communication cues. The central question was posed to the participant at the beginning of the interview and, depending on their responses, was pursued by follow-up questions.

The researcher did not rush the participants when they were answering the questions and therefore they were relaxed. The following communication techniques were used by the researcher during the interviewing sessions: listening skills (probing, clarification, summarization, reflection) and observation. A good researcher must have good listening skills which will help to obtain quality information during an interview. The researcher maintained good listening skills that enabled the researcher to draw more information from participants, have more understanding of the problem studied and to encourage the participants to talk more when they were being listened to. As a result, the researcher was able to maintain continuous and harmonious interaction with the participants and obtained clarity and meaning about the problem under study.

3.5.2.2 Probing

According to Zikmund and Babin (2010), probing is an interview technique that tries to draw deeper and more elaborate explanations from discussions. More probing was done depending on the participants' responses to obtain a greater depth of information about

factors contributing to health-seeking behaviours; this was done in line with the practice of Rubin and Bellamy (2012) who assert that probing for greater depth is a priority in interviews. The purpose of probing was to deepen the understanding of the researcher's part by asking comprehensive questions as guided by Flick (2006). The participants were able to elaborate more on their experiences and their adaptations after maternal deaths; the researcher maintained a good atmosphere in the conversations by keeping the participants relaxed while getting more information.

3.5.2.3 Clarification

The researcher used clarification whenever the statements provided by the participants were not clear and understandable, and more elaboration was needed. Clarification was also used to check whether the provided information was correct. This was done in line with Cormier, Nurius and Osborn (2013) who stated that clarification may be used to make a participant's statement explicit and to confirm the accuracy of the researcher's perceptions about the statement. The clarification also helped the researcher to translate what the participants had said into more familiar language so that it could be more understandable and also helped the participants to restructure their perceptual field as guided by Kadushin and Kadushin (2013).

3.5.2.4 Summarization

Munden (2006) described summarisation as restating the information as given by the participants. The researcher used summarisation at different points of the interview to structure the interview, aiding with transition and to ensure that the data collected was accurate and complete. Participants were able to add more information when they thought the information they have provided was still not enough.

3.5.2.5 Reflection

This is a process of reflecting on something important that the participants have said to get them to expand on that idea (de Vos et al., 2012). Munden (2006) also delineated reflection as repeating something that the participant has just said to obtain more specific information. The researcher repeated some information as given by the participants to confirm what they had meant in the statements provided.

3.5.2.6 Observation

Cohen, Manion and Morrison (2011) explained observation as looking and noting systematically the participants' behaviours. The researcher used observation to interpret and validate participants' non-verbal behaviour. Some participants were emotional as if they had just experienced a maternal death at that moment.

3.5.3 Post-Interview Phase

The semi-structured interviews lasted for 30 to 45 minutes. The researcher thanked the participants and reminded them about coming back to them should a need arise, and the participants agreed. The researcher assured the participants that arrangements would be made with the operational managers that more counselling could be offered to the participants who were emotional during interview sessions.

3.6 PILOT INTERVIEW

A pilot interview is a mini-study which tests part of the study before the main study (Joubert & Ehrlich, 2012). The researcher conducted a pilot interview in preparation for the main study to recognise and address some problems by obtaining information for improving the project or re-assessing the feasibility of the study. The pilot interview was done 2 weeks before the main study at the selected health care facility. The aim of the pilot interview was to investigate the feasibility of the proposed study to detect possible flaws in the methodology and to determine whether patients understood what was required of them; the pilot interview helped avoid the cost in the actual study. The researcher interviewed two male patients and three female patients during the pilot interview at Sister Mashiteng Clinic. Participants included in the interview did not form part of the main study. The results of the pilot interview were not included in the main study and the flaws identified were rectified.

3.7 DATA ANALYSIS

Du Plooy (2009) states that data analysis is when the collected data, such as the responses recorded during interviews, is interpreted to formulate findings which must be related to the context of the specific study.

In preparation for data analysis field notes and voice recordings were used as a point of reference during data analysis. The data was transcribed, and codes were developed

from the information. The researcher analysed using Tesch's open coding method were at the final stage of this method themes and sub-themes emerged and were presented in columns.

An independent coder who is experienced qualitative researcher was requested to analyse raw data independently. A meeting was held between the independent coder and the researcher to reach consensus about the categories identified independently. The qualitative research data was analysed using Tesch's coding method (Creswell, 2009). The following steps were used when analysing the data:

Step 1: The researcher listened to the recorded interview and transcribed the information verbatim, then organised, prepared and arranged the data.

Step 2: The researcher read through all the transcriptions carefully, making notes of ideas that came to mind getting a sense of the whole idea. The ideas were then written down.

Step 3: Involved organising the textual data during data collection into categories which were labelled with a term based on the actual language of the participants.

Step 4: Involved the coding process. Coding of topics resulted in the generation of a small number of themes which then appeared as major findings.

Step 5: Entailed how the themes were presented in the narrative; in this study, the researcher conveyed descriptive information about each of the interconnected themes.

Step 6: The researcher made a final decision on the naming of each theme and then separated the themes and sub-themes in a good manner.

Step 7: Involved the interpretation of data. The researcher interpreted meaning from collected data by providing detailed descriptions of themes and also compared them with findings from the literature.

Step 8: Involved writing a report in which the researcher presented data to support the findings and recommendations.

3.8 MEASURES TO ENSURE TRUSTWORTHINESS

Fenton and Mazulewicz (2008) define trustworthiness as supporting the argument that the study findings reveal as being worth paying attention to. The researcher proved that the information provided was true and not manipulated; this ensured trustworthiness in

this study. Credibility, conformability, dependability and transferability were also adhered to:

3.8.1 Credibility

According to (Brink et al., 2012), credibility alludes to the truth value of the study, confidence in the truth of the data and the data interpretation. Pertaining to this, the investigation was done in such a way that the findings demonstrated credibility. Confidence in the truth in this study was established through the following techniques. The prolonged engagement was ensured by staying in the field until data saturation was reached. In this study, the researcher spent two months in the field, taking field notes until data saturation was reached, and user voice records were made available to all interviewees for them to check for accuracy.

3.8.2 Dependability

Dependability refers to the provision of evidence such that if it were to be repeated with the same or similar participants in the same or similar context, its findings would be similar (Brink et al, 2012). This refers to the stability of data over conditions (Polit & Beck, 2010). Pitney and Parker (2009) called this process an “external audit” whereby someone examines the research process to ensure those study findings are consistent with its data. In this study, the researcher ensured dependability by enquiry audits to determine whether the study was acceptable or dependable, the use of a voice recorder, field notes and through the help of the supervisors. Furthermore, the researcher ensured dependability by compiling raw data, data collection and data analysis, process notes and handed them over to experts in qualitative research to confirm the findings and make them available for future use.

3.8.3 Transferability

Refers to the ability to apply the findings in other contexts or to other participants (Brink et al., 2012). Tappen (2011) defined transferability as the application of findings to another situation and to other individuals. In this study, transferability was ensured through the use of data collection and non-probability purposive sampling which comprised patients

who had defaulted in their treatment due to health-seeking behaviours. Participants were sampled until data saturation was reached.

3.8.4 Confirmability

Refers to the potential for congruency of data in terms of accuracy, relevance or meaning. It is concerned with establishing whether the data represents the information provided by the researcher's imagination. (Brink et al., 2012). Polit et al. (2010) defined confirmability as a measure of how well the study's findings are supported by data collected, referring to objectivity and interpretations. In this study confirmability, was be ensured by reflecting the voice of the participants, and not the researcher's biases or perceptions. The researcher provided raw data as evidence from the participants to the supervisors with the use of voice records to ensure conformability.

3.9 ETHICAL CONSIDERATIONS

According to Creswell (2009), ethics refers to the responsibilities that researchers bear towards those who participate in research and those who are potential beneficiaries of the research. The research project followed ethical rules and regulations that govern undertaking a research project. The following ethical considerations were therefore followed.

3.9.1 Permission to conduct the study

Ethical clearance was obtained from the Turfloop Research Ethics Committee (TREC/375/2017: PG) Permission to conduct the study was obtained from the Department of Health, Mpumalanga Province, from the Chief Executive Officer (CEO and from the Supervisors and the Operational Managers at Sister Mashiteng Clinic in the Nkangala District.

3.9.2 Informed consent

It is a legal procedure to ensure that the participants are aware of all the potential risks and costs involved in a research study (Polit et al., 2010). Information about the importance, purpose and objectives of the study was provided to the participants through

the language they understood. A written consent form was given to the participants to sign as a way of proving an agreement to participate in the study (Polit et al., 2010). According to Brink et al. (2012), consent forms entail various procedures and are a mechanism that researchers can use during a study to ensure that the rights of participants are protected.

In this study, the participants were informed that participation was completely voluntary and that they could withdraw from the study at any time if they wished to, without any penalty. This right was explained to the participants prior to engagement in the study and before the interview.

3.9.3 Privacy

Privacy refers to the freedom of an individual to determine the time, extent and general circumstances under which private information will be shared or withheld from others (Burns, Grove & Saunders, 2011). In this study, the privacy of the participants was maintained by not interviewing the participants in public; instead, participants were interviewed in private consulting rooms at the clinic.

3.9.4 Confidentiality and anonymity

Confidentiality and anonymity refer to the researcher's responsibility to prevent all data gathered during the study from being linked to the individual participants, divulged or made available to any other person (Brink et al., 2012). In the study, confidentiality was ensured by not disclosing the information to any other person who is not involved in the study. All information obtained from the participants was treated as confidential and real names were not used; instead, numbers were allocated to the participants to observe anonymity.

Anonymity is when the identity of the participant is unknown, even to the study investigator (Brink et al., 2012). The participants' names were not included when interviewed; instead, code names of numbers were given to each participant to ensure anonymity. Participants were reassured that their identity would not be disclosed to anyone outside the research team. They were given assurances of anonymity in all cases.

3.9.5 Justice

The principle of justice encompasses the right to fair treatment, equal share and fairness (Brink et al., 2012). The researcher selected participants in the study with fairness: participants were selected for reasons directly related to the research problem which were non-compliance to treatment and behaviours such as missing scheduled appointment. An equal opportunity was given to each of the participants to ask questions and to share their feelings.

3.10 BIAS

Bias is an influence that produces an error or distortion, which can affect the quality of evidence in qualitative studies (Botma & Greeff, 2010). In this study, the researcher avoided bias by using non-probability purposive sampling to select the participants at Sister Mashiteng Clinic, Mpumalanga Province. Leading questions were avoided to avoid bias and to allow participants to express themselves in their own way.

3.11 SIGNIFICANCE OF THE STUDY

The study helped improve the knowledge of the patients about factors contributing to health-seeking behaviours and the consequences thereof. The decreased number of patients who have defaulted treatment since then has thus eliminated complications resulting from health-seeking behaviour. The study has also filled gaps that were left by other studies like this one which was conducted before. It has also increased the body of knowledge on health-related matters on health-seeking behaviours.

3.12 CONCLUSION

This chapter focussed on the research methodology followed in this study. The research approach and research design, population and sampling method, data collection and analysis were discussed in this chapter. Measures to ensure trustworthiness and ethical considerations were also discussed. Chapter 4 will discuss the results and the research findings from the one-on-one interview sessions which were conducted using semi-structured questions and a voice recorder.

CHAPTER 4

DISCUSSIONS OF FINDINGS

4.1 INTRODUCTION

The previous chapter presented the research design and method which had guided the study: this included the study site, population and sampling, research design, data collection method used and data analysis. This chapter presents and discusses the research findings from the one-on-one interview sessions which were conducted using semi-structured questions and a voice recorder.

4.2. PRESENTATION AND DISCUSSION OF FINDINGS

The aim of presenting the demographic data is to provide a description of the participants' characteristics that might have an influence on the findings. Approximately ten participants were patients with communicable diseases three were males' patients seven were females five were participants with non-communicable diseases among that five three were female patients and two were male patients the characteristics of the participants are presented in Table 4.1.

Table 4.1 Characteristics of the participants

Participants total number	Gender	Age	Early missed appointment 2-3 weeks	Late missed appointment 2-3 months	Defaulters >90 days
Communicable Diseases 10	Females=7	18-35	1	1	6
	Males=3	36-40	0	1	1
		41-45	0	0	0
Non-communicable Diseases 5	Females-3	18-35	0	0	0
	Males-2	36-40	2	1	1
		41-45	1	0	0

4.3 DATA ANALYSIS

The data which were collected during one-on-one interview sessions were analysed using the 8 steps of Tesch's open coding qualitative data analysis method as described by Creswell (2014). The following steps were adhered to during data analysis:

Step 1 – Reading through the data. The researcher got a sense of the whole by reading all the verbatim transcriptions carefully. This gave ideas about the data segments and how they looked and meant. The meaning emerged during reading, were written down together with ideas as they came to mind. The researcher carefully and repeatedly read the transcripts of all the participants to be able to understand them fully.

An uninterrupted period to digest and think about the data in totality was created. The researcher engaged in data analysis and wrote notes and impressions as they come to mind.

Step 2 – Reduction of the collected data. The researcher scaled-down the data collected to codes based on the existence or frequency of concepts used in the verbatim transcriptions. The researcher then listed all topics that emerged during the scaling down. The researcher grouped similar topics together, and those that did not have association were clustered separately. Notes were written on margins and the researcher started recording thoughts about the data on the margins of the paper where the verbatim transcripts appeared.

Step 3 – Asking questions about the meaning of the collected data. The researcher read through the transcriptions again and analysed them. This time the researcher asked herself questions about the transcriptions of the interview, based on the codes (mental picture codes when reading through) which existed from the frequency of the concepts. The questions were “Which words describe it?” “What is this about?” and “What is the underlying meaning?”

Step 4 – Abbreviation of topics to codes. The researcher started to abbreviate the topics that have emerged as codes. These codes need to be written next to the appropriate segments of the transcription. The codes were differentiated from each other by including all meaningful instances of a specific code's data. All these codes were written on the margins of the paper against the data they represented with a different coloured pen as to the one used in Step 3.

Step 5 – Development of themes and sub-themes. The researcher developed themes and sub-themes from coded data and the associated texts and reduced the total list by grouping topics that related to one another to create the meaning of themes and sub-themes.

Step 6 – Compare the codes, topics and themes for duplication. The researcher in this step reworked from the beginning to check the work for duplication and to refine codes, topics and, where necessary. Using the list of all codes, she checked for duplication. The researcher grouped similar codes and recoded others where necessary so that they fitted into the description.

Step 7 – Initial grouping of all themes and sub-themes. The data belonging to each theme were assembled in one column and a preliminary analysis was performed, which was followed by the meeting between the researcher and co-coder to reach a consensus on themes and sub-themes that each one had come up with, independently.

Step 8: Involved writing a report in which the researcher presented data to support the findings and recommendations.

The results were presented through themes and their sub-themes, supported by direct quotes of participants' discussions and literature. Here they are tabulated below:

Table 4.2: Themes and sub-themes reflecting factors contributing to health-seeking behaviours of patients

Main themes	Sub-themes
1. Explanations related to the factors contributing to patients' health seeking behaviour.	1.1 Reasons for health-seeking behaviour linked to prescribed treatment 1.2 Universal test and treat (UTT) during consultation at the clinic led to health-seeking behaviours. 1.3 Socioeconomic background blamed for patient's health-seeking behaviour. 1.4 Lack of reasons for missing the scheduled appointment.

	<p>1.5 Health seeking behaviours due to avoidance of running out of treatment</p> <p>1.6 Lack of reliable transport blamed for health-seeking behaviours.</p> <p>1.7 Patients trust of private Doctors marked as factor health-seeking behaviours</p>
<p>2.Reasons for health seeking behaviours outside health care facilities</p>	<p>2.1 Access to health facilities blamed for health-seeking behaviours.</p> <p>2.2 Work commitments blamed health-seeking behaviours</p> <p>2.3 Lack of employers' support for patients</p> <p>2.4 Forgetfulness blamed for health-seeking behaviours</p> <p>2.5 Lack of adequate counselling by counsellors</p> <p>2.6 Fear of disclosure and stigmatisation outlined</p>
<p>3.Views about health seeking behaviours related to services provided at the clinics</p>	<p>3.1 Services at the clinic rated as good versus poor</p> <p>3.2 free healthcare services at primary health care level appreciated by patients</p>
<p>4.Related/existing health beliefs amongst patients</p>	<p>4.1 Beliefs on either western versus traditional medicines based on the type of diseases patients have</p> <p>4.2 Self-treatment an option prior to consultation at a health facility</p> <p>4.3 Religious beliefs mentioned as contributing towards lack of adherence</p> <p>4.5 Believing in family members' advice given</p>

THEME 1: EXPLANATIONS RELATED TO THE FACTORS CONTRIBUTING TO PATIENTS' HEALTH SEEKING BEHAVIOURS.

The findings pointed out that there are various and diverse explanations related to the factors contributing to patients' health-seeking behaviours; these come from different participants who outlined them during the interview sessions conducted. These emerged in the following sub-themes of this theme:

- 1.1 Reasons for health-seeking behaviours linked to prescribed treatment
- 1.2 Universal Test and Treat (UTT) during the consultation in the clinic lead to health-seeking behaviours
- 1.3 Socio-economic background blamed for patients' health-seeking behaviours
- 1.4 Lack of reasons for missing scheduled appoints or treatment marked
- 1.5 health-seeking behaviours due to avoidance of running out of treatment
- 1.6 Lack of reliable transport blamed for health-seeking behaviours
- 1.7 Patients' trust of private doctors marked as a factor for health-seeking behaviours
- 1.8 Family influence plays a role in health-seeking behaviour

Reasons for health-seeking behaviours linked to prescribed treatment

The findings pointed out that there are several reasons for the patients to portray health-seeking behaviour; some are related to the medications that are prescribed for them. The health-seeking behaviour related to prescribed medication was described in the following excerpts:

Participant 1 said: *"I have many tablets at home; the nurses gave me more tablets that last more than my appointment date. Then I see no need to go to the health facility because I still have tablets instead, I go seek health to my prophet".*

Participant 13 said: *"I was taking my wife's treatment because we take the same treatment and we were not around South Africa when it finished, we both go to traditional healers for help".*

Participant 13 further said: *“I don’t have a stationed job; we always migrate at my work like now I have been in Zimbabwe for the past three months and I can’t always take transfers because we come back and go”*.

Research conducted by Biressaw, Abegaz, Abebe, Taye, and Belay (2013), about Adherence to Antiretroviral Therapy and associated factors among HIV infected patients revealed that patients often overestimate adherence as measured by pill count and can only be determined when patients return their medication bottles and the count is deemed inflated if the pills that were not returned to the clinic have not been taken by the patient either. In this study research some participants sometimes move from the area where they live due to work purposes to other countries where they are not registered or enrolled in treatment, they then engage in health-seeking behaviours until they come back to South Africa as defaulter these was measured by pill count and missed scheduled appointments.

Universal Test and Treat (UTT) during consultation at the clinic lead to health-seeking behaviour.

In this study, findings revealed that during consultations at the healthcare facility, patients were tested for HIV and treated on the same day, thus indicating that inadequate counselling had taken place during consultation. This was indicated as being one of the reasons for defaulting. This was confirmed by the following statements:

Participant 7 said: *“I think this process of test and treat never worked for me; instead it gave me a shock and made me to default because I haven’t accepted it yet if there can be more counselling sessions before taking the treatment that would eliminate complications”*.

Participant 9 said: *“I went only once on the day when I was diagnosed HIV positive. From there I was never given counselling again and by that time, I still have not accepted”*.

It must be noted that Government decided to adopt UTT after research had shown that it would save money in the long term, mainly because it radically reduces the chance of an HIV-positive person passing the virus to others when they are on treatment and their viral

loads are undetectable (Cullinan, 2016). But then it affects patients and they then engage into health-seeking behaviours because some are still in denial, some go to prophets to confirm the diagnosis, some consults with their traditional healers to confirm the diagnosis, these had made participants be more vulnerable to health-seeking behaviours

Socio-economic background blamed for patients' health-seeking behaviour

The findings revealed that the socio-economic background of patients was often blamed for patient's health-seeking behaviours and some patients disagreed with that. This was confirmed by the following statements:

Participant 7 said: *"I don't think socioeconomic status has an impact because clinics provide the same treatment to both rich and poor, and they provide free and equal service"*.

Participant 6 said: *"For me to take treatment, I must have eaten food, even on the treatment is written "take before meals or take after a meal"; even transport to go to the clinic is needed, so economic status has an impact on health-seeking behaviour"*.

Participant 8 said: *"SES has an impact only on the TB clients because those TB tablets need real food, not just a normal meal, you really get hungry with those tablets; if possible that treatment should be given with food parcels"*.

According to the WHO (2011), Socio-Economic Status (SES) influences health-seeking behaviour by the distribution of power and knowledge of health that leads to patients being unsatisfied with their health care provider", which in turns leads to the shopping seeking treatment.

The demand for food parcels and financial support by the participants in the study reflects that current economic situation in most rural communities' influence health-seeking behaviours, the challenge faced by the participants is unemployment (Adeyini, Yogeswaran, Wright & Longo-Mbenza, 2015). In this study socioeconomic status contributed to health-seeking behaviours due to high rate of unemployment and burden of diseases, research in this study has shown that most TB defaulters defaulted treatment

because they are starving, and they stop treatment and seek health elsewhere treatment does not require food.

In the UK there are food banks that were developed and run for the people who needed food to survive, most of the users of the food banks reported that they were unable to afford to buy sufficient food and struggle to manage chronic conditions (Butler, 2017).

Lack of reasons for missing scheduled appointments

The research revealed that some patients lacked reasons for noncompliance to treatment. It showed that some patients chose to ignore advice regardless of the health education provided after being diagnosed with a chronic disease. This was confirmed by the following statements:

Participant 10 said: *“I was not drinking anything. I stay at home and ignore”*.

Participant 8 said: *“I just ignored that I’m sick. I didn’t seek health anywhere, I just came back now because I was traced”*.

Participant 12 said: *“I do believe in clinical treatment, but I don’t use anything, I just stay at home and ignore”*.

Again participant 12 said: *“I heard that everyone qualifies for ARV treatment regardless of CD4 Count but ignored and now that I’m pregnant, I came back”*.

According to Ndhlala et al., (2011), ignorant patients are the most vulnerable regarding health-seeking behaviours: false information is distributed in the form of posters and pamphlets which advertise potentially dangerous and harmful services such as abortions, cures for HIV/AIDS etcetera. The intentions of those pamphlets are not to heal but to destroy and take advantage of the ignorant, unsuspecting, desperate patients. Health seeking behaviours have made ignorant patients participate in activities seemingly inimical to their wellbeing. These patients blindly trust some pastors, preposterous claims of miracles, such as raising the dead and deliverance from evil etcetera.

South Africans have had tragic experiences of false prophets who misled their followers to believe in the superiority of miracles, which contributed to health-seeking behaviours Alley (2019).

Health seeking behaviours due to avoidance of running out of treatment

The study revealed that some participant behaviours such as skipping treatment were done intentionally and led to non-adherence. Findings revealed that participants' levels of knowledge about compliance with treatment were very low. This statement was supported by the following quotes from participants:

Participant 12 said: *"I sometimes skip the treatment intentionally for one week, and default because I still have treatment"*

Participant 3 said: *"I skip a few days in between so that I can save my treatment for two months"*

According to Mbonu et al. (2009), knowledge about HIV, which includes knowledge about one's HIV status, effects of sharing treatment modes of HIV transmission and effective treatment, is important for people living with HIV if they are to obtain adequate care. Morrison, Banushi, Sarnquist, Gashi, Osterberg, Maldonado and Harxhi (2011) conducted a study in Albania assessing the barriers to the care of HIV-positive patients. In this study, the research found that a lack of knowledge of people living HIV is associated with the existence of barriers to care. Patients often experience barriers to care due to clinics operating hours denying them access to care hence they don't get enough time to be educated about the effects of skipping treatment intentionally. Patients who lack knowledge about their diagnosis are the most vulnerable to health-seeking behaviours.

Lack of reliable transport blamed for poor adherence to scheduled appointments

The findings revealed that the distance separating patients from the nearest health facility has been marked as an important barrier to use, particularly in rural areas. The long

distances have even been a disincentive to seek care. The following quotes support this statement:

Participant 11 said: *“Sometimes I was sick and had no money for transport because I am far from the clinic, and another reason is that I’m now tired of drinking the pills, so I sometimes skip the treatment intentionally for one week, and default because I still have treatment”*

The same participant 11 said: *“I walk about 6 to 7 kilometres to the clinic”*

Participant 14 said: *“I work on orange farms and I can’t reach the clinic on time, I come every month end”*.

Non-availability of transport, the physical distance of the facility and time taken to reach the facility were found to be contributing factors to health-seeking behaviour and underutilisation of health services (Yekani and Mati 2014). In this study research shown that participants who are far from their health facilities often seek health to places that are convenient to them.

Patients’ trust of private doctors marked as a factor favouring health-seeking behaviour

Findings revealed that patients’ trust of private doctors could be marked as a factor contributing to health-seeking behaviours. Patients often consulted private doctors once-off and did not continue with chronic treatment at local clinics. This is supported by the following quote from a participant:

The participant said 9: *“I go to my private doctor and when I get there, I don’t mention my status but only the signs of sickness. Private doctors do not force to test for HIV like clinics”*.

Research conducted by Pearson and Makadzange (2008) revealed that private doctors and traditional healers are mostly preferred by patients for their perceived confidentiality and their ability to minimise embarrassment. In this study patients trust in private doctors contributed to health-seeking behaviours, research shown some patients with chronic diseases do not have medical aid, therefore, they only consult to their General Practitioner when they have money and when they don’t have money then do not go to primary health care facilities instead they engage in health-seeking behaviours.

Family influence plays a role in health-seeking behaviour

Research findings revealed that some advice given by family members leads to underutilisation of services. This is supported by the following quotes from patients:

One participant said: *“Before pregnancy, I used to take indayelo (prophecies tea) now that I’m pregnant my grandfather advised me to take traditional medicine to make the baby grow and to clean my bloodstream and I was also told that it is going to help me deliver early”*.

Participant 13 said: *“For hypertension, I was taking treatment from my uncle who is a traditional healer who gave me traditional medicines for lowering of high blood pressure and for HIV. I ignored it because I was still in denial”*.

In this study, research revealed that treatment from family members is sought first, followed by remedies from traditional healers. Modern treatment from hospitals or clinics was sought as a last alternative. Shaikh (2008) suggested that the advice of family members in care-seeking is strongly associated with gender, education, history of chronic illness, previous exposure to traditional medicine and health education.

THEME 2: REASONS FOR HEALTH SEEKING BEHAVIOURS OUTSIDE HEALTH CARE FACILITIES

The findings revealed that there are several reasons that exist and influence patients not to adhere to scheduled appointments with healthcare professionals. These are confirmed by the following sub-themes that will be discussed, supported with literature and direct excerpts from participants:

- 2.1 Access to health facilities blamed for health seeking behaviours (operating hours, long queues, long waiting hours, returned without consultation, staff attitudes, poor communication, clinic’s schedules)
- 2.2 Work commitments blamed health seeking behaviours
- 2.3 Lack of employers’ support for patients
- 2.4 Forgetfulness blamed for health seeking behaviours
- 2.5 Lack of adequate counselling by counsellors

2.6 Fear of disclosure and stigmatisation outlined

Access to health facilities blamed for health-seeking behaviours.

The patients offered several complaints that the healthcare facilities were not accessible due to clinic operational times and operational days; this became a major contributory factor to the under-utilisation of health services. This, in turn, led to health-seeking behaviours of patients that were expressed through several aspects which are confirmed by the direct quotes below:

Participant 4 said: *“If the Steve Tshwete Clinics can open on weekends, not to limit us because sometimes you get sick on weekends then you have to stay with your sickness while the condition gets worse, that was why I treated myself first because I didn’t want to wait for Monday to be seen by a health care provider, ‘cause if you get sick on Friday night, on Saturday or Sunday you’re in trouble.”*

Participant 9 said: *“Clinic must not close at 16h00; sometimes something comes up on that appointed date and time, and the time and date clashes, for example, “a job interview date and clinic appointment date clash so then I prioritise employment first. The clinic must not close”.*

Participant 5 said: *“if clinics can open on weekends, I won’t seek health anywhere except health care facilities because I’m a student. I come back from school tired and need to rest and do homework. I don’t get a chance to attend ANC and collect my ART treatment. I want to attend at weekends when I’m free from school books”.*

Participant 9 said: *“Long waiting periods at clinics, sometimes I come at 7h00 in the morning when they open and leave at 16h00 when they close. It’s not nice going to a clinic like you are going to work”.*

The study revealed that the delay in receiving adequate care, and the non-availability of human and material resources both became an influencing factor to patients’ health-seeking behaviour within communities at health care facilities. The patients’ health-

seeking care behaviours were associated with staff shortages of nurses working in the health care facilities, together with unavailability of treatments. According to Appiah-Denkyira, Herbst, Soucat, Lemiere and Saleh (2013), a lack of human resources for health prevent the health service from being accessed by those mandated to receive it. Dissatisfaction with primary care services in either sector led many people to a health care shop or to jump to higher-level hospitals for primary care, thus leading to considerable inefficiency and loss of control over efficacy and quality of services (Appiah et al., 2013).

Rural residents often experience barriers to healthcare that limit their ability to get the care they need. They then begin health-seeking behaviours that are inappropriate for their wellbeing (Kaiser, 2014)

Work commitments blamed health-seeking behaviours

The research revealed that operating hours of the Steve Tshwete clinic were limiting the clients' access to care; due to work commitments, participants revealed that they were expected to absent themselves from work to adhere to scheduled appointments. Therefore, work commitments were contributing to health-seeking behaviours; this was supported by the following quotes from participants:

Participant 1 said: *"I am working everyday 8h00 to 17h00 and all the Steve Tshwete Clinics close at 16h00, so when I knock off at 17h00, all the clinics are closed, so I'm denied access to my health due to the operating hours. I don't default because I like it but it's the situation, sister. Every month I have to ask my boss to go to the clinic, and I don't want to disclose my status to my boss, my boss is already complaining that every month I'm asking to go to the clinic why don't I go in my spare time on weekends when I'm off, and all the clinics are not operating on weekends, so I have to skip a month or 2 months so that my boss doesn't complain. That's how I end up seeking for health care in inappropriate places"*.

Participant 14 said: *"I work on orange farms and I can't reach the clinic in time, I come to every month end"*.

Research conducted by Kossek, Kalliath and Kalliath, (2012) on achieving employee wellbeing in a changing work environment stated that implementing and maintaining employee support strategies not only contributed to higher job satisfaction and less absenteeism in the workplace, but to the health and wellbeing of employees. Understanding and helping your employees to strive for health at work is a vital exercise for successful employee retention and needs to be enforced before it becomes too late. The study revealed that patients who are committed to work are vulnerable to health-seeking behaviours because when they come back from work they found all clinics of Steve Thswete local municipality closed, then begin to seek health in places that are inappropriate for their wellbeing.

Lack of support to patients by their employers

In this study, research findings revealed that some participants seek health in inappropriate places due to fear of losing their jobs. This was supported by the following quotes from participants:

Participant 1 said: *Every month I must ask my boss to go to the clinic, and I don't want to disclose my status to my boss, my boss is already complaining that every month I'm asking to go to clinic, why don't I go with my spare time on weekends when I'm off. All the clinics are not operating on weekends, so I must skip a month or 2 months so that my boss doesn't complain. That's how I end up defaulting".*

Participant 4 said: *"My boss thinks I'm a lazy employee, so I must miss some of the appointment dates at the clinic and go to work".*

Participant 2 said: *"At work, they don't accept clinic sick notes, they only accept Doctor's sick notes. If I go and consult at the clinic, I must go to the doctor again for a sick note that is acceptable at my workplace. The operating time and days of the clinic are killing me".*

According to UNAIDS (2008), there are reasons why it is necessary to deal with HIV and AIDS in workplaces: HIV and AIDS have a huge impact on the world of work because it

reduces the supply of labour and available skills, increase labour costs, reduce productivity, threaten the livelihood of workers and employers, and create environments which undermine the rights of workers. In this study research revealed that some employers are not supporting patients in their health and wellbeing; they only want productivity in the workplace and this was found to be most common in unskilled labour, for example, with domestic workers, taxi & bus drivers, farmworkers, employees working at shops like ShopRite, Spar, Pick and Pay, restaurants etcetera. These employees are neglected when it came to medical evaluation at the workplace and are working abnormal hours that leads to barriers to access care in health care facilities and they seek health in places that are inappropriate and convenient to them.

Forgetfulness blamed for health-seeking behaviours

The research revealed that some participants have a great deal on their minds and experience common socio stressors, therefore, they forget scheduled appointments and they begin health seeking behaviours. This was shown by the following quotes from participants:

Participant 11 said: *"I think there should be a specific tracer who traces defaulters, call us and remind us because sometimes we forget, we need to be reminded"*.

Participant 5 said: *"If we can be sent an SMS before collection date as a reminder for collection of treatment, and more clubs for collection"*.

Participant 1 with the same opinion said: *"I think if we can get SMS or phone calls before the appointment date reminding us about the collection of treatment because sometimes we forget due to family problems or being too busy at home"*.

According to Reese et al. (2012), simply forgetting to take a dose of medicine accounts for 39% of health seeking behaviours, while forgetting to refill a prescription and procrastinating on getting a renewal account for another 30%. Remembering to take a dose of medicine requires a patient's constant attention, often multiple times a day. The

study revealed that patients who forgot scheduled appointments contributed to health-seeking behaviours, they fear to go back to facilities when they missed a scheduled appointment because of attitudes of health care providers and seek health outside health care facilities.

Lack of adequate counselling by counsellors

The findings revealed that a lack of adequate counselling contributed to health-seeking behaviours. Some participants require continuous counselling after diagnosis of chronic disease, to pass all the denial and depression stages. The following quotes support this: One participant said: *“I went for counselling only once on the day when I was diagnosed HIV positive. From there I was never given counselling again and by that time I still have not accepted”*.

Participant 4 said: *“I think ignorance and denial made me stay at home and not take my treatment”*.

Participant 12 said: *“For hypertension, I was taking treatment from my uncle who is a traditional healer who gave me traditional medicines for lowering high blood pressure and for HIV. I ignored it because I was still in denial”*.

According to Høberg-Vetti, Bjorvatn, Fiane, Aas, Woie, Espelid, Rusken, Eikesdal, Haavind, and Knappskog, (2016). Many newly diagnosed people want to speak with others in the same situation. This help them get out of isolation and overcome stigma. Counselling is one of the significant factors determining the health-seeking pathways. In this study research revealed that inadequate counselling and the interpretation of symptoms had led to delays in patients seeking health care, patients often start seeking health in places that are inappropriate to their wellbeing before consulting primary health care facilities.

Fear of disclosure and stigmatisation outlined

The research revealed that patients fear of disclosure and stigmatisation led to health-seeking behaviours; some patients stated clearly that they stopped treatment because of

fear and stigmatisation of the community members. This statement was confirmed by the following statements:

Participant 8 said: *“I don’t think we are treated fairly at the clinic, I don’t like the different cards that HIV and TB clients are given. I feel like others could see that we are sick when handing our appointments cards to the admin clerks to receive files. Ours are kept separate; when they are taking out the files our cards are green, and others are white. Why are we not given the same colour appointment cards?”*

Participant 10 said: *“I only disclose to my sister whom I trust most; the rests I didn’t because I see the way they behave when we talk about HIV at home”.*

Participant 7 said: *“Failure to disclose my status, can contribute to health-seeking behaviour because when I hide at home I’m not free to take my treatment, and this thing of asking at work every month to go to clinic, my boss thinks I’m a lazy employee so I must miss some of the appointment dates at the clinic and go to work”.*

According to (Goffman, 2013), stigma or social devaluation “as a mark of social disgrace” often leads to seeing others as untrustworthy, incompetent, or tainted. Gender, race, social status, mental and physical health are topics vulnerable to stigma. It is important to note that some cultures or individuals feel that seeking treatment is a shameful thing because it’s akin to announcing to the public that you have an illness. The research revealed that patients fear of disclosure and stigmatisation led to health-seeking behaviours; some patients stated clearly that they begin health-seeking behaviours because of fear and stigmatisation of the community members, families and close friends, so they seek health to places that are private and affordable to them.

THEME 3: VIEWS ABOUT HEALTH SEEKING BEHAVIOURS RELATED TO SERVICE PROVIDED

Research findings revealed the participants’ views on services provided by the health care services: free health care services were appreciated at primary health care services

by patients. It emerged in two sub-themes of this theme which are presented in the discussions which follow:

3.1 Services at the clinic rated as good versus poor

3.2 free healthcare services at primary health care level appreciated by patients

Service at the clinic rated as good versus poor

The research revealed that though good service is provided in health care facilities aimed at decreasing patient delay times and complications, most patients still do not seek treatment in a timely manner, due to some gaps identified by patients. Benefits of early treatment must be promoted to decrease patient delay (Moser, Kimble, Alberts, Alonzo, Croft, Dracup, Evenson, Hand, Kothari, & Mensah, 2006). This statement was supported by the following quotes:

Participant 5 said: *“Service is good, just the long queues at clinics especially when you’re pregnant are stressful due to the long queues I skip appointments dates and seek health at my church”*

Participant 7 said: *“I can’t complain about the service, I always get the service I need, treatment is always there”*.

Participant 8 said: *“Service is good, we are treated well but the separation of appointments cards makes me feel discriminated against”*.

Patient’s satisfaction with treatment plays an important role in health-seeking behaviours (Rahman et al., 2011). Corno (2011) finds that previous health outcomes play a crucial role in shifting individual preferences to care. She indicates that patients who were healed by a healthcare system, either formal or informal, are likely to seek care from that system in the future and those who remained sick are likely to switch to an alternative system (Corno, 2011). The research revealed that If treatment is assessed as ineffective, health-

seeking behaviour may become cyclical, and further information and advice or further treatment may be sought and accessed.

Free health care services appreciated at the Primary health care service level appreciated by patients.

Findings revealed that even though there are several health-seeking behaviours practised by patients, they still appreciate free service offered to them by the government. The following extracts illustrate the above points:

Participant 5 said: *“Clinics provide the same treatment to both the rich or poor, and they provide free and equal service”*.

Participant 7 with the same opinion said: *“We get the treatment for free; we don’t pay even a cent, while others are paying in private sectors, and we get the very same treatment which is given in private sectors”*.

Participant 14 said: *“I prefer this clinic out of all clinics. I can give this clinic a 95% score”*.

Participant 7 said: *“I am happy about the service, I even prefer this clinic among all the Steve Tshwete clinics because service is quicker, and I always get my treatment”*.

A study conducted by Mohamed, Sami, Alotaibi, Alfarag, Almutairi and Alanzi, (2015) showed that satisfied patients are more likely to develop a good relationship with the health system, leading to improved compliance, continuity of care and ultimately better health outcomes. The research revealed that patients’ satisfaction is an important measure to evaluate the quality of health services and can promote both compliance and utilisation. Dissatisfaction with primary health care led many people led to health-seeking behaviours.

THEME 4: RELATED / EXISTING HEALTH BELIEFS AMONGST PATIENTS

Research findings revealed that the participants have related/existing health beliefs amongst patients; some of the health beliefs lead to health-seeking behaviours. This theme has emerged with four sub-themes presented in the discussions which follow:

- 4.1 Beliefs on either western versus traditional medicines based on the type of diseases patients have
- 4.2 Self-treatment an option prior to consultation at a health facility
- 4.3 Religious beliefs mentioned as contributing towards a lack of adherence
- 4.4 Believing in family members' advice

Beliefs on either western versus traditional medicines based on the type of disease

Research findings revealed that participants mix both western and traditional medicines, despite health education given by traditional healers and health care providers, that they should not mix the two. The following quotes directly from participants support this:

Participant 14 said; *"I believe in both because traditional medication helped me from the time I was away from the clinic. Who knows if I was going to be worse than this if I was not taking anything at all? At least now it's only the oedema of the legs, perhaps they are unknown side effects"*.

Participant 1 said: *"I do believe in western medicines and traditional medicines, and I believe that there are some diseases that need to be treated traditionally and there are some diseases that need to be treated by the health care providers, for example, HIV/AIDS has to be treated in health care facilities, then sexually transmitted diseases can be treated by traditional healers"*.

Studies in South Africa also indicate that African people will simultaneously access the services of western and traditional healers for the same symptoms, based on the cultural conception that illness is both physical and spiritual (Zondo, 2008). Asian-American cultures suggest that seeking help from health care professionals or seeking financial aid from the government to pursue treatment would be exposing the problem beyond their

family network, which is considered shameful and could pose a threat to the status or reputation of the family. Consequently, Asian-American people tend to turn to family members before pursuing external help, thereby delaying the act of seeking professional health care (Martucci & Gulanick, 2012).

In Pietermaritzburg, the capital of KwaZulu-Natal, patients seek health from different posters and pamphlets advertising herbal products and services that are distributed to people. There are, however, some potentially dangerous and harmful services that are also advertised, such as abortions, a cure for HIV/AIDS. Such services have led to a negative stigma that is now being associated with traditional medicine in KwaZulu-Natal. Such intentions are not to heal, but rather to destroy and take advantage of the ignorance of unsuspecting, desperate patients in urban communities (Ndhlala, Stafford, Finnie & Van Staden, 2011). Research findings revealed that the participants have health beliefs lead to health-seeking behaviours patients seek health where they strongly believe they will be healed before coming for consultations to health care facilities.

Self-treatment an option prior to consultation at a health care facility

Mbonu (2009) states that self-diagnosis and self-treatment remain widespread owing to stigmatisation. The pursuit of different therapeutic options is sometimes a result of the problematic social complexity linked to AIDS.

Participant 2 said: *“I used herbal medicine prepared at home to clean my bloodstream because sometimes the dirty blood in your bloodstream can make you sick, so cleaning the blood works for me because I never got sick even my CD4 is always okay”*.

The same participant 2 said: *“I believe in treating myself first, if I fail then I go to a health care facility”*.

Participant 6 said: *“I believe in church remedies and clinic medication; they actually both work for me”*.

O'Neil (2012) states that cultural beliefs and practices often lead to self-care, home remedies and consultation with traditional healers in rural communities and advice of the elderly in homes is also very instrumental. These factors result in delays in treatment-seeking (Shaikh & Barber, 2008). Mbonu (2009) further states that self-diagnosis and self-treatment remain widespread owing to stigmatisation. Witches and witchcraft remain an option for self-diagnosis of illnesses as well as for diagnosis by traditional healers. This fits with the first and second processes. The study revealed that people living with HIV/AIDS hides behind witchcraft since it is more culturally acceptable, and it avoids personal shame. People prefer to claim that they are bewitched or have (normal) tuberculosis rather than accept that they have HIV/AIDS. Such cultural beliefs led to health-seeking behaviours at home or self-care.

Religious beliefs mentioned as contributing to a lack of adherence

Findings revealed that participants' religious beliefs contributed toward health-seeking behaviours. Some patients believed that some illnesses are not supernatural but humanly induced, for instance, enemies may enlist a witch to curse a person. Such beliefs led to delays in seeking health care. The following quotes directly from participants support this:

Participant 4 said: *"I believe that if people see me starting antenatal care early, they will bewitch my baby, so people must not see early that I'm pregnant. It's safe when they see me when I'm about to deliver, that is why I start ANC late"*.

Participant 7 with the same opinion said: *"I believe in prophets, if I'm sick I go check if there are no people or enemies involved behind my sickness"*.

Participant 5 said: *"When I'm sick, I start consulting at church if it fails my grandfather is a traditional healer and he always supplies me with traditional medicine, so I believe both can help"*.

Golooba-Mutebi and Tollman (2007) indicate that, as in the case of other illnesses, afflictions related to HIV are interpreted within a prevailing framework of folk beliefs regarding illness and its causes, and responses are confined to what is locally believed

to be an appropriate therapy. Patients recognise personal susceptibility, action will not occur unless the individual perceives the severity to be high enough to have serious organic or social complications. These involve the beliefs that the patient holds concerning the factors contributing to the disease (Green & Murphy, 2014).

The patient's beliefs that the given treatment will cure the illness or help prevent it (Green & Murphy, 2014) is a perceived benefit. Perceived benefit signifies an individual's own judgment on the advantages of adopting and continuing with the proposed actions to reduce the severity or consequences of the illness. Factors such as cultural values and gender roles are significant in influencing the decision-making process associated with health-seeking behaviour (O'Neil, 2012). Cultural beliefs and practices often lead to self-care, home remedies and consultation with traditional healers in rural communities, advice of the elderly in homes also being very instrumental. These factors result in delays in treatment-seeking.

Believing in family members' advice

Research findings revealed that advice taken from family members remains a strong catalyst of health-seeking behaviours. Some advice leads to underutilisation of services. This is supported by the following quotes from patients:

Participant 5 said: *"Before pregnancy, I used to take indayelo (prophecies tea); now that I'm pregnant, my grandfather advised me to take traditional medicine to make the baby grow and to clean my bloodstream. I was also told that it is going to help me deliver early"*.

Participant 14 said: *"For hypertension, I was taking treatment from my uncle who is a traditional healer, who gave me traditional medicines for lowering high blood pressure and for HIV. I ignored it because I was still in denial"*.

The study revealed that treatment by family members is sought first, followed by remedies from traditional healers. Modern treatment from hospitals or clinics was sought as a last alternative. The advice of the elderly in homes was also very instrumental. These factors resulted in delays in treatment-seeking (Shaika & Barber, 2008). According to the health

belief theory conducted by (Green & Murphy, 2014) cues to action relate to information and ideas about non- adherence to treatment and the sources thereof, whether internal (symptoms, past experiences) or external (health care workers, friends, relatives, mass media), which influence their health-seeking behaviour and continuity with care.

4.3 CONCLUSION

This chapter discussed the main findings of the study and the factors contributing to the health-seeking behaviour of patients. Data saturation, as relating to the major themes and sub-themes, was achieved and confirmed by the identification of more verbatim quotes from the transcription provided in data analysis. The themes and sub-themes were discussed and supported by relevant literature. Chapter 5 will discuss conclusions, limitations and recommendations of the study.

CHAPTER 5

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

5.1 INTRODUCTION

The findings of this study and the literature control have been discussed in Chapter 4. This chapter discusses the findings and recommendations generated by the semi-structured interviews and responses of the respondents together with limitations recommendations and conclusion of the report. The study reflects factors contributing to health-seeking behaviour and strategies to enhance good health-seeking behaviour. The recommendations have been generated from the research findings against the objectives stated in Chapter One.

5.2 CONCLUSION OF THE STUDY FINDINGS

In conclusion, the findings are discussed by reflecting on the objectives of the study, the strategies and the recommended guidelines that could be used to determine factors contributing to health-seeking behaviours of patients at Sister Mashiteng Clinic under the Steve Tshwete Local Municipality.

5.2.1 Aim of the Study

The study aimed to describe the factors contributing to health-seeking behaviour of patients at Sister Mashiteng Clinic in the Nkangala District under Steve Tshwete Local Municipality.

6.2.2 Objectives of the Study

The objectives of the study were:

- To describe and explore the factors contributing to health-seeking behaviour of patients in primary health care facilities in the Nkangala District under Steve Tshwete Local Municipality.

The researcher achieved this by obtaining information from semi-structured one-on-one interviews with the participants. The participants shared knowledge of the factors contributing to health-seeking behaviours. The explanations indicated by the participants were related to the factors contributing to health-seeking behaviours.

- To describe factors contributing to health-seeking behaviours of patients

The researcher achieved this objective through the information that was obtained from the participants. The findings revealed that the participants used different sources to seek health, other than health care facilities.

5.3 LIMITATIONS OF THE STUDY

Every study has a set of limitations or potential weaknesses or problems. A limitation is an uncontrollable threat to the validity of a study and explicitly stating the research limitations is vital to allow the researchers to replicate or expand on the study (Creswell, 2005).

The study was limited to only Steve Tshwete Local Municipality in Nkangala District of Mpumalanga Province. Therefore, the results cannot be generalised to all the clinics in the Nkangala District nor the whole Province. The reason for conducting the study in Steve Tshwete municipality was that the high defaulter due to health-seeking behaviours was recognised at Sister Mashiteng clinic.

5.4 THE FINDINGS OF STUDY

In this chapter, the findings were discussed in the context of the existing literature. These were also discussed according to the emerging themes presented in Chapter 4. This was followed by the discussion of the results in accordance with the theoretical framework that informed the present study, and a setting out of the implications of the theory.

The findings of this study revealed that the whole Steve Tshwete sub-district clinics are operating from 7h00 to 16h00, with only one referring hospital. Therefore, access to health care is limited, leading to a high level of defaulters lost to follow up and patients prone to health-seeking behaviours. These health-seeking behaviours were found mostly in patients suffering from communicable diseases like HIV/AIDS, TB, STIs etcetera. The

following themes emerged from the data analysis, using Tesch's inductive, descriptive coding technique of qualitative data analysis.

THEME 1:

Theme 1 pointed out that there are various and diverse explanations related to the factors contributing to patients' health-seeking behaviour from different participants which were outlined during the interview sessions conducted. Participants shared similar knowledge about factors contributing to health-seeking behaviour. These emerged in the following sub-themes of this theme: reasons for health-seeking behaviour linked to prescribed treatment; universal test and treat (UTT) during consultation at the clinic led to health-seeking behaviours ; socio-economic background of patients blamed for health-seeking behaviour; lack of reasons towards missing scheduled appointments; health-seeking behaviours due to avoidance of running out of treatment; lack of reliable transport blamed for health-seeking behaviours; patients trust of private doctors marked as a factor for health-seeking behaviour and family influence playing a role in health-seeking behaviour.

THEME 2:

Theme 2 revealed that there are several reasons which exist that influence patients' non-adherence to scheduled appointments with healthcare professionals. Several experiences of patients at different levels in the health care facilities and access to health care were stated as the main reasons for lack of adherence to scheduled appointments. Furthermore, the findings revealed that communicable diseases such as HIV and TB contributed to the burden of disease and affected poor and disadvantaged populations, reducing new HIV infection remained a priority while ensuring that those in need have access and adhere to treatment. Six sub-themes emerged from this theme: access to health care facilities blamed for health-seeking behaviours; work commitments blamed for missing scheduled appointments; lack of support by the employers; forgetfulness blamed for health-seeking behaviours; Lack of adequate counselling by counsellors; fear of disclosure and stigmatisation were outlined.

THEME 3:

Theme 3 revealed views health-seeking behaviours of participants related to the service provided at clinics by health care professionals, service was appreciated at primary health care services by patients It has emerged in two sub-themes of this theme which are:

service provided at clinic rated as good versus poor, free health care services at PHC level appreciated by patients

THEME 4

Theme 4 revealed that the participants had related /existing health beliefs. Amongst patients, some of the health beliefs had led to health-seeking behaviours. Furthermore, findings revealed that patients often started with traditional healers, churches, and different religions to seek health care before patients presented themselves at the health care facility with health care problems. From this theme, there emerged four sub-themes presented in the discussions: beliefs in either western versus traditional medicines, based on the type of disease a patient had; self-treatment an option prior consultation at a health facility; religious beliefs mentioned as contributing towards a lack of adherence, believing in family members' advice etcetera.

5.5 RECOMMENDATIONS

The recommendations will be presented based on the themes that emerged during data analysis.

5.6 RECOMMENDATIONS FOR EXPLANATIONS RELATED TO THE FACTORS CONTRIBUTING TO PATIENTS' HEALTH SEEKING BEHAVIOUR

Theme 1 had eight sub-themes that emerged indicating various explanations related to the factors contributing to health-seeking behaviours. These were: reasons for health-seeking behaviour linked to prescribed treatment; universal test and treat (UTT)during consultation at the clinic led to health-seeking behaviours; socio-economic background of patients blamed for health-seeking behaviour; lack of reasons towards missing scheduled appointments; health-seeking behaviours due to avoidance of running out of treatment; lack of reliable transport blamed for health-seeking behaviours; patients trust of private doctors marked as a factor for health-seeking behaviour and family influence playing a role in health-seeking behaviour. The recommendations are discussed for each sub-theme:

5.6.1 Reasons for health-seeking behaviour linked to prescribed treatment

Quality interaction with patients must be implemented, for example, directly observed treatment (DOT), which are treatment supporters who watch the patients swallowing the tablets in a way that is sensitive and supportive to the patients' needs: the treatment supporter may be a health care worker or family member or whoever the patient chooses, but this will help to counter any factors that may result in treatment interruption.

5.6.2 Test and treat during the consultation in the clinic leading to health-seeking behaviour

Study findings revealed that during consultations at the healthcare facility, patients who were tested for HIV and others who were diagnosed with chronic diseases were treated on the same day with insufficient counselling during the consultation. This was indicated as being the one reason which led to health-seeking behaviours from prophets, traditional healers, family advice and more to confirm if their diagnosis is true, therefore, continuous counselling is required until a client is satisfied with counselling. Furthermore, clinics should open their doors to counselling every day; it should be facilitated for those in need.

5.6.3 Socio-economic background blamed for patients' health-seeking behaviour

Patients with low socioeconomic status are vulnerable to health-seeking behaviours because they are desperate for good health and they have no money no food they just want things to happen fast for free and they end up in scams and false prophets , therefore it is recommended that private institutions together with government should work hand in hand to assist the low socio-economic communities with free health care , also the government should provide food parcels to needy patients with chronic illness.

5.6.4 Lack of reasons towards behaviours of missing scheduled appointments

The research revealed that the individual's ability to understand and act on health information by itself contributes to health-seeking behaviours. Health knowledge is one of the significant factors determining the health-seeking pathways taken. Patient education that is well planned and combined with other interventions must be given to ensure adherence and it should be used in conjunction with other interventions. The goal

is to change patient health behaviours by providing them with information that motivates them to follow a treatment plan to enhance each patient's care plan.

5.6.5 Health seeking behaviours due to avoidance of running out of treatment

The individual's ability to understand and act on health information by itself contributes to health-seeking behaviours. Health knowledge is one of the significant factors determining the health-seeking pathways taken. Therefore, health education should be emphasised about the dangers of health-seeking behaviours through health-seeking behaviours campaigns and it should be emphasised and implemented.

5.6.6 Lack of reliable transport blamed for health-seeking behaviours

Within the clinical setting, missing appointments due to a lack of transportation is common. The empirical literature suggests that between 10% – 51% of patients report transportation as a barrier to obtaining healthcare (Syed et al., 2013)

Transportation barriers should be identified within the healthcare service. Health education should be given to patients to utilise primary health care which is nearby their residential address to avoid the transportation barrier.

5.6.7 Patients trust of private doctors marked as a factor for health-seeking behaviour

Research conducted by Pearson and Makadzange (2008) revealed that private doctors and traditional healers are most preferred by patients for their perceived confidentiality and their ability to minimise embarrassment. Patients with chronic diseases without medical aid would go to private doctors only when they have money to consult and when they don't have money for consultation they stop taking their treatment and begin behaviours such as buying treatment on streets with the least money they have, Therefore, incorporation of private doctors into the public health system and asking them to refer all chronic patients without medical aid to health care facilities is recommended.

5.6.8 Family influence play a role in health-seeking behaviour

The research revealed that treatment from family members is sought first, followed by remedies from traditional healers. Modern treatment from hospitals or clinics was sought as a last alternative. Shaikh (2008) suggests that the advice of family members in care-seeking is strongly associated with gender, education, history of chronic illness, previous exposure to traditional medicine, and health education. It is recommended that family members should be involved when health education is given to clients about the risk of health-seeking behaviours.

5.7 RECOMMENDATIONS FOR REASONS FOR SEEKING HEALTH OUTSIDE HEALTH CARE FACILITIES.

Theme 2 had six sub-themes emerging: access to health care facilities blamed for health-seeking behaviours; work commitments blamed for health-seeking behaviours; lack of support by the employers; forgetfulness blamed for health-seeking behaviours; lack of adequate counselling by counsellors; fear of disclosure and stigmatisation were also outlined. The sub-themes are discussed as follows:

5.7.1 Access to health facilities blamed for health-seeking behaviours

Levesque, Harris and Russell (2013), define health care access as access to a service, a provider or health care facility, whereby there is an opportunity for health care customers to use suitable services relating to their health needs. According to the research findings, patients experienced poor access to health care facilities, both in rural and urban areas. Findings of the study revealed that access was denied due to operating times of all Steve Tshwete clinics. It is recommended that there should be at least two or more Community Health Centre (CHC) which render a 24/7 service delivery to decrease the number of health-seeking behaviours displayed by patients.

5.7.2 Work commitments blamed for health-seeking behaviours

Participants revealed that they come back from work while all the health care facilities of Steve Tshwete municipality are closed since there's no CHC in Steve Tshwete, therefore,

work commitments become a contributing factor to health-seeking behaviours. It is recommended that if there can be a 24/7 CHC where patients can access health care after working hours, this could assist in decreasing health seeking behaviours.

5.7.3 Lack of support to patients by their employers

Unskilled labour such as domestic workers, farm labourers, cashier's etcetera was found to be more vulnerable to health-seeking behaviours due to the lack of support by employers by not giving them enough day-offs to visit health care facilities, therefore, it is recommended that unskilled labour should be offered medical evaluation and exit by government nurses. This would promote the employers' support of their employees and their knowledge about health problems.

5.7.4 Forgetfulness blamed for health-seeking behaviours

Sociological stressors and family problems led to forgetfulness of participants, and when they miss scheduled appointments they go anywhere where convenient to them to seek for health therefore if there could be involvement of social media like WhatsApp Adherence Group/ Support (WAGs) for newly diagnosed, stable and unstable patients to keep the patients connected, reminding them about the next scheduled appointment, it would be advantageous.

5.7.5 Lack of adequate counselling by counsellors

Continuous counselling of patients should be carried out in both Communicable Diseases (CD) and Non-Communicable Diseases (NCD'S) to improve adherence. The research revealed that counselling at health care facilities are only given once to non-communicable diseases like hypertension and this had led to a lack of knowledge about the condition. Continuous counselling is recommended for sufferers of both communicable and non-communicable diseases to improve adherence to treatment.

5.8 RECOMMENDATIONS FOR VIEWS ABOUT HEALTH SEEKING BEHAVIOURS RELATED TO SERVICE PROVIDED

Theme 3 revealed views of participants to service provided at clinics by health care professionals. Service was appreciated at primary health care services by patients. It

emerged in two sub-themes: service provided at clinics rated as good versus poor, free health care services at PHC level appreciated by patients. The recommended guiding principles for each sub-theme are discussed below:

5.8.1 Service at the clinic rated as good versus poor

Despite good service provided in health care facilities aimed at decreasing patient delay and complications, most patients still do not seek treatment in a timely manner due to some gaps identified by patients. Benefits of early treatment must be promoted to decrease patient delay (Moser, Kimble, Alberts, Alonzo, Croft, Dracup, Evenson, Hand, Kothari, & Mensah, 2006). Rewards to the clinic rated good by patients should be given: this can be done in the form of certificates per clinic or per staff member to improve the client's satisfaction and productivity.

5.8.2 Free health care services at the Primary Health Care service level appreciated by patients

Patient satisfaction must be a priority to all health care facilities rendering health care services so as to decrease the number of health-seeking behaviours of patients.

Appiah-Denkyira et al. (2013) state that dissatisfaction with primary care services in either sector leads many people to health care shops or to jump to higher-level hospitals for primary care, leading to considerable inefficiency and loss of control over efficacy and quality of services.

5.9 RECOMMENDATIONS FOR RELATED / EXISTING HEALTH BELIEFS AMONGST PATIENTS

Theme 5 had four sub-themes indicating that the participants had related /existing health beliefs which were perceived to be operational, that is, beliefs in either western versus traditional medicines based on the type of disease the patient has; self-treatment an option prior consultation at a health facility; religious beliefs mentioned as a contributing factor towards lack of adherence and believing in family members' advice. The recommended guiding principles are discussed for each sub-theme:

5.9.1 Beliefs on either western versus traditional medicines based on the type of disease

Studies in South Africa also indicate that African people will simultaneously access the services of western and traditional healers for the same symptoms, based on the cultural conception that illness is both physical and spiritual (Berg, Swartz & Zondo, 2008). Participants were simultaneously accessing the services of western and traditional healers for the same symptoms, based on the cultural beliefs that illness is both physical and spiritual; traditional healers, therefore, should tell patients not to mix western and traditional medicines.

5.9.2 Self-treatment an option prior to consultation at the health care facility

Research conducted by Kleinman, Eisenberg, and Good, (2006). revealed that cultural differences affect patients' attitudes about medical care and their ability to understand, manage, and cope with the course of an illness, the meaning of a diagnosis, and the consequences of medical treatment. Patients and their families bring with them culture-specific ideas and values related to concepts of health and illness, reporting of symptoms, expectations for how health care will be delivered, and beliefs concerning medication and treatments. In addition, culture-specific values influence patient roles and expectations, how much information about illness and treatment is desired, gender and family roles, and processes for decision-making. Therefore, it is recommended that health education should be given in the form of health campaigns.

5.9.3 Religious believes mentioned as contributing to a lack of adherence

According to Mbonu et al. (2009), people hide behind witchcraft by claiming that they are bewitched since this is more culturally acceptable and it avoids personal shame. Many patients stop taking antiretroviral medication when the symptoms are gone and resort to traditional medication.

Therefore, an on-going health promotion programmes like WOBOT Ward Based Outreach about health-seeking behaviours should be extended to communities at large, this could lead to the provision of effective care, amelioration of the condition, early prevention of diseases and promotion of a healthy lifestyle among the population at large.

5.9.4 Believing in family members advice

Shaikh (2008) suggests that the advice of family members in care-seeking is strongly associated with gender, education, history of chronic illness, previous exposure to traditional medicine, and health education. Treatment from family members is sought first, followed by remedies from traditional healers. Modern treatment from hospitals or clinics was sought as a last alternative. Therefore, family members should be involved in the treatment journey of a patient to support each other to overcome health seeking behaviours.

5.10 RECOMMENDATIONS OF THE STUDY

The following recommendations, if implemented effectively and efficiently, can enhance developmental factors contributing to health-seeking behaviours.

EXPLANATIONS RELATED TO THE FACTORS CONTRIBUTING TO PATIENTS HEALTH SEEKING BEHAVIOURS

- The use of mobile phones to trace patients, interventions can involve sending text messages or WhatsApp's before the clients' appointments to remind them about their appointment or request them to report to the health care facilities for follow up care.
- Transportation barriers should be identified within the healthcare service, health education should be given to patients to utilise primary health care facilities which are nearby their residential address to avoid the transportation barrier.
- Providing cell phones for the Out-Reach Team Leader (OTL) for patient tracking and early active, follow up of patients missing appointments to reduce health-seeking behaviours.
- Continuous support groups after diagnosis should be emphasised, regardless of UTT, patients should test and treat and continue with counselling sessions.
- Quality interaction with the patient must be implemented, for example, Directly Observed Treatment (DOT), who are treatment supporters who watch the patient swallowing the tablets in a way that is sensitive and supportive to the patients' needs, would be advantageous. The treatment supporter may be a health care

worker or family member or whoever the patient chooses, but this will help to counter any factors that contribute to health-seeking behaviours.

REASONS FOR MISSING SCHEDULED APPOINTMENT BEHAVIOURS

- Use of computers in consultation rooms instead of hand-written files could speed up queues and minimise waiting periods at primary health care facilities.
- More pick-up points should be established using churches and halls as venues to decrease the waiting time and the number of consultations at health care facilities.
- The government must hire the right number of registered nurses to improve patient outcomes, reduce mortality rates and increased productivity.
- Since most health-seeking behaviours were found in people living with HIV/Aids it is suggested that ARVs should also be in the form of injections to avoid the forgetfulness of patients.
- Provision of health books to patients, which could be utilised in any health care facility, would be a benefit.
- The government should hire more support group in the health care facilities and those employees should be people living with HIV and virally suppressed because many newly diagnosed people want to speak with others in the same situation. This can overcome stigma and health-seeking behaviours.

VIEWS ABOUT HEALTH SEEKING BEHAVIOURS RELATED TO SERVICES PROVIDED AT THE CLINICS

- The government must include patients' inputs when evaluating PMDS recognition to promote high-quality patient care.
- Rewards to the employees rated good by patients should be given: this can promote both client and employee's satisfaction and promote productivity

RELATED EXISTING HEALTH BELIEFS AMONGST PATIENTS

- The government should offer training for traditional healers for the prevention of communicable diseases and non-communicable diseases to strengthen their skills

- Nurses should attend training together with other health practitioners like prophets and traditional healers with the aim of fighting together against infectious diseases
- family members should be involved in the treatment journey of a patient to support each other to overcome health seeking behaviours.
- Traditional healers and leaders should be involved and empowered to identify and refer patients for HCT, TB, and NCD screening and testing.
- Traditional healers should be given referral forms which can be used to refer patients with communicable and non-communicable diseases to the health care facility.
- Campaigns about dangers of health-seeking behaviours should be implemented.

5.11 CONCLUSION

In this chapter, the study findings were discussed as well as the limitations of the study. The study recommendations were discussed according to the main themes of the findings of the study.

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APPENDIX

APPENDIX A: CONSENT FORM

DEPARTMENT OF NURSING SCIENCE ENGLISH CONSENT FORM

Statement concerning participation in a Clinical Research Project*.

Name of Project / Study: Factors contributing to health seeking behaviour of patients at Sister Mashiteng Clinic of Steve Tshwete Local Municipality, Mpumalanga Province.

I have read the information and heard the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurised to participate in any way.

I know that sound recordings will be taken of me. I am aware that this material may be used in scientific publications which will be electronically available throughout the world. I consent to this study provided that my name and hospital number are not revealed.

I understand that participation in this Study / Project is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for my condition; neither will it influence the care that I receive from my regular doctor.

I know that this Study / Project has been approved by the Turfloop Research Ethics Committee (TREC). I am fully aware that the results of this Study / Project will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

The Study/Project envisaged may hold some risk for me that cannot be foreseen at this stage. Access to the records that pertain to my participation in the study will be restricted to persons directly involved in the research.

Any questions that I may have regarding the research, or related matters, will be answered by the researcher/s. If any medical problem is identified at any stage during the research, or when I am vetted for participation, such condition will be discussed with me in confidence by a qualified person and/or I will be referred to my doctor.

I indemnify the University of Limpopo and all persons involved with the above project from any liability that may arise from my participation in the above project or that may be related to it, for whatever reasons, including negligence on the part of the mentioned persons.

I hereby give consent to participate in this Study / Project.

Signature of researched person.....

Signature of researcher.....

Signed at..... this.....day of.....20

Contact No.....

APPENDIX B: INTERVIEW GUIDE:

DATE OF INTERVIEW:

GENDER: MALE \FEMALE

AGE:

OCCUPATION:

RACE:

PURPOSE OF THE STUDY

To describe and explore factors contributing to health seeking behaviour on patient's health at Nkangala District of the Mpumalanga Province

QUESTIONS

Central Question

Please share with me what brings you to the clinic today?

Probing Questions

What do you think are the main reasons for patients to default treatment and seek health from other sources?

Tell us about the factors contributing to health seeking behaviour?

Can you tell us about service you get from your clinic?

What do you think should be done to eliminate complications caused by health seeking behaviour?

How does socio economic status have an impact on health seeking behaviour?

Tell us about the health beliefs and self-medication as the first recourse of health-seekers.

What strategies can be implemented to encourage people to seek appropriate treatment as soon as possible?

APPENDIX B1: INTERVIEW GUIDE IN SISWATI

Umbuto wekucala

Ngitjele kabanti yini lekuletse emtfolampilo namuhla?

Imibuto lelandzelako

Ucanga kutsi yini imbangela yekutsi tigulane tingeti emtfolampilo ngemala letiniketwe wona?

Sitjele ngembangela yekufuna Lusito lwetempilo etindzaweni letehlukahlukene?

Sittjele kabanti ngelusito lolutfolakala emtfolampilo wangakini

Simo semnotfo sitsikameta njani ekufuneni lusito lwetempilo emitfolaphilo

Sitjele ngekholo, lonayo ngemitsi lenicala ngayo emakhaya ngaphambi kwekufuna lusito emtfolamphilo

Yini indlela locabanga kutsi ingentiwa kugcuzelela bantfu kutsi bafune lusito lwetempilo emtfolaphilo

APPENDIX: C TRANSCRIPTIONS OF SEMI STRUCTURED INTERVIEWS

Central Question

Researcher Can you please tell us what brings you to the clinic today?

Participant I am sick and was traced telephonically by a nurse. all along I was using herbal medicine prepared at home to clean my blood stream, because sometimes the dirty blood in my blood stream made me sick.

Probing Questions

Researcher What do you think are the main reasons for you to default your treatment and seek health from other sources?

Participant Clinics are always full, and always with long queues, if you come late they sometimes cut the line, telling you they want to finish the queue first, so if I wake up late, I don't bother to come to the clinic, and at work, they don't accept clinic sick notes; they only accept Doctor's sick notes, so if I have to go to clinic I have to go to the Doctor again for a sick note that is acceptable at my work place. The operating time and days of the clinic are killing me

Researcher Tell us about the factors contributing to health seeking behaviour?

Participant The operating time and days of the clinic

Researcher Can you tell us about service you get from your clinic?

Participant Clinic? Sometimes nurses set their own rules which are not seen on notice boards like, they instruct you to test for HIV before consulting even if you didn't come for that. Otherwise I'm not complaining about other things.

Researcher What do you think should be done to eliminate complications caused by health seeking behaviour?

Participant I think if we can get a SMS or phone calls before the appointment date reminding us about collection of treatment, because sometimes we forget due to family problems or being too busy at home.

Researcher How does socio economic status have an impact on health seeking behaviour?

Participant Because we all not working and not from the same background, if you are hungry, where can you get energy to go to the clinic? Even the treatment needs to be taken with food.

Researcher Tell us about the health beliefs, self-medication as the first recourse of health-seekers.

Participant I believe in treating myself first; if it fails then I go to the health care facility.

Researcher What strategies can be done to encourage people to seek appropriate treatment as soon as possible?

Participant If the Steve Tshwete clinics can open on weekends, not to limit us, because sometimes you get sick on weekends then you have to stay with your sickness while the condition gets worse. That is why I treat myself first because I don't want to wait for Monday to be seen by a health care provider, because if you get sick on Friday night, Saturday, or Sunday, you're in trouble.

APPENDIX: D: ETHICS CLEARANCE CERTIFICATE



University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 4029, Fax: (015) 268 2306, Email: Abdul.Maluleke@ul.ac.za

**TURFLOOP RESEARCH ETHICS
COMMITTEE CLEARANCE CERTIFICATE**

MEETING: 02 November 2017

PROJECT NUMBER: TREC/375/2017: PG

PROJECT:

Title: Factors contributing to health seeking behavior of patients at Sister Mashiteng Clinic Nkangala District of Steve Tshwete Local Municipality Mpumalanga Province

Researcher: N Maseko

Supervisor: Ms MA Bopape

Co-Supervisor: Prof TM Mothiba

School: School of Health Care Sciences

Degree: Masters in Nursing Science


PROF TAB MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: REC-0310111-031

- Note:**
- i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
 - ii) The budget for the research will be considered separately from the protocol.
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding solutions for Africa

APPENDIX E: SUPPORT LETTER FROM THE DIRECTOR OF PRIMARY HEALTH CARE



No.3, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200, Mpumalanga Province
Private Bag X11285, Mbombela, 1200, Mpumalanga Province
Tel | +27 (13) 766 3429, Fax: +27 (13) 766 3458

Litiko Letemphilo Department van Gesondheid UmNyango WezeMaphilo

Letter of Support Signed by Chief Director (CD)/CEO/District Manager (DM)/Programme Manager (PM)

1. Name & contact no. of Applicant	Maseko Nonhlankhla		
2. Title of Study:	Factors contributing to health seeking behaviour at sister mashieng clinic, Nkangala District of Steve Tshwete Local Municipality, Mpumalanga Province.		
3. Aim and population target:	To determine factors contributing to health seeking behaviour of patients at sister mashieng clinic. Population: patients in the facility		
4. Period to undertake the study	From:	to:	
5. Resources Required from Facility/Sub-district/Community			
5.1: Facility Staff Required to assist with the Study	Yes		NO ✓
	How many:		
	Nurses:		
	Doctors:		
	Other, please specify:		
5.2: Patient Records/Files	Yes ✓		NO
5.3: Interviewing Patients/ participants at Facilities	Yes ✓		NO
5.4: Interviewing Patients/ participants at Home	Yes		NO ✓
5.5: Resource Flow (Are there benefits to Patients/community)	Yes ✓		NO ✓
	Please list:	compliance to Rx. clinic knowledge	
5.6: Resource Flow (Are there benefits to Facility/District)	Yes ✓		NO
	Please list:	0 rate defaulters	
6. Availability of Required Clearance			
6.1: Ethical Clearance	Yes ✓	Pending	NO
	Clearance Number:	TREC.375/2017:PC	
6.2: Clinical Trial	Yes	Pending	NO ✓
	Clearance Number:		
6.3: Vaccine Trial	Yes	Pending	NO ✓
	Clearance Number:		
6.4: Budget	Yes		NO ✓
	Source of fund:	student	
Declaration by Applicant: I Mr(Ms)/Dr/Prof/Adv. Maseko Nonhlankhla agree to submit/present the result of this study back to the CEO/Institution/District.			
Comment by CEO/DM/PM:		Supported / Not Supported	
Please provide the findings & recommendations of the study on completion.		Supported	
Signature of CEO/CD/DM/PM Name:		15/12/2017 Stamp/Date:	
Please email completed form to: JerryS@mpuhealth.gov.za or ThembaM@mpuhealth.gov.za			

Please note that this letter is not an approval to undertake a study, but a support letter from identified facility/district. i.e. the CEO/District Manager acknowledges to have been consulted on the study

APPENDIX F: APPROVAL LETTER FROM MPUMALANGA DEPARTMENT OF HEALTH



health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

No.3, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200, Mpumalanga Province
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Litiko Letemphilo

Departement van Gesondheid

UmnNyango WezeMaphilo

Enquiries: Research (013) 766 3511/3757/3766

Ms Nonhlanhla Maseko
P O BOX 1159
BARBERTON, 1300

Dear Ms Maseko

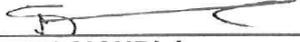
APPLICATION FOR RESEARCH APPROVAL: FACTORS CONTRIBUTING TO HEALTH SEEKING BEHAVIOUR OF PATIENTS AT SISTER MASHITENG CLINIC NKANGALA DISTRICT OF STEVE TSHWETE LOCAL MUNICIPALITY MPUMALANGA PROVINCE

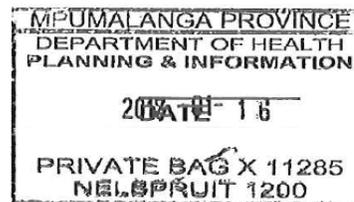
The Provincial Health Research Committee has approved your research proposal in the latest format that you sent.

Mp_201712_004
Approval valid for 1 year
Data collection period: January 2018- December 2018
Approved facilities: Sr Mashiteng Clinic

Kindly ensure that the study is conducted with minimal disruption and impact on our staff, and also ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Kind regards


MR J SIGUDLA
SECRETARIAT: MPUMALANGA PHRC



APPENDIX G: INDEPENT CODER CERTIFICATE

Qualitative data analysis

Master's Degree

For

Maseko Nonhlanhla

Study Title: Factors contributing to health seeking behaviour of patients at Sister Mashiteng clinic Nkangala District of Steve Tshwete local municipality Mpumalanga province

THIS IS TO CERTIFY THAT:

Professor Maria Sonto Maputle has co-coded qualitative data which was collected through:

Unstructured one-to-one interviews

I declare that the candidate and I have reached consensus on the major theme reflected by the data during a consensus discussion meeting.

Prof MS Maputle

Signature:

18 JUNE 2018

APPENDIX H: CERTIFICATE OF PROOFREADING AND EDITING

CERTIFICATE OF PROOFREADING AND EDITING: TO WHOM IT MAY CONCERN

I have 42 years' experience in the teaching profession, both at high school and tertiary level. In my last position before retiring in December 2016, I was a Teaching and Learning Consultant and had acted as Manager of the Teaching and Learning Centre (TLC) of the University of Fort Hare on three different occasions. As a consultant, I facilitated modules on the Post Graduate Diploma in Higher Education and Training (PGDHET) and also evaluated lecturers' teaching and their courses. My skills set allowed me to focus on management, language, research and student development. Activities which speak to this included being the Co-ordinator of the Language and Writing Advancement Programme (LWAP) and the Supplemental Instruction Programme (SI) for two years plus being the Editor of the TLC's bi-annual newsletter for approximately eight years.

I hereby certify that I have proofread a dissertation submitted to me by the corresponding author, Nonhlanhla Maseko, (student number 201107694), of the University of Limpopo. The thesis is being submitted in fulfilment of the Maters of Nursing Sciences qualification. The authors' research topic is:

'FACTORS CONTRIBUTING TO HEALTH SEEKING BEHAVIOUR OF PATIENTS AT SISTER MASHITENG CLINIC, NKANGALA DISTRICT OF STEVE TSHWETE LOCAL MUNICIPALITY, MPUMALANGA PROVINCE'.

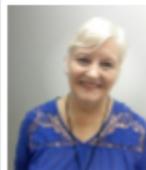
I have corrected superficial errors and have edited the manuscript. I trust that the layout of margins, use of Arial in font size 12 with 1.5 line spacing, in-text referencing plus end-referencing in Harvard style, as prescribed in the UL Manual for Post Graduate Studies, will meet with the examiners' approval and that the language used accurately reflects the intended meaning of the author. Furthermore, I have made every effort to ensure that there is no confusion or misunderstanding. The principles of anonymity, confidentiality, accountability and reliability were respected by all researching parties.

Should there be any questions that arise from this exercise, kindly contact me on lscheckle@gmail.com.



Linda Scheckle (Private Editing Service)

14 December 2018



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5241