HEALTH SEEKING BEHAVIOURS AMONG CAREGIVERS OF PATIENTS WITH MENTAL ILLNESS AT HOSPITAL IN WATERBERG DISTRICT, LIMPOPO PROVINCE

By

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DEDICATION

This study is dedicated to my family and friends who supported me throughout the dissertation.Special thank you to my friend Vutomi for always being there for me.

DECLARATION

I declare that the **HEALTH SEEKING BEHAVIOURS AMONG CAREGIVERS OF PATIENTS WITH MENTAL ILLNESS AT HOSPITAL IN WATERBERG DISTRICT, LIMPOPO PROVINCE** hereby submitted for the degree of master of public health has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

Baloyi GS (Ms)	**September 2024**
Surname, Initials (title)	Date

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ABSTRACT

Inadequate knowledge about mental illness seems to affect the health seeking behaviour of caregivers of people with mental illness. The aim of the study is to explore and describe the health seeking behaviours among caregivers of patients with mental illness.

A qualitative approach with narrative research design was employed to interview caregivers at Polly clinic. The caregivers were purposefully sampled from the clinic register and key informants were identified based on the services they provide. Narrative research design was used for this study guiding the data collection from participants. The semi structured interview guide was used to collect data. Data was analysed using thematic analytic method.

The study found that there is inadequate knowledge of mental illness among caregivers. They commonly utilize district hospitals instead of clinics as first point of contact. The health seeking behaviour of participants include modern, traditional, and spiritual care.

It is recommended that the Department of Health should find strategies to increase knowledge regarding mental illness among community members. The caregivers must be psychoeducated about mental illness.

Key concepts: Caregivers, Health seeking behaviours, Mental illness, Patient, Health Care Workers.

DEFINITION OF CONCEPTS

Caregivers - according to Centres for Disease Control and Prevention (2022), caregivers are people who help and care for people who are unable to take care of themselves. In this study, caregivers refer to family members of people who have a mental illness.

Health seeking behaviours - is defined as the steps individuals take to achieve wellness (Tjomiadi & Surit, 2017). In this study, health-seeking behaviours will be steps caregivers take to assist people who are diagnosed with mental illness in their household to get mental health services. It will be the steps that they take when they find that their family members have a mental illness.

Mental illness - according to the World Health Organization (2019), mental illness is the impairment of emotions, thoughts, perceptions, and social relationships. In this study, mental illness refers to any cognitive, neurological, behavioural or social problems that impair all spheres of functioning, such as depression, anxiety, post-traumatic disorders, and attention deficit disorders.

Patient - is defined as anyone who is receiving medical care (WHO, 2011). In this study, it refers to people who are admitted to the hospital or are receiving treatment for mental illnesses.

Health Care Workers- Is defined as any worker who provides health service to patients by using evidence-based methods (WHO, 2019). A health care worker is anyone who provides health services to those who needs the service. In this study a health worker is anyone who directly or indirectly provides mental health services to people with mental illness**.**

ACRONYM

CHW	-	Community Health Worker
DoH	-	Department of Health
HSDP	-	Health sector development plan
HCW	-	Health Care Worker
NMHPF	-	National Mental Health Policy Framework and Strategic Plan
NDoH	-	National Department of Health
PHC	-	Primary Health Care
S. A	-	South Africa
SADAG	-	South African Depression and Anxiety Group
SAHRC	-	South African Human Rights Commission
SREC	-	School Research Ethical Committee
SSA	-	Sub Saharan Africa
TREC	-	Turfloop Research Ethical Committee
UHC	-	Universal Health Coverage
UL	-	University of Limpopo
UN	-	United Nations
US	-	United State of America

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 Introduction

Mental illness ranks among the top ten diseases that cause the greatest burden globally. The burden of mental illness globally has not diminished between 1990 and 2019. Comparing anxiety and depression to other mental illnesses, their prevalence was higher worldwide. Considering that depression can result in suicide, this high incidence is concerning. Deppression was ranked number 13 on the disability adjusted life years. Despite the significant burden of mental illness, there remains a low fatality rate (Global Burden of Disease, 2022).

In Chinese communities mental illness is attributed to infectious diseases and supernatural forces. The beliefs affect the health seeking behaviour of caregivers and delay their health seeking (Yeung, Irvine, zNg & Tsang, 2017). The first point of contact for family caregivers when seeking mental health is alternative health care. This causes caregivers to delay seeking health from health facilities (Liu, Li, Wu, Tung & Hahm, 2019).

A study conducted in Ghana showed that the first point of contact for caregivers when seeking health care is modern health care. Some of the caregivers used both traditional health care and modern health care (Daliri, Aninany Laari, Abagye, Dei-Asamoa, Afaya & Afaya, 2024). Ghanaians attribute mental illness to spiritual causes, physical problems and epilepsy (Lambert, Nantogmah, Dokurugu, Alhassan, Azuure, Yaro & Kørner, 2020). Their health seeking behaviour include going to both traditional and modern health care facilities. The community believes that a traditional healer treats the spiritual part of the mental illness, and the health care facilities treat the physical aspect of the problem (Lambert et al, 2020).

In South Africa (SA), in the Eastern Cape Province, there are problems in accessing mental health care services as facilities are far from the villages, therefore, people go to traditional healers for services, as they are easily accessible. Traditional healers are in their villages. They do not need transportation to access them. They need transportation to access mental health care facilities, but patients cannot afford transport to get to the facilities (Schierenbeck, Johansson, Andersson, Krantz, & Ntaganira, 2016). Poverty is one of the reasons people are unable to access mental healthcare. Access to mental healthcare requires transport as facilities are far from

villages (Hailemariam, Fekadu, Prince& Hanlon, 2017). According to the Department of Statistics South Africa (2021), in the first quarter of 2021, unemployment rate in S.A was 32.6%. The unemployment rate among the youth is 59.5%. This increases poverty in different communities. Hence, they cannot afford transportation to health facilities for mental health services.

In South African communities, there are also misconceptions and inadequate knowledge about mental illness. Misconceptions lead to the questioning of the effectiveness of Western treatment, and people are discouraged from seeking health care from mental health facilities (Schierenbeck et al., 2016). A study conducted in Limpopo Province, Venda, shows that the first point of contact for caregivers when seeking mental health care is traditional healers. Caregivers believe that mental illness is caused by supernatural causes such as ancestors and witches. Family caregivers reported that they have not attended health facilities when their family members experience mental health problems. They seek health from traditional healers as they believe that mental illness has a supernatural origin (Matambela, 2019).

A study conducted in South Africa shows that 59% of people were diagnosed with mental illness before the national lockdown in 2020. Common mental illnesses were depression at 46%, followed by anxiety disorder at 30%, and bipolar at 12%. The emergence of coronavirus has affected the social life of South Africans and has led to the worsening of mental health (South African Depression and Anxiety Group, 2020).

In S.A, one out of six people has depression, anxiety, or substance use disorders. Only 27% of those who have severe cases of mental illness get access to treatment (The South African College of Applied Psychology, 2019). According to the American Psychiatric Association (2022), more than half of the individuals showing symptoms of mental illness do not seek health care. They avoid and delay seeking health care out of fear of discrimination and stigmatisation.

Delaying and avoiding seeking health care leads to the worsening of symptoms of mental illnesses. This negatively affects individuals' social and professional relationships. Mental illness affects an individual's ability to function properly in society. Mental illness causes self-hatred, despair, and shame in an individual. Mental illness, which is not managed, may lead to people harming themselves and the people around them (Wahlbeck, Park, & Mcdaid, 2019). There is a limited knowledge of mental health

in South African communities. The limited knowledge delays the health seeking of caretakers (Nortjie, Oladeji, & Seedat, 2016).

1.2 Problem statement

The health-seeking behaviour of the caregivers in the community is influenced by their knowledge of mental illness. There is a shared knowledge in the community about the origin of mental illness. The shared knowledge is that mental illness is caused by supernatural forces (Nortjie, Oladeji, & Seedat, 2016). Therefore, it cannot be treated at health care facilities hence; they prefer to use traditional methods. Thus, health facilities are not the first point of contact when seeking treatment for mental illness (Nortjie, Oladeji, & Seedat, 2016).

According to Labys, Susser, and Burns (2016), in Kwazulu Natal and Vulindlela rural communities, there are various health-seeking behaviours. The health seeking behaviour of the community include going to primary health care facilities, traditional healers and faith leaders. The first point of contact for the Vulindlela community is traditional healers. Most people go to traditional healers first when they experience mental illness due to their easy accessibility. They have knowledge of alternative health care, and they have confidence in its effectiveness to treat mental illness. Primary health care (PHC) and community services, such as churches, as a first point of contact, were less likely to be chosen.

Inadequate knowledge of caregivers causes a delay in seeking health from health care facilities. Inadequate knowledge affects the adherence to medication. This in turn causes the worsening of the symptoms and delays the integration of the affected individual into the society. Although Traditional healers seem to be important and easily accessible in communities there is not enough evidence to prove their effectiveness in treating mental illness. Only a few studies assume the effectiveness of traditional healers in the treatment of mental illness (Norje, Oladeji & Seedat, 2016).

1.3 Preliminary literature review

Literature has explained the health seeking, knowledge, misconception, and belief systems from a global perspective, a Sub-Saharan African perspective, and a South African perspective. International countries, the literature focused on Brazil, China, and Italy. The Sub-Saharan countries that literature focused on were Ghana, Uganda,

Tanzania and Kenya. The South African provinces that the literature focused on were in Kwa-Zulu Natal province, Limpopo province, and Western Cape

1.3.1 Global perspective

Literature was reviewed from studies conducted in Brazil, China and Italy.

In Brazilian communities there are misconceptions about mental illness. Despite the misconceptions the community has, a high number of members of the community seek health care from professionals (Santos, Barros, & Santos, 2016). Italians' communities have knowledge about mental illness. They seek health from health care facilities (Coêlho, Santana, Viana, Wang, & Andrade, 2021). In Chinese communities caregivers of those with mental illness and individuals experiencing mental illness have limited knowledge about mental illness. Limited knowledge about mental illness delays their health seeking (Yeung, Irvine, Ng & Tsang, 2017)

1.3.2 Sub-Saharan Africa (SSA)

Literature was reviewed from studies conducted in Ghana, Uganda, Kenya and Tanzania

In countries such as Ghana, they attribute mental illness to supernatural forces and seek health care from faith-based healers and traditional medicine. Some seek health care from professional health workers (Asare & Danquah, 2017). A study conducted in Uganda shows that its community uses modern and alternative interventions when seeking health care (Shah, Wheeler, Sessions, Kuule, Agaba, & Merry, 2017). In Tanzania caregivers seek health from alternative health care practices though they have knowledge of mental illness (Bakar & Moshi, 2022). A study conducted in Kenya showed that the health seeking behaviour of caregivers is motivated by their cultural beliefs. Their health seeking behaviour included going to faith healers, churches and using alternative medication (Ombok, Kareith & Wanderi, 2022).

1.3.3 South African perspective

Literature was reviewed from studies conducted in Kwa-Zulu Natal province, Limpopo province, and Western Cape.

In South African communities, mental illness is attributed to both supernatural causes and neurological causes. Communities seek health from both traditional healers and

professional health care. A study conducted in Capricorn district, Limpopo province found that caregivers first consult at traditional healers and faith leaders when they first find out that their family member has a mental illness. When the mental illness of their family members gets worse they go to health facilities (Nkuna, 2019). Another study conducted in Western Cape, Stellenbosch found that caregivers lack adequate knowledge of mental illness. They are are not able to recognize when one of their family member had a mental illness. This in turn causes delay in seeking health (Gerrick, 2022).

1.4 Purpose of the study

Aim

This study aims to explore the health-seeking behaviours among caregivers of patients with mental illness at a hospital in Waterberg district, Limpopo province.

Objectives

- To explore the health seeking behaviours among caregivers of patients with mental illness at a hospital in Waterberg District, Limpopo Province.
- To describe the health seeking behaviours among caregivers of patients with mental illness at a hospital in Waterberg District, Limpopo Province.
- Exploring the mental health knowledge among caregivers of patients with mental illness at a hospital in Waterberg District, Limpopo Province.

1.5 Research question

What are the health seeking behaviours of caregivers of patients with mental illness at a hospital in Waterberg District, Limpopo province?

1.6 Research methodology

1.6.1 Study site

The study was conducted at Mabula Village, Harmansdaal Village, Kabeane Village and Marulaneng Village. George Masebe is a district hospital, which is in the same yard as a PHC facility. PHC is the first point of contact for those who are experiencing health problems. The PHC is called Polly clinic. Polly clinic is a feeder clinic for George Masebe hospital. George Masebe village has 15 feeder clinics. Mabula village is

between Leyden and Marulaneng village. The GPS coordinates of George Masebe Hospital are 23 º 52' 30.99" S; 28º 41' 35.64" E. Mabula, H, consists of a majority of Sepedi-speaking people and a minority of Tsonga-speaking people.

1.6.2 Study Approach

Qualitative study was used to conduct the study. The research design that was used is narrative research design. Narrative research design is the exploration and narration of an individual’s life stories and experiences.

1.6.3 Population

The study population consists of key informants and caregivers of patients with mental illness who consult at a hospital in Waterberg district, Limpopo province. The names, phone numbers, and addresses of patients were obtained from Polly Clinic, which is a feeder clinic of George Masebe Hospital. Appointments were made with participants, and they were visited in their homes. The researcher went with a home-based care worker to the participants' homes. The key informants are the traditional healer, nurse manager and a prophet. The community members referred the researcher to the traditional healer and prophet.

1.6.4 Sampling

The non-probability purposive sampling method was used to choose participants for the study. Selected participants were caregivers who had experience and could provide in-depth data. The data gathered was able to address the research problem, aims, and objectives of the study (Leavy, 2017). In purposive sampling, a sample is chosen with a specific purpose in mind. The sample is chosen based on its relevance and appropriateness to the research problem (Merriam & Tisdell, 2016).

The purposive sampling that was used is homogenous sampling. Homogenous sampling collects data from individuals with the same characteristics and traits. It collects data from people who are similar. The participants in the study were caregivers of patients with mental illness. The caregivers utilize the same health care facility. (Name the characteristic that makes them similar) (Creswell & Poth, 2018). In this study, the participants all had the same experiences. They have family members who are diagnosed with mental illness.

1.6.5 Sample size

The sample size was made up of caregivers of patients with mental illnesses. Key informants of the study were traditional healer, spiritual advisor, and nurse manager. Key informants are service providers and leaders in the community. Key Informants provide health care to caregivers and their family members when family experience mental health problems. They have knowledge about the health seeking behaviour of community members. The sample size was determined by data saturation. One hospital was chosen due to the qualitative nature of the study. George Masebe hospital was chosen as there have not been any studies done about the health seeking behaviour of the caregivers at the hospital. The community believe that mental illness has a supernatural origin. The community utilize alternative health care practice. That might delay their health seeking behaviour. The participants utilize Polly clinic which is a feeder of George Masebe.

1.6.6 Instruments for data collection

A semi-structured interview was conducted using an interview guide which was developed to collect data. A notebook was also used to record gestures and expressions of participants. Audio recordings were used to record the sessions.

1.6.7 Data collection

The interviews were conducted at Kabeane village, Marulaneng village, Harmansdal village, and Mabula village. A room was requested at participants' homes for the sake of privacy and a quiet environment. Interviews took about 20 minutes. The languages used were Sepedi and Xitsonga. Data was collected from caregivers whose family member has a mental illness.

1.6.8 Data analysis

A six step thematic analysis method was used to analyse collected data. The following steps were followed:

The researcher familiarised themselves with collected data. Initial codes were generated. After generating initial codes the researcher searched for themes. The themes were then reviewed, and modified. The reviewed and modified themes are then

defined. The final step of the analysis is writing down findings based on the results analysis (Maguire & Delahunt, 2017).

1.7 Measures for ensuring trustworthiness

1.7.1 Credibility

Audio recordings were listened to, and data was transcribed verbatim on the recordings. Participant responses were not altered to ensure the credibility of the study. Participants' responses were replicated from the audio recordings; no alterations or additions were made.

1.7.2 Conformability

Thus, to ensure conformability, participants' responses were recorded using an audio recorder. Field notes were written during data collection and after the data collection process.

1.7.3 Dependability

Most importantly, to ensure dependability, the methodology has been clearly outlined and described to ensure that other researchers can replicate the study.

1.7.4 Transferability

The researcher will describe in detail the methods which were used. The setting and the type of participants who were interviewed are clearly explained.

1.8 Study bias

1.8.1 Sampling bias

In this study, purposive sampling introduced bias. Purposive sampling could not randomly select participants, so we could not avoid potential for bias.

1.8.2 Researcher bias

To address researcher bias, the methodology was clearly outlined and followed. Thus, to minimize influence during data collection, the interview guide was used by the researcher for data collection.

1.8.3 Social desirability

Participants were informed about confidentiality at the beginning of data collection to address social desirability bias. It was explained to them that their names will not be on the records, and there will be no consequences for speaking truthfully. Therefore, to address acquiescence bias, participants were told from the beginning of data collection to be truthful. They were assured of the protection of their identity and that there will be no punishment for speaking truthfully.

1.9 Significance of the Study

This study is significant as there is lack of any research about the health-seeking behaviour of caregivers in the Waterberg District. The study will contribute to the body of knowledge in research. This can lead to mental illness being prioritised in rural communities. This will help officials strengthen mental health education and promotion in resource-limited settings like villages. Communities that have been educated on mental health will know the steps to take when they experience mental illness symptoms. This will ensure people seek health care from health facilities and increase adherence to treatment for those who have already been diagnosed. It will ensure that the first point of contact for those who have mental illness is a health facility.

The health seeking behaviour will lead to improved symptoms and successful management of mental illnesses. According to the Department of Health (2021), the focus areas of research priorities in S.A are suicide, substance abuse, anxiety disorders, mood disorders, and depression. The Department of Health (2018) published the National Health Research Summit Report, which proposes the importance of funding in areas that need development, such as Limpopo Province. It proposes addressing the improvement of personal health and public health. There should be no disparities in accessing health; factors such as socioeconomics and rural and urban factors should be considered.

The research findings can assist the Department of Health in the planning and allocation of resources to ensure that everyone gets access to health care without financial losses and has knowledge of where to access it.

1.10 Chapter Outline

The study consists of five chapters;

Chapter 1: Contains an introduction, problem statement, preliminary literature review, purpose of the study, research question, research methodology, measures for ensuring trustworthiness, study bias, and significance of the study.

Chapter 2: Consists of a literature review. It explains health-seeking from a global perspective, an African perspective, and a local perspective.

Chapter 3: Comprises of research methodology.

Chapter 4 Comprises of research results, Interpretations and discussions.

Chapter 5: Discussion of findings.

Chapter 6: Summary, Conclusions, limitation of the study and recommendations.

1.11 Conclusions

Chapter 1 consists of the overview of the study, purpose of the study, research question, and preliminary literature review, significance of the study and research methodology. The following chapter will review the literature of the study. It will review the study from the global perspective, Sub Saharan perspective and locally.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The literature explains and describes the global perspective of mental health seeking behaviour, health seeking behaviour in Sub Saharan Africa (SSA), and the South African perspective of mental health seeking behaviour.

2.2 Global perspective of mental health seeking behaviour.

Misconceptions about mental illness in Brazil such as the belief that mental illness is of supernatural origin affect the health-seeking behaviours of individuals and caregivers in the community (Santos, Barros, & Santos, 2016). This leads to stigma, which affects the health-seeking behaviour of caregivers (Santos, Barros, & Santos, 2016).

Individuals who experience mental illness and their caregivers in Brazil are stigmatized. Stigma causes delays in the health-seeking behaviour of individuals. Due to the fear of stigmatisation, people who are experiencing symptoms of mental illness will not tell their families that they are experiencing symptoms of mental illness. When the family finds out their family member has a mental illness, they will hide the person. They also send away the person so that their community does not find out that their family member has a mental illness (da Silva, Baldaçara, Cavalcante, Fasanella, & Palha, 2020).

A systematic review conducted in Brazil of papers from 1989–2013 shows that caregivers and religious leaders of the person experiencing symptoms of mental illness can recognise it when the person needs mental health. Some caregivers are not able to recognise that their family member needs mental health. This affects the health seeking behaviours of the caregivers. Caregivers who are unable to notice when their family member has a mental illness delay to seek health care (Amaral, Onocko-Campos, de Oliveira, Pereira, Ricci, Pequeno, Emerich, dos Santos, & Thornicroft, 2018).

According to the review, though mental health is associated with religion in Brazil, there has been an increase in caregivers who seek treatment from health care facilities. There is a decrease of caregivers who seek mental health from alternative health practices. Though some understand mental illness to have a religious origin, they seek health from health facilities. Religion provides an explanation and support for those who

have mental illness. Religious leaders promote professional service for their members who have mental illnesses and refer them to health facilities to get treatment (Amaral et al., 2018).

A baseline study conducted in 2005–2007 in Brazil (São Paulo) found that 10% of 2942 people had received treatment in the past 12 months when experiencing mental illness. The study found 38.5% of mental health providers were psychiatrists, 33.3% were other mental health providers, and 33% were general health care providers. The prevalence of the disease in the 12 months before the interview was 29.6%. Regardless of the prevalence, few individuals got treatment, and fewer individuals adhered to the treatment. Failure to adhere to treatment and failure to seek treatment were due to structural and attitudinal barriers. Structural barriers were access to health facilities and affordability. Attitudinal barriers were stigma, ineffective treatment from facilities, and the belief that they could treat the disorder on their own (Coêlho, Santana, Viana, Wang, & Andrade, 2021).

In Italy, communities are knowledgeable about mental illness. A study conducted in Italy found that most of the community believes that those who experience symptoms of mental illness should seek health from health facilities and counselling. Thus, 85, 2 % of the participants explained that health should be sought from health facilities. Therefore, 61 % of participants explained that health should be sought from counselling services (Tesfaye, Agenagnew, Terefe, Anand, Birhanu, Ahmed, Getenet & Yibarek, 2020).

Though the Italian communities have knowledge about mental illness, they still have misconception about mental illness. Misconceptions are that mental illness can be treated by marriage and witchdoctors. Factors such as affordability and accessibility are some of the reasons alternative options are preferred. Though there is knowledge of mental illness in the communities, the affected individuals are discriminated against in the community (Tesfaye et al, 2020).

Chinese communities also experience the same mental health challenges as African communities. This affects the health seeking behaviour of caregivers and individuals who has mental illness. Family caregivers of those with mental illness and individuals experiencing mental illness have limited knowledge about mental illness. Limited knowledge about mental illness delays their health seeking. They are able to notice

changes when their family member starts having mental illness. They do not attribute the change to mental illness. It takes some caregivers years to seek health (Yeung, Irvine, Ng & Tsang, 2017).

A study conducted in Northwestern China showed that 13 out of 21 respondents with mental illness went to general practitioners, 2 out of 21 sought help from social workers or spiritual advisors, and 6 out of 21 sought help from mental health workers. Those who sought help from mental health workers were delayed before they could seek help. The participants' reasons for delaying seeking mental help were: the belief that the mental illness was not serious when they started experiencing symptoms of mental illness; the treatment would not be effective; the treatment has not been effective for those who were on treatment; the mental illness will disappear without needing treatment; they can treat the symptom on their own; they did not get expected services in health facilities; expensive mental health services; and medical insurance did not cover mental health treatment (Liu, Chen, Ni, Yang, Huang, Liu, Wang & Yang, 2018).

The study quantified the reasons Chinese communities delay seeking health as follows: 18.8% thought that the mental illness was not serious when they started experiencing symptoms of mental illness; 18.8% thought that the treatment would not be effective; 18.8% thought that the treatment had not been effective for those who were on treatment; 9.09% thought that the mental illness would disappear without needing treatment; 9.09% thought that they could treat the disorder on their own; 9.09% did not get expected services from health facilities; 9.09% said the mental health treatment was expensive; and 9.09% reported that medical insurance did not cover mental health treatment (Liu, Chen, Ni, Yang, Huang, Liu, Wang & Yang, 2018).

Lack of knowledge among caregivers has been associated with alternative medication which delays the health seeking of caregivers (Liu, Li, Wu, Tung, & Hahm, 2019). Alternative medicine is one of the options utilised. Some prefer going to traditional Chinese practitioners or utilising traditional religious practices. Traditional religion and traditional Chinese medicine are preferred because they are affordable, and patients have had bad experiences with mental health professions in their previous consultations. The experience has made patients develop a negative attitude towards mental health professionals (Shi, Shen, Wang, & Hall, 2020).

There are beliefs in the Chinese communities that mental illness is a personal problem and can be handled by an individual. Family members believed mental illness was a condition that could be managed by thinking right. Their perception is that individuals with mental illness do not need professional help, but it is up to them to treat them by controlling their thought processes. Misconception delays the health seeking of individuals (Yu, Kowitt, Fisher, & Li, 2017).

Caregivers of people who have mental illness are ashamed to seek health. They hide the individual who has mental illness. Family caregivers believe that if community members know that one of their family members has a mental illness, it will embarrass the affected person and their families (Liu, Li, Wu, Tung, & Hahm, 2019). The knowledge that one of the family members has a mental illness negatively affects the lives of the family members in the community. In communities where marriage is still negotiated traditionally, the history of mental illness decreases the marriageability of the whole family. It is believed that mental illness is genetic and hereditary. By not allowing marital relations with families that have members with mental illness, they are trying to prevent their inheritance to future generations (Yu, Kowitt, Fisher, & Li, 2017).

2.3 Health seeking behaviour in Sub-Saharan Africa

The beliefs about the causation of mental illness are different among Ghanaians. Some attribute it to supernatural forces. Others believe the cause to be sickness and the use of substances. Their beliefs and knowledge affect their health-seeking behaviour (Lambert, Nantogmah, Dokurugu, Alhassan, Azuure, Yaro, & Kørner, 2020).

A case study done in Ghana, found that the health seeking of the family caregivers are are western interventions and traditional interventions. The health seeking behaviour of Ghanaians is traditional medicine, spiritual healing and western medication. Western interventions are less preferred than traditional or faith based interventions as they believe that mental illness are caused by supernatural forces such as spiritual attacks, witchcraft, God, Demons and Satan (Asare & Danquah, 2017).

Individuals with mental illness are treated in an inhumane way in the alternative health care facilities. They are physically restrained, shackled, flogged, and forced to fast. The inhumane treatment causes the symptoms to worsen. Despite the treatment that they receive, people with mental illnesses are still taken to traditional facilities as they are

cheaper than hospitals. A positive outcome was reported as compared to the treatment received at the hospitals (Lambert et al, 2020).

The study conducted by Shah, Wheeler, Sessions, Kuule, Agaba, and Merry (2017) revealed that health-seeking behaviour in Uganda is influenced by both modern interventions and alternative health care practices. Alternative health care practice includes going to witchdoctors and faith healers. Personal beliefs and knowledge of mental illness guide the health-seeking behaviour of individuals. The attribution of mental illness to supernatural makes people seek health from traditional health care alternatives. There is a lack of knowledge about the causation of mental illnesses. Mental illness is attributed to using substances such as tobacco, weed, and alcohol. They also believe that mental illness is caused by being weak and a failure.

Moreover, to address this challenge, the Ugandan government established the Health Sector Development Plan (HSDP) for 2015–2016 and 2019–2020. It is a five-year plan aimed at achieving the 2040 vision of universal health coverage (UHC). The health sector development plan for 2015 has an overall goal. ‘‘The overall goal of national health policy is to attain a good standard of health for all people in Uganda to promote healthy and productive lives. One of the objectives of the policy is to ensure communities, households, and individuals are empowered to play their role, take responsibility for their own health and wellbeing, and participate actively in the management of their local health services ‘’ (Ministry of Health, 2015, p. 24).

A study found that 76% of caregivers in Tanzania had adequate knowledge of mental illness; whereas 24% of caregivers had no knowledge of mental illness. Despite having knowledge of mental illness, caregivers first point of contact when seeking health is altenative health care practice. The study found that 58% of caregivers sought health from health care facilities, 41% of caregivers sought health from alternative healthcare (Bakar & Moshi, 2022).

According to Ombok, Kareith and Wanderi (2022) the health seeking behaviour of Kenyan caregivers is influenced by their cultural beliefs. Caregivers believe that mental illness is a result of supernatural forces. Their health seeking behaviour includes going to faith healers, churches and using alternative medication. They believe that mental illness is best managed by alternative practices as it is a result of supernatural forces (Ombok, Kareith & Wanderi, 2022).

2.4 South African Perspective of mental health seeking behaviour.

Mutola, Pemunta and Ngo (2021) found that communities seek health from traditional healers for numerous illnesses. Traditional healers are easily accessible and can be trusted to keep confidentiality. The traditional healers seem to provide satisfactory results for their clients. Seeking health from health facilities is seen as ineffective as the belief is that supernatural forces are the cause of mental illnesses..

Kometsi, Mkhize and Pillay (2019) found that people in rural villages know of mental illness. They give different names or recognise the names of the mental illness. They accept that some mental illnesses have a psychological origin while others have a supernatural origin. Schizophrenia was explained as having a supernatural origin; it was explained as a person having trouble with the ancestors or witchcraft. Psychosis, on the other hand, was seen as a mental illness. Their perception of mental illness is different from Western perception. The rural people did not understand what depression is and thus labelled it stress. They have normalised depression. This misunderstanding of what depression is can cause people not to seek for psychological help from trained professionals (Kometsi, Mkhize & Pillay, 2019).

A study conducted in, Capricorn district, Limpopo province found that some caregivers' first point of contact is traditional health care. They sought health care from churches. There is a belief that mental illness is caused by supernatural forces such as witchcraft. This delayed their health seeking and worsened their symptoms. Health care facilities are only utilized when the affected person does not show improvement. (Nkuna, 2019).

Another study conducted in South Africa, Thulamela Municipality found that the health seeking behaviour of caregivers included going to faith healers, churches and traditional healers. Faithhealers, Traditional headers and churches provide the caregivers with support (Matambela, 2019).

Caregivers in Thulamela municipality lack adequate knowledge about mental illness. They believe that mental illness is caused by supernatural forces such as evil spirits (Matambela, 2019). A study by Gerrick (2022) supports the findings. Caregivers who reside in the Western Cape, Stellenbosch lack adequate knowledge of mental illness. They are are not able to recognize when one of their family member had a mental illness. Caregivers are not able to identify the mental illness that their family member

has. They do not see the need for seeking health as they believe that the mental problems do not require professional intervention.

A study conducted by Vergunst (2018) found that the health-seeking behaviour of people in rural villages is different. In the rural villages, they utilise both traditional and professional healthcare facilities. Another study conducted by Mkabile and Swartz (2019) collaborated on the findings. The study found that caregivers use more than one treatment method for mental illnesses. They utilise both mental health facilities and alternative practices. When mental illness causation is believed to be caused by supernatural causes, health seeking in rural villages includes only alternative medication. This shows the importance of traditional healers in villages (Vergunst, 2018

The mental health service in S.A is not fully integrated into the general health services. Inadequate integration into general health has impacted health-seeking behaviour and access to health care. The government is not allocating enough funds to mental health services (Docrat, Lund, & Chisholm, 2019). In Limpopo Province, there are challenges in providing mental health services as compared to other provinces. There are insufficient mental health workers, a lack of budget to provide quality mental health services, poor infrastructure, and poor de-institutionalisation in the province. According to a report by the Human Rights Commission, there are three psychiatrist hospitals in Limpopo province. There is one psychiatrist, 10 occupational therapists, and 5 psychologists. It was noted that there was a shortage of staff in psychiatric hospitals (South African Human Rights Commission, 2017). Inadequate funding affects accessibility to the services. More than 90% of people who need mental health services do not receive them (University of Witwatersrand, 2020).

2.5 Summary

In Brazil, more people seek health care from health facilities than from alternative treatments. In Italy, they seek health care from health facilities. In China, health is sought from both traditional alternatives and health facilities. The health-seeking behaviour of African communities seems to be the same. They seek health from faith healers, traditional healers, and health facilities. The reason for alternative treatment seems to be the belief that mental illness has a supernatural cause.

CHAPTER 3 RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the methods and procedures that were used to collect data from participants. The methodology is explained as the study followed a qualitative approach.

3.2 Research approach

A qualitative approach was used to conduct the study to get in-depth and deeper meanings of the health seeking behaviour of caregivers of family members who have mental illness. The approach assisted the researcher to explore and explain the health seeking behaviour of caregivers. It seeks to find deeper meanings in the events and experiences (Leavy, 2017).

3.3 Research design

The narrative research design was used to explore and narrate the individual's life stories and experiences. Narrative research design assisted the researcher to collect data from participants to reach the study conclusion. When using a narrative design, interviews, observation, documents, and pictures can be used for data collection to explore oral history, stories and experiences of research participants. The caregivers' health seeking experience was explored and explained guided by the narrative research design. An interview was used as a data collection method to explore and explain the individual experiences of caregivers (Creswell & Poth, 2018).

3.4 Study settings

The study was conducted at Mabula Village, Harmansdaal Village, Marulaneng Village, and Kabeane Village in Mogalakwena local municipality, Waterberg District, Limpopo Province. The PHC is the first point of contact for those who are experiencing health problems. George Masebe village has 15 feeder clinics. It is a District Hospital, which is in the same yard as the PHC facility. The PHC is called Polly clinic. Polly clinic is a name given to a feeder clinic. Mabula village is between Leyden and Marulaneng village. The GPS coordinates of George Masebe Hospital are 23 º 52' 30.99" S; 28º 41' 35.64" E. Mabula, H, consists of a majority of Sepedi-speaking people and a minority of Tsonga-speaking people.

3.5 Population

The study population consists of three (3) key informants and twelve (12) caregivers of patients with mental illness who consult at a hospital in Waterberg District, Limpopo Province. Key informants are the service providers with different health care services for the community members at the research setting. The researcher was directed by the community member's to the traditional healer and the prophet who agreed to serve as key informants. The nurse manager who specializes in mental health care services was chosen based on her speciality area of operation at the hospital.

3.6 Sampling

The non-probability purposive sampling method was used to choose participants for the study. Selected participants were caregivers and key informants who had experience and could provide in-depth data. The data gathered was able to address the research problem, aims, and objectives of the study (Leavy, 2017). In purposive sampling, a sample is chosen with a specific purpose in mind. The sample is chosen based on its relevance and appropriateness to the research problem (Merriam & Tisdell, 2016).

The purposive sampling that was used is homogenous sampling. Homogenous sampling collects data from individuals with the same characteristics and traits. The participants in the study were caregivers of patients with mental illness. The caregivers utilize the same health care facility available in the community. Key informants are service providers and had knowledge of mental illness. The community members' referred the researcher to the traditional healer and prophet. Nurse Manager was choosen as she works at George Masebe hospital. The nurse manager specializes in mental illness (Creswell & Poth, 2018). In this study, all participants had the same experience. They have family members who are diagnosed with mental illness. The names, phone numbers, and addresses of patients were obtained from Polly Clinic register, which is a feeder clinic of George Masebe Hospital.

3.7 Sample size

The sample size was made up of caregivers of patients with mental illnesses and key informants. The Key informants of the study were three including: traditional healer, spiritual advisor, and a nurse manager. They provide health care services to care givers and their family members when family experience mental health problems including mental illnesses. They were also purposefully selected because they have

knowledge about the health seeking behaviour of community members. The participant's sample size was finally determined by data saturation.
One hospital was chosen due to the qualitative nature of the study. The participants utilize Polly clinic which is a feeder of George Masebe hospital. George Masebe hospital was chosen as there have not been any studies done about the health seeking behaviour of the caregivers at the hospital. The community believe that mental illness has a supernatural origin. That might delay their health seeking behaviour.

3.8 Data collection tool

A semi-structured interview was conducted using an interview guide. Semi-structured interviews are flexible and less structured; therefore a pilot study was not necessary as the questions are flexible. The interview was guided by a list of questions that were the same for all participants. The interview guide had open-ended questions (Merriam & Tisdell, 2016). The central question was; what is the health-seeking behaviour of caregivers who care for patients with mental illness. Questions were read on the interview guide and answers were written on the interview guide. The interview guide was in English and was translated for participants in Sepedi and Xitsonga. Based on the answers given, probing was done to get more information. The interview guide had three sections. The sections were bibliographical information, health seeking behaviours, and factors affecting health seeking behaviour. A notebook was also used to record gestures. Audio recordings were used to record the sessions.

3.8.1 Data collection

Data collection is the process of collecting data through methods such as interviews, focus groups and participant observations (Lune & Berg, 2017). The interviews were conducted at Kabeane village, Marulaneng village, Harmansdaal village, and Mabula village. The names, phone numbers, and addresses of patients were obtained from Polly Clinic, which is a feeder clinic of George Masebe Hospital. Appointments were made with participants, and they were visited in their homes. The researcher went with a home-based care worker to the participants' homes. A room was requested at the homes for the sake of privacy and a quiet environment. Interviews took about 13 minutes. The languages used were Sepedi and Xitsonga. Data was collected from caregivers whose family members are diagnosed with mental illness. Data saturation started when participant number eight (8) was interviewed but data collection continued

up to participant number twelve (12) to ensure that there is no new information coming forth from participants.

The key informants of the study were traditional healers, spiritual advisors, and facility managers. Key informants were interviewed at their workplace. The nurse manager was interviewed at George Masebe hospital. The traditional healer was interviewed at his home in Mabula Village. The prophet was interviewed at Kabeane, at her residence. The interviews were recorded using an audio recorder, and notes were taken to capture any form of gesture or body language of participants. The real names of participants were protected during data collection. Numbers were used to identify participants. Their names were not mentioned on the transcript. The interview questionnaires were written in English. Interpretation was done in Sepedi and Xitsonga. The interpretation was done by the researcher as the researcher is fluent in Xitsonga and Sepedi.

3.9 Selection criterion

A selection criterion is developed based on the research problem. Selection criteria determine who will be included or excluded in the sample (Merriam & Tisdell, 2016).

- Inclusion criteria

  The study included caregivers who are 18 years and above, and have a person with mental illness in the family, and are eligible to give consent. The caregiver had a family member who had a mental illness and consulted at George Masebe Hospital. Caregivers lived within the Waterberg district.
- Exclusion criteria

  Caregivers who were under 18 years old were excluded. Caregivers who were not able to give consent due to age or mental state were excluded. Caregivers who do not live in the Waterberg district were excluded from the study.

3.10 Data analysis

The thematic data analysis method was used to analyse the collected data. The thematic data analysis method looked for patterns and themes from the data. The patterns and themes were used to answer the research question (Maguire & Delahunt, 2017).

Steps in thematic data analysis were followed;

Step 1: Familiarisation with data

The data, which is in audio, was transcribed into written words. The transcribing process helped with data familiarisation (Michele & Varpio, 2020). Audio-recorded data was transcribed from Xitsonga and Sepedi to English. The data was reread, and comparisons were made. The researcher became familiar with all the data they had collected, including the notes that were jotted down during the interview. The researcher listened to the audio and transcribed verbatim what the participant had said (Maguire & Delahunt, 2017).

Step 2: Generating initial codes

The data was organised. Data was reduced and put in in systematically. Codes were identified. The researcher went through the data and identified similar ideas. The ideas were put together (Maguire & Delahunt, 2017).

Step 3: Searching for themes

Codes were grouped under specified themes. The codes were put under relevant themes. The themes were relevant to the research question (Maguire & Delahunt, 2017). A three-column table has been created. The first column is for the codes. The second column is for themes. The third column is for subthemes.

Step 4: Reviewing themes.

This step involved the reviewing and modification of themes that had already been found. The researcher checked if the data made sense. The data that is relevant to each theme was revised to see if it supports the theme (Maguire & Delahunt, 2017).

Step 5: Defining themes.

This step involved looking for themes and subthemes in existing data. The relationship and interaction of sub-themes and themes were established. The themes were grouped accordingly to the table that was developed. Meanings were given to each theme and how it relates to the problem being addressed (Maguire & Delahunt, 2017).

Step 6: Writing up.

Findings were written down based on the results analysis (Maguire & Delahunt, 2017).

3.11 Measures to ensure trustworthiness.

Trustworthiness is the rigour of the research design—the extent to which qualitative research is truthful and the results are believable. The study must be replicable and transferable to other studies (Rose & Johnson, 2020).

3.11.1 Credibility

Credibility seeks to determine the truth of the results. It establishes whether the results represent the information gathered from participants and their original views. Therefore, to obtain credibility, different strategies are used (Korstjens & Moser, 2018). Thus, to ensure credibility, the services of an independent auditor were used to analyse the research data. An independent auditor confirmed the research findings and brought new perspective to the study. Audio recordings were listened to, and data was written as said on the recordings. Participant responses were not altered to ensure the credibility of the study. Participants' responses were replicated from the audio recordings; no alterations or additions were made.

3.11.2 Conformability

Conformability ensures that the results obtained reflect the participants' experiences and were not influenced by the researcher's experiences and expectations (Abdalla, Oliveira, Azevedo, & Gonzalez, 2018). Thus, to ensure conformability, participants' responses were recorded using an audio recorder. Field notes were written during data collection and after the data collection process.

3.11.3 Dependability

Dependability is when the results stay the same when replicated using the same method (Korstjens & Moser, 2018). Thus, to ensure dependability, the methodology has been clearly outlined and described to ensure that other researchers can replicate the study. The data that was collected was documented and kept safe.

3.11.4 Transferability

Transferability is the extent to which the research result can be replicated and used in other studies using the same method. Transferability can be obtained through a clearly defined methodology (Korstjens & Moser, 2018).

The researcher described in detail the methods which were used. The setting and the type of participants which were used are clearly explained. A clear description enables those who will read the study to be able to determine if the study can be transferred to others which have the same characteristics (Creswell & Poth, 2018). Transferability depends on communities. Findings may not be transferable because communities are not the same, and their practices are not the same.

3.12 Study bias

3.12.1 Sampling bias

Sampling bias occurs when the sample is not a true representative of the population being studied. Randomly selected participants provide a sample representative of the population (González de la Cuesta, 2021). In this study, purposive sampling has introduced bias. Purposive sampling did not randomly select participants, so there was a potential for bias. The sample was small and depended on data saturation. The results cannot be generalised to other studies as the sample was small. All caregivers who consulted at George Masebe were allowed to participate in the study. There is potential for bias.

3.12.2 Researcher bias

This occurs when the researcher's views, experience, values, and beliefs influence the research results. Research bias may also occur when the researcher has negative or positive feelings towards the participants. A researcher can dislike a participant or have sympathy for the participant (Bryman & Bell, 2018). Thus, to address researcher bias, the methodology has been clearly outlined and followed. Thus, to minimise the researcher's influence during data collection, the interview guide had open-ended questions. Probing was done based on the answers given by participants. Before collecting data, any personal feelings, views, experiences, and beliefs were jotted down in the notebook. As the data collection process progresses, any feelings and views that may resurface are jotted down in the notebook. It indicated in the research proposal how the experiences and beliefs have influenced the study.

3.12.3 Social desirability

Social desirability is when participants are not truthful and give socially correct answers. The participants might be afraid that giving truthful answers will give a bad

impression of them (Bryman & Bell, 2018). To address social desirability bias, participants were told about confidentiality as part of the informed consent. It was explained to them that their names would not be on the records, and there would be no consequences for speaking truthfully. Interview guide questions were not leading. The questions were neutral and non-offensive.

3.12.4 Acquiescence bias

Acquiescence bias occurs when the participants agree with the researcher or when the participant answers what they think the researcher wants to hear (Edmonds & Kennedy, 2017). Thus, to address acquiescence bias, participants were informed from the beginning of data collection to be truthful. They were assured of the protection of their identity and that there would be no punishment for speaking truthfully. The questions on the interview guide were not leading.

3.13. Ethical considerations

The researcher was conversant with the following ethical principles to meet the standards of ethical considerations when engaging with the participants (Bothma, 2016).

3.13.1 Permission

A request for ethical clearance was sought from the Turfloop Research Ethics Committee (TREC). Permission to conduct research was obtained from the Limpopo Provincial Department of Health, George Masebe hospital management, and the participants. The researcher was given verbal permission to conduct the study by the tribal leaders.

3.13.2 Approval

Approval was requested from the Department of Public Health. The Department of Public Health forwarded the proposal to the school of health care science research committee (SREC) for approval. The SREC forwarded the proposal to the Turfloop Research Ethics Committee (TREC). TREC gave the researcher ethical clearance to collect data.

3.13.3 Informed consent

The purpose of the interview was explained. Informed written consent from caregivers was obtained before the interviews took place. During the process of obtaining consent, participants were informed that participation was voluntary and that they could withdraw from the study without any penalty. Only caregivers 18 years and older were allowed to sign the consent form. Caregivers who had family members who consulted at George Masebe Hospital and were eligible to give consent gave consent.

According to Mental Healthcare Act 17 of 2002, Chapter 3, Section 13, a person, or health establishment may not disclose any information that a mental health care user is entitled to keep confidential in terms of any other law. Informed consent was obtained from caregivers who can give consent before the interview takes place. Spouses who are married out of the community of property and family members were required to produce proof of their legal status to administer the rights of the patient. According to National Health Act 61 of 2004, Chapter 2, section 7(b): states that in the case that a patient is unable to give consent, it can be given by the spouse, parent, grandparent, adult child or a brother or sister of the user of health care.

3.13.4 Confidentiality

Confidentiality is safeguarding and protection of the identity of participants. This involves excluding the names of the participants on the data collection tool and protecting the records of the participants (Lune & Berg, 2017). During the process of obtaining consent, participants were informed about confidentiality. They were informed that their names would not be linked to the information they shared during interviews. Pseudo-names were used during data collection to protect participants' identities. The identity of the participants was protected. This was done by ensuring that no one could access documents about patients on the computer. The computer in which documents are saved is protected by a password.

3.13.5 Privacy

This involves the protection of the participant. This includes protecting sensitive information participants disclose that they do not want to be shared (Creswell & Creswell, 2018). The researcher did not disclose any sensitive information. Participants were not forced to share information they did not want to share.

3.13.6 Anonymity

Anonymity is ensuring that identifying information of participants such as email address; addresses, and names of participants are not on the records (Lune & Berg, 2017). The interview guide does not have a section which includes the name, email address and address. The information was not written anywhere in the interview guides.

3.13.7 Non-maleficence

Most importantly, to avoid harm, participants must not be identified by names on the report (Creswell & Creswell, 2018). The study will be free from harm, and the researcher will ensure a harm-free environment by adopting the following aspects:

- Physical harm

The researcher kept the environment safe; harmful destruction was eliminated on time. The researcher ensured the participants were comfortable and not exposed to fatigue or harmful substances. COVID-19 protocols were observed. Masks were worn by both the participants and the researcher. There was distance between the participants and the researcher. Hand sanitisers were used during the data collection process.

- Psychological harm

When answering questions, participants were not anxious or embarrassed. The researcher monitored the feelings and emotions of the participants. No psychological harm occurred to participants.

- Economic harm

The researcher ensured that the study did not involve any financial loss. No costs were required from participants to take part in the study, and the participants did not incur any financial loss.

- Dignity harm

The researcher ensured that participants were treated with respect and were allowed to address their preferences and values before the study. The researcher adhered to the planned time and duration of the interviews to avoid inconveniences for participants.

- Vulnerable participants

Vulnerable participants are those who cannot give informed consent to participate in the study. This includes children, people with mental illness, or people who are

pressured by others to participate in the study (Surmaik, 2018). Therefore, no vulnerable participants took part in this study.

CHAPTER 4: FINDINGS

4.1 Introduction

The previous chapter discussed the reseach methodology. This chapter describes the study's findings of family caregivers who consult at George Masebe Hospital. The study discusses the themes and subthemes that have emerged in the study. Three themes were discussed in the study. The voices of participants are included included and discussed.

Family caregivers who are 18 years of age and older and can give consent and have a family member with mental illness who fetches treatment for their mentally ill patients. The institute is a 72-hour institution in South Africa. Its catchment area includes 15 feeder clinics. The mental health coordinator referred the researcher to the nearest feeder clinic. The names, phone numbers, and addresses of patients were obtained from Polly Clinic, which is a feeder clinic. Appointments were made with participants, and they were visited in their homes. The researcher went with a home-based care worker to the participant's home. Participants were from Marulaneng Village, Harmansdaal Village, Kabeane Village, and Mabula Village. Twelve (12) participants and three key informants were interviewed. Data was collected until saturation was reached.

The demographic characteristics of participants and key informants, the themes and subthemes which were derived from the data are explained below.

4.2 Demographic characteristics of participants

Table1: The demographic characteristics of participants

No of participants	Gender	Age range	Ethnicity	Home language	Highest grade range
1 0	Females Males	18-40 years	African	Sepedi	Grade 10
2 5	Females Males	41-60 years	African	Sepedi Xitsonga	Grade 2 to college
2 1	Females Males	61-80 years	African	Xitsonga Sepedi	Grade 7 to grade 8
1	Females	81-100	African	Xitsonga	None

0	Males	years			
12	**Participants**				

Participants were male and female Africans who spoke Sepedi and Xitsonga. Their level of education ranged from no education at all, to a college qualification. The interviews were conducted at their homes, and they lasted for about 13 minutes

4.2.1 Demographic characteristics of key informants

The key informants were two females and one male, a traditional healer, a prophet, and a nurse manager. Key informants are service providers. All key informants spoke Sepedi. The nurse manager has a college degree. The traditional healer and prophet have secondary education. The school leaving grade of the traditional healer is grade 10. The school leaving grade of the prophet is grade 9. The key informants were purposefully selected because they have knowledge about mental illness and have treated people with mental illness. A traditional healer and the prophet were chosen because they can relate to the participants, and they bring in the cultural and religious perspective of the health care seeking behaviours of clients. A nurse responsible for mentally ill patients was selected because she specialises in mental illness. She has knowledge of the health-seeking behaviours of clients and is working with patients with mental illness in the clinic or hospital catchment area.

4.3 Themes and subthemes

The findings of the study are presented in Table 4.2 as themes and subthemes.

Table 2: Themes and subthemes of the study

Themes	Sub-themes

Theme	Sub-themes
Theme 1: Inadequate knowledge among caregivers regarding the mental illness of their family members.	1.1 Caregivers lack knowledge of early signs of mental illness. 1.2 Caregivers have no knowledge of the diagnosis of their family members. 1.3 Poor knowledge results in a delay in appropriate health seeking 1.4 Poor knowledge interrupts treatment and leads to relapse of mental health care users. 1.5 Minimal discussion between healthcare workers and caregivers on the nature of the mental illness. 1.6 Belief that mental illness is a result of supernatural causes.
Theme 2: Easy access to District Hospitals as the first point of healthcare contact versus clinic services.	2.1 Caregivers do not use clinics as a first point of contact when family members have mental illness. 2.2 Caregivers use district hospitals for mental illness as part of emergency care. 2.3 Health care workers prioritise mentally ill patients as emergency patients.
Theme 3: Patterns of Health-seeking behaviour include modern, traditional, and spiritual care.	3.1. District hospitals are the first point of contact for mental illness. 3.2 Traditional and spiritual health are sought as alternative health care practice. 3.3 Social workers used to access social grants and some personalised care

4.3.1 Theme 1: Inadequate knowledge among caregivers regarding the mental illness of their family members

The following are the sub-themes of the study: Caregivers lack knowledge of early signs of mental illness, caregivers have no knowledge of the diagnosis of their family members, poor knowledge results in a delay of appropriate health seeking, poor knowledge interrupts treatment and leads to relapse of mental health care users,

minimal discussion between healthcare workers and caregivers on the nature of the mental illness and belief that mental illness is a result of supernatural causes.

- Subtheme 1.1: Caregivers lack knowledge of early signs of mental illness.

Caregivers are not able to recognise the early signs of mental illness. They are not able to see that their family members have a mental illness when they first start showing the symptoms. The statements below attest to this:

''In 2012, he had it, but we didn't think it was a mental illness. When he was showing strange behaviour, we would get angry at him. I started noticing when I was staying with him that something was not right''. (*Participant 7)*

''I took…I think two years. When his mother passed away, he was like that''. (Participant 11)

''I thought it was just an illness. It was not yet clear to me it was a mental illness.(lack of knowledge) When she started by undressing we started seeing that this could be a mental illness. We thought it was stress at first'' (Participant 1)

- Subtheme 1.2: Caregivers do not know the diagnosis of their family members.

When participants were asked about the kind of mental illness, they said that they were not told what sort of mental illness the patient was suffering from. Some said that they were told it was a mental illness only. Participants did not know the diagnosis of their family member's mental illness. The following statements indicate this:

''No, they did not tell us. They just said it's a mental illness.'' (Participant 10)

In response to the probing question: "Then what did the doctor say when you got to the hospital?" One of the participants said, "The doctor……...they just said this person is ill''. (Participant 7)

In response to the question: ''Then what did the doctor say, what kind of illness is it? The participants responded "The doctor just said she has a mental illness''. (Participant 1)

In response to the question : "What did the doctor say? What kind of mental illness is it?" The participant responded, "He only said mental illness. That he is not okay in the head" (Participant 4)

- Subtheme 1. 3: Poor knowledge results in a delay in appropriate health seeking

The participants delayed seeking health care when the patient's symptoms were not severe, and the patients did not harm themselves. The caregivers reported that they observe the patient and take advices from communty members before sending them to the hospital to understand what the problem is.

In response to the question, "How long did it take before the patient was taken to the hospital?" One of the participants said, "It took a long time. We wanted to see what was happening first''. (Participant 1)

''It did not take long after the school told us about him. The principal took him home. We watched her for a few days. Then……Then we said, let us take her to the hospital. The hospital will be the one to tell us that this person is ill''. (Participant 2)

In response to how long did it take to seek help? How long did it take to seek help after he showed that he has a mental illness? One of the participant responded, " two to three years we were inquiring what was happening". (Participant 3)

The critical informant supports the statement that caregivers delay seeking health for their family members. This is confirmed by the statement that:

''Most they can take more than 3 months, 4 months before they realise that this person has a mental illness''. (Key informant 1)

- Subtheme 1.4: Poor knowledge interrupts treatment and leads to relapse of mental health care users.

Lack of knowledge results in caregivers not being able to provide care for their family members who have mental illnesses. Patients do not adhere to the treatment. This leads to their relapsing.

''Me. The step I took When I grew up my mom had a…had a mental illness. She was treated and the illness was dormant. As I grew up the illness came back again. When I

asked elders, they said this illness your mom got it when you were young. I took my mother to the hospital''. (Participant 1)

''Because he was not taking pills''. (Participant 10)

"Then he didn't drink the pills then they told him they will take the money" (participant 11)

- Subtheme 1. 5: Minimal discussion between healthcare workers and caregivers on the nature of mental illnes*s*

There was no discussion about the kind of illness between the health care worker (HCW) and the caregivers. Caregivers did not know what kind of mental illness their family member had.

In response to "Then what did the doctor say,what kind of mental illness it is"? The participant responded "They said it's a mental illness" Participant 11

''They just said this person is ill. He has a mental illness…he is not okay...We have to take care of him''. (*Participant 7)*

In response to ''the participant responded *"they didn't tell you anything; what kind of mental illness was it''? The participant responded ''*No, they didn't tell us. They just said it's a mental illness'' *(Participant 10)*

- Subtheme 1.6 Belief that mental illness results from supernatural causes*.*

Some families believe that mental illness is a result of witchcraft by evil people. One caregiver mentioned that mental illness is a result of witchcraft. Knowledge of causation stems from their belief.

''Some say he was… He was bewitched''. (Participant 5)

''There are illnesses which…are natural and some that people cause.'' (Key informant 2)

4.3.2 Theme 2: Easy access to District Hospitals as the first point of healthcare contact versus clinic services

Caregivers reported that they were not using clinics as their first point of contact. They used district hospitals to access health care. When patients consult, they are prioritised as emergency patients.

- Subtheme 2.1 Caregivers do not use clinics as the first point of contact when family members have mental illness.

Caregivers take their family members to the district hospital when they first have a mental illness. They do not use clinics around them as their first point of contact. This is confirmed by the statement that:

"I took her to the hospital. At the hospital they checked her and said that this person has a mental illness. They started giving her pills''. (*Participant 1)*

"Firstly, we take him to the hospital'' (Participant 2)

"I took him to the hospital. WhenI told them he is starting to change. He is starting to act in a way that I'm not used to" (participant 12).

- Subtheme 2.2 Caregivers use district hospitals for mental illness as part of emergency care.

Caregivers predominantly use district hospitals to access health care. They use district hospitals as emergency care when their family members start showing that they have a mental illness. The statement below support the sub-theme:

''Firstly, we take him to the hospital.'' (Participant 2)

''*I took him here in the hospital.'' (Participant 3)*

"I took him to the .hospital" (Participant 8)

- Subtheme 2.3 Health workers prioritise mentally ill patients as emergency patients.

Some caregivers mentioned that when they consult at health facilities, they receive priority attention from HCW. Health workers reach a point where they know clients and can give them first preference. This is supported by the statement below:

''Yes, when I come to the hospital, they treat me well. When I get here, we would be in a queue, and they will tell me you are not supposed to stand in a queue with your mother. Take the file and go to the front of the queue so that they can help you''. (Participant 1)

4.3.3 Theme 3: Patterns of Health-seeking behaviour include modern, traditional, and spiritual care.

The theme focuses on the health-seeking behaviour of caregivers, which includes modern, traditional, and spiritual care within a given community. Social norms, traditions, and cultural practices determine how community members will behave during times of illness, and family caregivers are not an exception.

- Sub-theme 3.1 District hospitals are the first point of contact for mental illness.

In this theme, participants indicated that their first health-seeking behaviour is to consult at hospitals, where they are seen by various professionals such as doctors, psychologists, nurses, and social workers. This is supported by the statements below, where the participants indicated that:

"I took him to the hospital" (Participant 8)

''I took her to the hospital. At the hospital, they checked her and said that this person has a mental illness. They started giving her pills''. (Participant1)

''Firstly, we take him to the hospital''. (Participant 2)

Key informants confirmed that caregivers take their family members to the hospital when they experience mental illness. The following statement confirms the health-seeking behaviour:

''Most of them take them to the hospital, but most of them have already come here… They go to traditional healers… Because it's According to Ratombo (2020), some caregivers go to health facilities first when their family member has a mental illness.

Most of them who have come to our side, and we helped them with things like that. You see". (Key informant 1)

Subtheme 3.2 Traditional and spiritual health are sought as alternative health care practice.

These are alternative health-seeking behaviours by caregivers who sought health care from religious and traditional healers. This includes going to traditional healers, churches, prophets, and other alternative health care providers. This is confirmed by the statement below:

"Prophets…We took her to prophets…We took her to traditional healers".(Participant 5)

"I didn't take him anywhere. I only took him to the church that we attend. Then I took him to the hospital so that they could explain it to me. That's where people are taken. I never took him to traditional healers. But my custom is my custom. At church, they told me to go and buy a goat and do a sacrificial ritual for him. And we did that. We did the ritual. When they did the ritual, he was not speaking". (Participant 8)

Key informants reported that when the caregivers first see that one of their family members has a mental illness, they take them to alternative health care services. Below is the statement made by the key informant.

"They go to traditional healers, or they go to prophets to consult and find out what they are seeing. They believe that it is not natural; it is not possible for the person to be doing what they will be doing. They want to find out what is making the person behave in a strange way, showing symptoms that the person might have mental illness". (Key Informant 3).

- Subtheme 3.3 Social workers used to access social grants and some personalised care.

Caregivers reported that they consult social workers only for the purpose of following the process of getting the grant for their family members. When they consult other health workers, they are referred to social workers so that the patient can be officially classified as a disabled person with medical reasons and can get a social grant. This is confirmed by the following statements:

''Yes, at the social workers. So, they give him grant because he cannot do things for himself''. (Participant 4)

''No, we went to the doctor then the doctor sent us to social workers. Then we applied social grant for her for having mental illness'' (Participant 9)

"We go to social workers first".Participant 3

CHAPTER 5 DISCUSSIONS OF FINDINGS

5.1 Introduction

This chapter discusses the findings of the study. The study explored and explained the health-seeking behaviour among caregivers at George Masebe Hospital. The themes and subthemes of the study are also discussed to understand the similarities and differences found in other studies. The objectives of the study are to explore and explain health-seeking behaviours among caregivers of patients with mental illness at a hospital in George Masebe. The study explored health seeking among caregivers of patients with mental illness at George Masebe Hospital. It seeks to answer the question: What is health-seeking behaviour among caregivers of patients with mental illness at George Masebe Hospital?

5.2 Discussion

The themes and subthemes of the study will be discussed below:

5.2.1 Theme 1: Inadequate knowledge among caregivers regarding mental illness of their family members.

It is important for the caregivers to have knowledge of early signs and symptoms of mental illness so they can take the family member for health care before the condition gets worse. In this study, participants showed lack of knowledge and understanding related to the early signs and symptoms of mental illness. They only notice the behaviour change in the way the family members conduct themselves. These findings will be compared to the findings of studies conducted in previous years in different areas.

- Subtheme 1.1 Caregivers lack knowledge of early signs of mental illness.

Caregivers in Thulamela municipality lack adequate knowledge about mental illness (Matambela, 2019). A study by Gericke (2022) found that caregivers in Western Cape, Stellenbosch are not able to recognise signs and symptoms when one of their family members has a mental illness. In the present study caregivers were not able to recognise their family members' change of behaviour. They took time to realise that their family member has a mental illness. Similarly a study conducted in Iran by

Dehbozorgi, Fereidooni-Moghadam, Shahriari and Moghimi-Sarani, (2022) found that caregivers did not have enough knowledge of the symptoms of mental illness. They lack understanding of mental illness. Though their knowledge and understanding of the symptoms for mental illness is limited, caregivers can notice changes in their family members. In contrast to the present study findings Monnapula-Mazamban and Peterson, (2021) reported that caregivers in South Africa, can notice the symptoms of mental illness. They know the symptoms of mental illness but not the names of mental illnesses that their family members have. A systematic review of papers, conducted in Brazil from 1989–2013 shows that family members have some knowledge of mental illness. It was found that family members and religious practices of the person experiencing symptoms of mental illness were able to recognise when their family member needs mental health (Amaral et al., 2018). Caregivers in this study lacked knowledge of mental illness. Though caregives lacked knowledge of mental illness only a few attributed mental illness to supernatural forces. Some caregivers believed that mental illness is caused by witchcraft. One cause of mental illness that was raised during data collection was the loss of a twin, where the other twin remaining is affected by mental illness. The literature that was reviewed did not indicate any association between the twin that passed on and the development of mental illness upon the remaining twin. Caregivers seem not receive any form of education or awareness regarding mental illness and their causes. Mental illness care and service are supposed to be provided as part of the Primary health care services and district health care. The service providers should be able to raise awareness among mental health care service users regarding mental illness.

- Subtheme 1.2 Caregivers do not know the diagnosis of their family members.

A study conducted in South Africa by Sumner, Lund, and Peterson (2014) found that caregivers of people with mental illness have low levels of knowledge regarding their family member's diagnosis.In the present study all caregivers were unable to give diagnosis of their family members' mental illness. They are unable to recognise signs and symptoms and behaviour associated with mental illness. In one of the quantitative studies conducted in Nigeria, Niger delta region, support these findings. The study found that only 16 % of caregivers did not know the kind of mental illness their family members are suffering from. However, they did not know the exact diagnosis. Caregivers did not know the kind of mental illness their family members had according

to clinical records. In the same study, only 24% of caregivers knew the diagnosis and the kind of mental illness their family member are diagnosed with (Jack-Ide & Amegheme, 2016). The caregivers in the present study were not able to name the mental illness of their family members. They refer to mental illness generally. Caregivers in the study were not informed of the name of mental illness by the health care worker they consulted. It seems there are no discussions or there are minimal discussions between caregivers and health care providers.

- Subtheme 1.3 Poor knowledge results in a delay of appropriate health seeking

Dutta, Spoorthy, Patel, and Agarwala (2019) found that caregivers in India delayed seeking health because they were unable to recognise the symptoms of mental illness at the onset.In the current study, it was found that caregivers delayed seeking health care when their family members' symptoms were not severe, and the person did not harm themselves. The caregivers observe the patient first before they can send them to the hospital to see what the problem is. Caregivers did not recognise the change of behaviour as mental illness. The delay in seeking mental health led to worsening of symptoms. Key informants confirmed that family caregivers delay seeking health care when family members start having mental illnesses. The findings are consistent with the study conducted in Rwanda, Kabutare district where it was found that lack of knowledge about mental illness causes mental health users to delay seeking health care from health facilities. Findings of the study conducted in 2021, reflect that 8 out of 10 have a low understanding of mental illness and facility users had no knowledge of the available services (Muhorakeye & Biracyaza, 2021). Another study conducted in North Western China found that the participants reasons for delaying to seek mental help were: the belief that the mental illness was not serious when they started experiencing symptoms of mental illness, the treatment will not be effective, the treatment has not been effective for those who were on treatment, the mental illness will disappear without needing treatment, they can treat the symptom on their own, did not get expected services in health facilities, expensive mental health services and medical insurance did not cover mental health treatment (Liu, Chen, Ni, Yang, Huang, Liu, Wang & Yang, 2018).

- Subtheme 1.4 Poor knowledge interrupts treatment and leads to relapse of mental health care users.

Family caregivers are unable to understand their family members' mental illness and thus are unable to give them support (Ntsayagae, Poggenpoel and Mburgh, 2019). In the present study, caregivers reported that their family member relapsed as they were not taking medication. Patients stop taking medication when they feel better. Caregivers do not advise them to continue taking medication. Participant 1 was not able to detect that her mother has mental illness. Due non adherence to medication the symptoms which were managed resurfaces and worsens. It seems that caregivers do not have any support and guidance from knowleadgeable people about mental illness. In support of the findings, one of the studies found that the Chinese community relapsed because of poor knowledge. Those who were on treatment believed that it has not been effective, the mental illness will disappear without needing treatment and that they can treat the symptom on their own (Liu, Chen, Ni, Yang, Huang, Liu, Wang & Yang, 2018). In contrast, a study showed that health users completed their treatment. Adherence to treatment varied according to the patient's personal characteristics (Milne-Ives, Caroll, & Meinett, 2022). According to Mokwena and Ndlovu (2021), mental health care users would stop medication when they feel better. Non-adherence would lead to health care users relapse. Mental health care users were not given enough information at the facilities about the prognosis of the mental illness when treatment is interrupted.

- Subtheme 1. 5 Minimal discussions between healthcare workers and caregivers on the nature of the mental illness

According to Rooyen, Topper, Shasha and Strumpher (2019), caregivers did not know the nature of their family member's mental illness. Caregivers report that they were only told it is a mental illness. The health worker provided minimal education. In the present study caregivers were not given information about their family members' mental illness and how to better support the family member. They were not given psychoeducation about the mental illness of their family member. It is clear that there is minimal discussion between health care providers and the mental health care users, which interferes with the condition of the mentally ill family members. Health service providers are not sharing relevant information with the mental health care service users. Adequate knowledge of mental illness may equip caregivers with skills of how to better

support their family member. This may improve prognosis and reduce the chances of non adherence to medication. In support of the findings, a study found that caregivers were not given information on how to care for their family member who has a mental illness. There was no adequate communication between the health workers and the caregivers (Asgari, Adib, Nayeri, & Rezayat, 2023). In contrast, Gupta, Sood, Verms and Singh, (2019) found that 22% of health users knew their diagnosis. 38% of caregivers knew the diagnosis of their family members. About 14% of health care users knew the mental illness medication, and 68% of caregivers knew their family members mental illness medication. Most importantly, 82% of caregivers knew how to deal with their family members or what to do in terms of emergency situations that arise. In the same study, the caregivers inquired about the mental illnesses of their family members so that they could take better care of them. They communicate with health workers to gain an understanding of their family members' mental illnesses. When their family members started having mental illness, the caregivers did not have knowledge of mental illness (Aldiabat, Alsrayheen, Alshammari, Navenec, & SCTI, 2023).

- Subtheme 1.6 Belief that mental illness is a result of supernatural causes.

In the present study some caregivers believed their family member’s mental illness was a result of supernatural forces. One caregiver indicated that he was told that his family member was bewitched. Caregivers have limited knowledge of mental illness. Though caregivers have limited knowledge of mental illness, a few caregivers sought health from alternative health care. Most caregivers in the study sought health from district hospitals. Their beliefs did not influence their health seeking behaviour. In support of the study findings, Muhorakeye and Biracyaza (2021) found that caregivers believed that mental illness is caused by supernatural forces such as witchcraft. Their knowledge regarding the causation of mental illness is limited, as it is based on the belief and cultural norms. Caregivers attribute mental illness to supernatural causes. They believe that causation of mental illness is related to supernatural causes such as witchcraft, demon possesion and evil forces. They believe that mental illness is caused by supernatural forces, then it should be treated by either faith healers or traditional healers depending on their belief system. According to Ratombo (2020), witchcraft is believed to be one of the causes of mental illness in Limpopo, Sinthumule. The community in Sinthumule believed that the reason why others practice witchcraft is

because they are jealous of them. As much as they believe that it is caused by witchcraft. They still take their family members to the health care facilities.

5.2.2 Theme 2: Easy access to District Hospitals as the first point of healthcare contact versus clinic services

The first point of contact for the community when seeking health should be the clinic. The HCW's will then transfer the patient to a district hospital if there is a need. In this study participants went to district hospitals first. They bypassed the clinic. Participants reported they were prioritized when they got to the hospital. Patients who need urgent care are treated first. These findings will be compared with previous findings of other studies.

- Subtheme 2.1 Caregivers do not use clinics as a first point of contact when family members have mental illness.

A study by Labys, Susser, and Burns, (2019) found that 46.9% of caregivers in Kwazulu Natal, South Africa sought health services at clinics, general hospitals, and psychiatrist hospitals when one of their family members had a mental illness. In the current study caregivers first point of contact when seeking health was the district hospital. The caregivers did not use clinics as a first point of contact. It seems that they do not have knowledge that they have to utilize the clinic as first point of contact. They will then be reffered to district hospitals. Contrary to the study findings, Babatunde and Akintola (2022) found that caregivers in South Africa, Kwazulu Natal first point of contact when seeking health is the clinic. Another study by Bwanika, Hawkins, Kamulegeya, Onyutta, Musinguzi, Kusasira, Musinguz, Usasira, Musoke and Kabeega, (2022) found that mental health care users sought health care from a national psychiatric hospital. Health users bypassed regional government hospitals and consulted at national psychiatric hospitals. In support of the findings, a quantitative study conducted at Kwazulu Natal, South Africa found that hospitals and clinics are used as a second health seeking method after caregivers have utilised the services of traditional healers. About 49.1 % of health care users consulted health facilities. Health users consulted both the clinic and hospitals when seeking health care (Labys, Susser & Burns, 2016). Caregivers in the study all reported going to the district hospitals.They have bypassed going to the clinic as a first point of contact as per the requirement of the referral system. It seems that they do not have knowledge of the referral system.

- Subtheme 2.2 Caregivers use district hospitals for mental illness as part of emergency care

Health seeking behaviour of caregivers in South Africa, Johannesburg, included going to public hospitals as a second point of contact after receiving the services of traditional healers (Galvin, Byansi, Chiwaye, Luvuno & Moola, 2023). In the present study most caregivers used district hospital as part of emergency care. When their family members started showing signs of mental illness they took them to the district hospital. Despite lack of knowledge and cultural beliefs and norms caregivers took their family members to health facility. It seems they acknowledge that health facilities are able to provide support and manage the symptoms of people who have mental illness. Their health seeking is not influenced by their cultural beliefs and norms. In support of the study findings, a study conducted in Ghana by Ibrahim, Hor, Bahari, Dwamoh, Mckay, Esena and Agsypong (2016) found that 53.2% of health care users' first point of contact is the hospital. Therefore, 21.5% sought health care at a general hospital when they first experienced symptoms of mental illness.Around 29% sought health care from other health workers. Khiari, Ouali, Mrabet, and Nacef, (2019) collaborated this findings, in the first instance, 40.9% went to psychiatrists in general hospitals, private practices, and private hospitals. The study found that 19.0% of health users utilise the services of health facilities after the first health seeking is not effective. Therefore, 12.0% went to general private practitioners. Approximately, around 5.2% of health users utilised the services of a doctor in the public sector. Moreover, 30% utilised the services of doctors in PHC. Similarly, Lilhare, Pathak, Mathew and Subudhi (2020), found that about 82.1 % of caregivers in India utilized the services of the hospital when seeking mental health care for their family members. The study findings are contrary to the other studies done in the past. Caregivers in this previous studies reported that their first point of contact when seeking healthcare is alternative health care. Most participants in these study reported going to the hospital as a first point of contact.

- Subtheme 2.3 Health workers prioritise mentally ill patients as emergency patients

A study conducted in South Africa found that mental health users with severe mental illnesses were not prioritised when they consulted at the hospital. Mental health users queued for a long period of time. This caused mental health users to be agitated (Rooyen et al., 2019). In the present study, contrary to previous findings, some

caregivers reported that health care workers prioritise them when they consult at the hospital. It seems that triage system is not a normal practice. The introduction and practice of triage system may be one way of providing support for caregivers and lessening their anxiety when they are consulting with their family member at the health facility. According to Adeni and Mash, (2016) Health users perceived the triage system as being unfair. They complained that health workers were practicing favouritism and ensuring those they knew went to the front of the queue. They had no knowledge of the triage system. A study conducted in South Africa by Phukubye, Ntho, Muthelo, Mbombi, Bopape and Mothiba, (2023) found that health users had mixed perceptions of the triage system. Some found it to be helpful whereas others did not view the triage system as very helpful. It was viewed as being an unfair practice.A study by Büyükbayram and Engin (2018 found that emergency nurses did not practice triage system towards the patient, as they avoided them when they came to the facility.They were not trained adequately to deal with mentally ill patients when they came to the hospital. Health workers were afraid of the mentally ill patient.

5.2.3 Theme 3: Patterns of Health-seeking behaviour include modern, traditional, and spiritual care

The alternative practices that were used by caregivers who sought health care were modern, religious and traditional healing. This includes going to traditional healers, churches, and prophets. Most participants reported that they went to district hospitals. This indicates that participants can acknowledge the importance of health facilities in treatment of mental illness.

- Subtheme 3.1. District hospitals are used as a first point of contact for mental illness

According to Ratombo (2020), few caregivers utilized health facilities as a first point of contact when their family member has a mental illness.The current study found that most caregivers seek health care at the hospital when their family member starts having a mental illness. Despite cultural belief that mental illness is a result of supernatural forces, caregivers in this study first visited health facilities when their family members first started showing they had a mental illness. They visited health workers such as social workers, nurses, psychologists, and doctors. Key informant 1 also supported this statement that caregivers take their family members to health

facilities when they start having mental illnesses. These findings are supported by the findings by Raj, Das, Pattnaik, Das, and Ravan (2022), who found that a majority of caregivers' first point of contact when seeking health is health facilities. Around 66% sought the services of medical practitioners, 17% sought health from mental health workers, and 17% sought health from traditional healers. The findings of the study are in contradiction to most of the studies conducted in Africa, where people first go to traditional healers when their family members start having mental illnesses. A study conducted in South Africa, Kwazulu Natal by Labys, Susser, and Burns (2016) found that communities have different health-seeking methods, with the first point of contact being traditional healers. People utilise the services of traditional healers because of their accessibility. A study conducted in Northwestern China showed that 13 out of 21 respondents with mental illness went to general practitioners, 2 out of 21 sought helps from social workers or spiritual advisors, and 6 out of 21 sought helps from mental health workers (Liu, Chen, Ni, Yang, Huang, Liu, Wang & Yang, 2018).

- Subtheme 3.2 Traditional and spiritual health are sought as alternative health care practice.

In South Africa caregivers' first point of contact when seeking health is faith healers and traditional healers. Health care faclilites are sought as a second option (Ratombo, 2020). In the present study some of the participants consulted prophets, churches, and pastors. Religious and traditional practices provide support for participants. Religious leaders advise caregivers to seek health care from facilities.The belief system seems to encourage some of the caregivers to have trust and provides hope that the spiritual healing always bring forth healing of any form of sickness. The Key informant 3 reports that caregivers take their family members to religious healers when they first notice that their family member has a mental illness. This is consistent with the studies conducted by Muhorakeye and Biracyaza, (2021) in Rwanda, Kabutare District, where family caregivers consulted the churches when their family members started showing symptoms of mental illness. Churches seem to be a support system for family caregivers and their family members. One of the intervention methods used by family caregivers is praying for the person who has a mental illness. According to Asare and Danquah, (2017) health-seeking behaviour among caregivers in Ghana are western and traditional interventions. The Ghanaians prefer traditional medicine, spiritual healing, and western medication. Western interventions are less preferred than

traditional or faith-based interventions as they believe that mental illness is caused by supernatural forces such as spiritual attacks, witchcraft, God, demons, and Satan. Personal beliefs and knowledge of mental illness guide the health-seeking behaviour of individuals. The attribution of mental illness to supernatural forces makes people seek health from traditional alternatives (Shah, Wheeler, Sessions, Kuule, Agaba, & Merry 2017). Personal beliefs and knowledge of mental illness guide the health-seeking behaviours of caregivers. In these study a few caregivers used alternative health care as a first point of contact. This is in contrary to the literature reviewed. It seems that the health seeking behaviour of the community has changed.

- Subtheme 3.3 Social workers are used to access social grants and some personalised care.

A study conducted by Ndlovu & Mokwena, (2023) in S.A, Kwazulu Natal found that 77% of caregivers are receiving social grant for their family members who are diagnosed with mental illness. In the present study caregivers consult social workers when their family members started having mental illnesses to get recommendations for grant allocation. The social workers refer them to other health workers for further treatment. The participants have to be referred to different health care workers before their grant can be approved. Social grant seems to provide assistance for caregivers and their family member, as the family member with mental illness is unable to work. Similarly a study by Gericke, (2022) found that caregivers, residing in Western Cape, Stellenbosch were referred by other health workers to the social workers so that they may get additional services. Social workers were not their first point of contact when seeking health care. Letsie (2016) found that in South Africa, patients are assessed by the medical doctor first before they can receive the grant. About 39% of those who applied for the grant can get it quickly, while 61% take a long time to receive the grant. Other health care providers can not recommend a mentally ill patient for a grant, only medical doctors can do so. In South Africa those with mental illness receive social grant. This is based on Social Assistance Act no. 13 of 2004, which indicates that the mentally ill patients cannot generate income as they are mentally handicapped and therefore, after confirmation by the medical doctor, they qualify for grant (Government gazette, 2004). A study done in Northwestern China found that two out of twenty-one (2/21) health users sought health care from social workers when they experienced mental illness (Liu et al., 2018).

CHAPTER 6: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 Introductions

This chapter summarises the findings of the study, outlines the limitations, discusses the recommendations, and provides a conclusion to the study.

6.2 Conclusions

The objectives of the study were met. The study explored and explained health-seeking behaviours of caregivers for patients with mental illness at George Masebe Hospital. The study explored the mental health knowledge among caregivers of patients with mental illness at a hospital in Waterberg District, Limpopo Province.

6.2.1 Theme 1: Inadequate knowledge among caregivers regarding the mental illness of their family members.

The study found that caregivers lack knowledge of mental illness. Caregivers are unable to notice the symptoms of mental illness. They have no knowledge of the diagnoses of their family members. Due to a lack of knowledge, there is a delay in seeking health care and this creates interruptions in their treatment. The discussion and knowledge transfer between caregivers and health workers about mental illness was found to be minimal.

6.2.2 Theme 2 Easy access to District Hospitals as the first point of healthcare contact versus clinic services.

Caregivers commonly use district hospitals as their first point of contact. They bypassed clinics as their first point of contact when people get ill health, which is against the rule according to the Department of Health Referral System. The first point of contact for the community members when they are sick must be PHC institutions, commonly known as clinics. They serve as points of entry into the health care system of the country. The community must go to primary health for any health concerns they might have. They will receive the services that they require or will be referred to the

hospital if PHC is not equipped to deal with their health concerns (Department of Health, 2020).

6.2.3 Theme 3: Patterns of Health-seeking behaviour include modern, traditional, and spiritual care.

Caregivers use health facilities as a first point of contact when one of their family members has a mental illness. Only one caregiver sought the services of a traditional healer. Caregivers consulted social workers to receive grants for their family members who are affected by mental illness. When caregivers and the mentally ill patient get to the hospital, they are prioritised.

6.3 Limitations of the study

- The study was conducted in four locations. Participants gave their own experiences. Generalisations cannot be made about the health seeking of the caregivers locally or nationally.
- The caregivers were not found in the hospital, they had to be traced. Interviews were conducted at their homes instead of the hospital.
- Sample size was small, the findings cannot be generalised to the research population.
- One methodology was used to collect data. Triangulation could have yielded better results.
- There might have been biases of the researcher when collecting data.

6.4 Recommendations

Theme 1: Inadequate knowledge among caregivers regarding mental illness of their family members

- Department of Health should conduct awareness campaigns in the communities and health facilities to empower care givers regarding mental illness.
- Caregivers must get health education about mental illness and how to assist their family members who have mental illness.
- The Department of health should increase the number of psychiatric hospitals in different provinces so that they are easily accessible to people.

- The Department of Health should hire more mental health workers who will create awareness in the community and educate people about mental illness in the communities, schools, clinics, and hospitals.
- There should be monitoring and evaluation of mental health programs to ensure that the programs yield expected results. Public health officers must take lead and implement monitoring and evaluation for mental health programs in the hospitals.
- The department of health must conduct outreach campaigns about the dangers of not seeking health earlier for mental illness. They must teach the community about mental illness to create awareness of the signs and symptoms. Care givers should immediately take the patient to the health facilities when their family member shows signs and symptoms of mental illness..

Theme 2: Easy access to district hospital as the first point of contact versus clinic services.

- HCW should encourage caregivers who take patients to the hospital when they first come to the hospital.
- Nurses or emergency services personnel must be trained in triage. The triage system should be encouraged to ensure that mentally ill patients who need urgent assistance are attended to first.

Theme 3: Patterns of health-seeking behaviour include modern, traditional, and spiritual care.

- HCW should encourage caregivers who are not utilizing health facilities as a first point of contact to utilise them.

6.5 Conclusion

The study found that caregivers lack adequate knowledge of mental illness. Caregivers use district hospitals as their first point of contact instead of clinic services. Caregivers have different health-seeking methods, with the first point of contact being health facilities. Most caregivers used the services of faith healers as an alternative option. Only one caregiver confirmed using the services of the traditional healer.

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Appendix A: Map

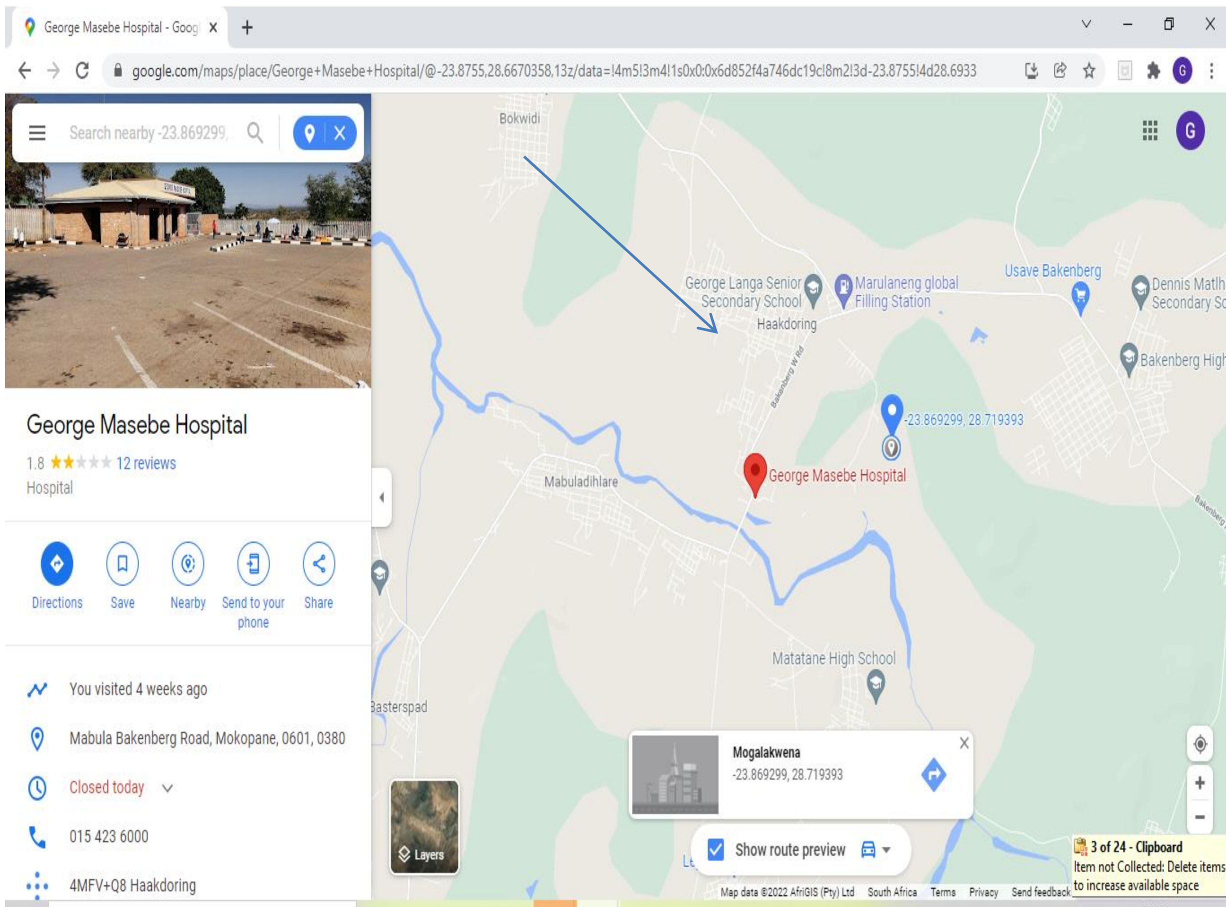

Figure 1: George Masebe hospital in Mabula village. Local map source. www.google.com/maps/place/George+Masebe+Hospital/@-23.8755,28.6670358,13z/data=!4m5!3m4!1s0x0:0x6d852f4a746dc19c!8m2!3d-23.8755!4d28.6933

Appendix B: Interview guide

BALOYI GRANNY SHALATE BALOYI

Department of public health

Faculty of health sciences

School of health care sciences

My name is Granny Shalate Baloyi. I am a master's student in public health student in the department of public health, University of Limpopo. Research study is part of my degree. Participation in the research study is voluntary.

Title of research: Health seeking behaviours among caregivers of with patients with mental illness at hospital Waterberg District, Limpopo province

SECTION A: BIBLIOGRAPHICAL INFORMATION

1. Identifier
2. Gender
3. Age
4. Ethnicity
5. Home Language
6. Level of education

SECTION B: HEALTH SEEKING BEHAVIOURS

Objectives

- To explore health seeking behaviours among caregivers of patients with mental disorders at a hospital in Waterberg District, Limpopo Province.
- To describe the health seeking behaviours among caregivers of patients with mental illness at a hospital in Waterberg District, Limpopo Province.

1. Central question: What is your health seeking behaviour as caregivers of patients?
2. What are the symptoms that you observed that prompted you to seek health for your family member?
3. When did your family member start having those symptoms/ when were they diagnosed?
4. Where did you take them when they started showing symptoms?
5. Which other alternative services did you use? Tell me about them
6. Which mental health facilities are there. How far do you have to travel to access the services?
7. How long did it take to seek health? What informed your decision to go there?

SECTION C: FACTORS AFFECTING HEALTH SEEKING BEHAVIOUR

Objective

- To explore the factors that influences health seeking among caregivers of patients with mental illness at a hospital in Waterberg District, Limpopo Province.

1. Tell me your view of health facilities.
2. Tell me your view of alternative practices
3. Tell me about the treatment people get from health facilities
4. Tell me about your experiences with health facilities before and after your family member was diagnosed
5. Before your family member diagnosed were you aware of the mental illness?
6. What do you know about other mental illnesses?
7. Tell me about other mental illness you know ?
8. What is you view of mental health workers?

Appendix B: (ii) Interview guide: Sepedi

BALOYI GRANNY SHALATE BALOYI

Department of public health

Faculty of health sciences

School of health care sciences

Lebitso laka ke Granny Shalate Baloyi. Ke tsena sekolo ko unibesithi ya Limpopo. Ke ithutela thuto godimo ewe e bitswago “mastese” wa “public health. Ke swanetse ke dire dinyakisiso gore ke fetse thuto godimo. Ke kgopela thuso ya gore o arabe dipotsiso tsewe ke nang le tsona. Ga o go gapeletse gore o arabe dipotsiso, o araba fela ge o ithaopile, ga o gapeletsiwe goba karolo ya . resetšhe.

Lebitso la nyakisiso: Ke magato afe batho ba leloko ba a tseyang ge o mongwe wa lekolo la bona a na le bolwetsi ba monagano?

KAROLO A: TSHEDIMOSO YA BAO BA ITHAOPILEGO GO TSENELA NYAKISISO

1. Nomoro ya moithopi
2. Bongwe
3. Ngwaga:
4. Mohlobo
5. Leleme la gae
6. Mafelelo a thuto

KAROLO A: MAGATO A BATHO BA A TSEYANG GORE BA HUMANE THUSO KA TSA MAPHELO

1 Potsišo Kgolo: Ke magato a fe awe o a tšeyang ge o mongwe wa lapa la gago a thoma go bontsha gore o lwala monaganong?
2 Mpotse gore o bone a dira eng, sa go šupetsa gore o na le bolwetsi bja monagano.
3 O thomile neng go bontsha gore o na le bolwetsi ba monagano? Ngaka e le boditse gore o na le bolwetsi bja monagano neng?
4 O mo isitše kae ge a thoma go bontsha gore o na le bolwetsi ba monagano?
5 O tseba ko gongwe ko batho ba go ba le bolwetsi ba monagano ba isiwago gona gore ba humane thuso? Mpotse ka gona
6 Ko o dulang gona, go na le diliniki, di ngaka goba dipetlele tse dingwe kowe le ka isang batho ba go ba le bolwetse ba monagano?
7 O tseere nako e kang go yo nyaka thuso? Mpotse gore o dirile ke eng gore o yo nyaka thuso kowe

KAROLO C: DILWANA TSA GO OKETSA MOTHO GORE A YO NYAKA THUSO KA TSA BOPHELO

1. Mpotse gore o nagana eng ka di kliniki le dipetlele
2. Mpotse gore o nagana eng ka mafelo a mangwe a we motho a ka kgopelang thuso go ona.
3. Mpotse ka mokgwa owe batho ba bangwe ba swariwang ka gona mo dikliniking le dipetlele
4. Mpotse ka mokgwa owe le tshwariwang ge leya dipetlele le dikliniking
5. Pele ga leloko la gago le ba le bolwetsi ba monagano ne o tseba eng ka bolwetsi ba monagano?
6. Mpotse o nagana eng ka babereki ba dipetlele le dikliniking.

Appendix B: (iii) Interview guide: Xitsonga

BALOYI GRANNY SHALATE BALOYI

Department of public health

Faculty of health sciences

School of health care sciences

Vito ra mina hi mina Granny Shalate Baloyi. Ndzi le ku yindleni ka ti dyondzo ta swa rihanyu ra machudeni. Ku endla vulavisisi hi swi n'wani swa leswi ndzi faneleke ku swi endla e ka digiri ya mina. Ku nghenelela e ka vulavisisi I ku tinyiketela.

Title of research: Ndzi lava kutiva kuri loko vanhu va dyangu ya wena vari na munhu loyi a nga na vuvabyi bya miehleketo va sungula va ya kwini loko va lava ku pfuneka hi swa vuvabyi bya miehleketo

XIYENGE XA A: VUXOKOXOKO VA MUNHU LOYI A NGENELELAKO KO EKA VULAVITISISI

1. Nambara ya xihondla
2. Rimbewu
3. Malembe
4. Rixaka
5. Ririmi ra manana
6. Tidyondzo le ti o ti fikeleleko

XIYENGE XA B: MAHANYELO YO LAVA RIHANYO

1. Xivutiso nkulu: "Xana hi wa hi mahanyelo yo lava rihanyo tani hi vahlayisi"?

2. Hlamusela swikoweto leswi endleke leswaku u lava rihanyo ra xirho xa ndyangu wa wena? Hlamusela hi ku enta mayelana na swirho swa ndyangu leswi karhatiwaka hi vuvabyi bya miehleketo.

3. Xana xirho xexo xa ndyangu xi sungule rini ku va na swikoweto sweswo? Va hlahluviwile rini?

4. Xana hi yihi ndhawu leyi u va yiseke kona loko va sungule ku va na swikoweto?

5. Hi swihi swin'wana swo lava ku pfuneka u nga swi tirhisa?

6. Hi tihi tindhawu ta vutshunguri bya swa miehleketo leti nga kona? Xana I mpfhuka wo tani hi kwini lowu u faneleke ku wu famba leswaku u ta kuma ku pfuneka?

7. Xana swi teke nkarhi wo tani hi kwini ku kuma mpfuneto wa swa rihanyo? Xana I ncini lexi xi nga endla leswaku u teka xiboho xo tano?

XIYENGE XA C: LESWI KAVANYETAKA KU KUMA MPFUNETO WA SWA RIHANYO

1. Hlamusela hi matitwelo ya wena hi tindhawu ta swa rihanyo?

2. Hlamusela hi matitwelo ya wena hi tindlela tin'wani to lava ku pfuneka?

3. Hlamusela hi wa hi makhomeriwelo ya vanhu eka tindhawu ta vutshunguri?

4. Hlamusela hi ntokoto lowu inga hlangana na wona eka tindhawu ta swa vutshunguri, loko xirho xa ndyangu wa wena xi nga se hlahluviwa/endzhaku ka ku hlahluviwa.

5. Loko xirho xa ndyangu xi nga se hlahluviwa a wu ri na vutivi hi vuvabyi bya miehleketo?

6. U tiva yini hi vuvabyi byin'wana bya miehleketo?

7. Hlamusela hi vuvabyi byin'wana bya miehleketo lebyi u byi tivaka?

Appendix B: (IV) Interview guide: Facility Manager

BALOYI GRANNY SHALATE BALOYI

Department of public health

Faculty of health sciences

School of health care sciences

My name is Granny Shalate Baloyi. I am a master in public health student in the department of public health, University of Limpopo. Research study is part of my degree. Participation in the research study is voluntary.

Title of research: Health seeking behaviours among caregivers of with patients with mental illness at hospital Waterberg District, Limpopo province

SECTION A: BIBLIOGRAPHICAL INFORMATION

1. Identifier
2. Gender
3. Age
4. Ethnicity
5. Home Language
6. Level of education

SECTION B: HEALTH SEEKING BEHAVIOURS AND FACTORS AFFECTING HEALTH SEEKING

Objectives

- To explore health seeking behaviours among caregivers of patients with mental disorders at a hospital in Waterberg District, Limpopo Province.
- To describe the health seeking behaviours among caregivers of patients with mental illness at a hospital in Waterberg District, Limpopo Province.
- To explore the factors that influences health seeking among caregivers of patients with mental illness at a hospital in Waterberg District, Limpopo Province.

8. Central question: What are health seeking behaviour of caregivers?
   I am interested in hearing about your experience about health seeking of caregivers of patients experiencing mental illness, through working in the hospital
9. Tell me about the experience you had of caregivers' health seeking
10. What are the consequences of delaying to take the patient
11. Is the hospital equipped with necessary resources to take care of mentally ill patients.

12. Tell me about the medical treatment people get from health facilities
13. Tell me about the attitude of caregivers when it comes to mental illness
14. Tell me about cases where people have defaulted

Appendix B: (V) Interview guide: English: Faithhealer/Traditionalhealer

BALOYI GRANNY SHALATE BALOYI

Department of public health

Faculty of health sciences

School of health care sciences

My name is Granny Shalate Baloyi. I am a master's in public health student in the department of public health, University of Limpopo. Research study is part of my degree. Participation in the research study is voluntary.

Title of research: Health seeking behaviours among caregivers of with patients with mental illness at hospital Waterberg District, Limpopo province

SECTION A: BIBLIOGRAPHICAL INFORMATION

1. Identifier
2. Gender
3. Age
4. Ethnicity
5. Home Language
6. Level of education

SECTION B: HEALTH SEEKING BEHAVIOURS

Objectives

- To explore health seeking behaviours among caregivers of patients with mental disorders at a hospital in Waterberg District, Limpopo Province.
- To describe the health seeking behaviours among caregivers of patients with mental illness at a hospital in Waterberg District, Limpopo Province.

15. Central question: What is the health seeking behaviour of caregivers?
    I am interested to know about your experience in this area as a faith healer/traditional healer/health facility manager
16. What are the symptoms that you observed that prompted people to seek health from you?
17. When caregivers explain to you, How long did they take to consult after the patients symptoms have started.
18. Where did they take them when they started showing symptoms?
19. Which other alternative services did they report they used? Tell me about them
20. Which mental health facilities are there? How far do you have to travel to access the services?
21. What informed their decision to go there?

SECTION C: FACTORS AFFECTING HEALTH SEEKING BEHAVIOUR

Objective

- To explore the factors that influences health seeking among caregivers of patients with mental illness at a hospital in Waterberg District, Limpopo Province.

9. Tell me your view of health facilities./Tell me the importance of mental health workers as a first point of contact
10. Tell me your view of alternative practices
11. Tell me about the treatment people get from health facilities
12. Tell me about your experiences with health facilities before and after your family member was diagnosed/Tell me about their attitude after the come to the health facilities. Tell me about the adherence treatment
13. When did start becoming aware of mental illness? Tell me about mental ilnesses
14. What do you know about other mental illnesses?
15. Tell me about other mental illness you know ?
16. What is you view of mental health workers?/what is the role of mental health workers in the hospital

Appendix B :(VI) Interview guide: Sepedi:Faith healer/Traditional healer

BALOYI GRANNY SHALATE BALOYI

Department of public health

Faculty of health sciences

School of health care sciences

Lebitso laka ke Granny Shalate Baloyi. Ke tsena sekolo ko unibesithi ya Limpopo. Ke ithutela thuto godimo ewe e bitswago “mastese” wa “public health. Ke swanetse ke dire dinyakisiso gore ke fetse thuto godimo. Ke kgopela thuso ya gore o arabe dipotsiso tsewe ke nang le tsona. Ga o go gapeletse gore o arabe dipotsiso, o araba fela ge o ithaopile, ga o gapeletsiwe goba karolo ya . resetšhe.

Lebitso la nyakisiso: Ke magato afe batho ba leloko ba a tseyang ge o mongwe wa lekolo la bona a na le bolwetsi ba monagano?

KAROLO A: TSHEDIMOSO YA BAO BA ITHAOPILEGO GO TSENELA NYAKISISO

1. Nomoro ya moithopi
2. Bongwe
3. Ngwaga:
4. Mohlobo
5. Leleme la gae
6. Mafelelo a thuto

KAROLO A: MAGATO A BATHO BA A TSEYANG GORE BA HUMANE THUSO KA TSA MAPHELO

8 Potsišo Kgolo: Ke magato a fe awe o a tšeiwang ke batho ge ba thoma go bontsha gore ba na le bolwetsi ba monaganong?
Ke na le kgahlego ya go tseba ka botsebi ba gago ka ga magato a batho ba a tseyang ge ba thoma goba le bolwetsi ba monagano
9 Mpotse gore o bone molwetsi a dira eng, sa go šupetsa gore o na le bolwetsi ba monagano.
10 Go ya le ka lapa la balwetsi, ba tsea nako e kae go tlisa balwetsi go wena ka morago wa gore ba thome go bontsha gore ba na le bolwetsi ba monagano
11 Ba lapa bare ba mo isitše kae ge a thoma go bontsha gore o na le bolwetsi ba monagano?
12 O tseba ko gongwe ko batho ba go ba le bolwetsi ba monagano ba isiwago gona gore ba humane thuso? Mpotse ka gona
13 Ko o dulang gona, go na le diliniki, di ngaka goba dipetlele tse dingwe kowe le ka isang batho ba go ba le bolwetse ba monagano?
14 Mpotse gore bare ba dirile ke eng gore ba yo nyaka thuso kowe

KAROLO C: DILWANA TSA GO OKETSA MOTHO GORE A YO NYAKA THUSO KA TSA BOPHELO

7. Mpotse gore o nagana eng ka di kliniki le dipetlele
8. Mpotse gore o nagana eng ka mafelo a mangwe a we motho a ka kgopelang thuso go ona.
9. Mpotse ka mokgwa owe batho ba bangwe ba swariwang ka gona mo dikliniking le dipetlele
10. Mpotse ka mokgwa owe batho ba tshwariwang ge baya dipetlele le dikliniking
11. Mpotse gore o thomile go tseba neng ka bolwetsi ba monagano?
12. Mpotse o nagana eng ka babereki ba dipetlele le dikliniking.
13. Mpotse ka malwetsi a monagano a mangwe awe o a tsebang
14. O nagana eng ka babereki ba go thusa batho bawe ba nang le bolwetsi ba monagano

Appendix B: (VI) Interview guide: Xitsonga:Faith Healer/Traditional Healer

BALOYI GRANNY SHALATE BALOYI

Department of public health

Faculty of health sciences

School of health care sciences

Vito ra mina hi mina Granny Shalate Baloyi. Ndzi le ku yindleni ka ti dyondzo ta swa rihanyu ra machudeni. Ku endla vulavisisi hi swi n'wani swa leswi ndzi faneleke ku swi endla e ka digiri ya mina. Ku nghenelela e ka vulavisisi I ku tinyiketela.

Nhloko mhaka ya ndzavisiso: Ndzi lava kutiva kuri loko vanhu va dyangu vari na munhu loyi a nga na vuvabyi bya miehleketo va sungula va ya kwini loko va lava ku pfuneka hi swa vuvabyi bya miehleketo

XIYENGE XA A: VUXOKOXOKO VA MUNHU LOYI A NGENELELAKO KO EKA VULAVITISISI

1. Nambara ya xihondla

2. Rimbewu

3. Malembe

4. Rixaka

5. Ririmi ra manana

6. Tidyondzo le ti o ti fikeleleko

XIYENGE XA B: MAHANYELO YO LAVA RIHANYO

1. Xivutiso nkulu: "Xana hi wa hi mahanyelo yo lava rihanyo tani hi vahlayisi"?

Ni lava ku tiva hi vutivi lebyi o riku na vona hi swa vuvabyi bya miehleketo

2. Hlamusela swikoweto leswi endleke leswaku va ndyangu va lava mpfuno e ka wena?

3. Loko va hlamusela vari vat eke nkari ngaki ku lava mpfuno.

4. Xana hi yihi ndhawu leyi va yaka a ka yona loko va sungule ku va na swikoweto?

5. Hi swihi swin'wana swo lava ku pfuneka u nga swi tirhisa?

6. Hi tihi tindhawu ta vutshunguri bya swa miehleketo leti nga kona? Xana I mpfhuka wo tani hi kwini lowu u faneleke ku wu famba leswaku u ta kuma ku pfuneka?

7. Hi ncini lexi xi nga endla leswaku va lava pfuno kwa leno?

XIYENGE XA C: LESWI KAVANYETAKA KU KUMA MPFUNETO WA SWA RIHANYO

1. Hlamusela hi matitwelo ya wena hi tindhawu ta swa rihanyo?

2. Hlamusela hi matitwelo ya wena hi tindlela tin'wani to lava ku pfuneka?

3. Hlamusela hi wa hi makhomeriwelo ya vanhu eka tindhawu ta vutshunguri?

4. Hlamusela hi ntokoto lowu inga hlangana na wona eka tindhawu ta swa vutshunguri

5. Loko xirho xa ndyangu xi nga se hlahluviwa a wu ri na vutivi+ hi vuvabyi bya miehleketo?

6. U tiva yini hi vuvabyi byin'wana bya miehleketo?

7. Hlamusela hi vuvabyi byin'wana bya miehleketo lebyi u byi tivaka?

8. Xana hi wahi mavonelo ya wena hi vatirhi va swa vuvabyi bya miehleketo

Appendix C: Limpopo Department of Health: Letter for permission

APPLICATION LETTER FOR PERMISSION TO CONDUCT RESEARCH

P.O BOX 10064

Bakenberg

0611

Limpopo Department of health

Private Bag X9302

0700

Dear Sir/madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I hereby request permission to conduct research at Waterberg District hospital. I am doing master's in public health at the University of Limpopo. The title of my study is Health seeking behaviours among caregivers of patients with mental illness at George Masebe hospital, Limpopo province. My supervisor is Dr TJ Mashamba.

I undertake to abide by the rules and regulations to ensure ethical adherence

I hope my request will be considered

Yours faithfully

Baloyi G.S

Appendix D1: Letter of consent for participants

LETTER OF CONSENT FOR PARTICIPANTS

PARTICIPANTS IN RESEARCH

Dear participant

I, Granny Shalate Baloyi request your participation in my study. The study is about health seeking behaviours among caregivers of patients with a mental illness. Participation is voluntary and you have the right to decline participation at any time before and at any time during the process of interview. Your name will not be in the interview guide. Your identity will be protected. The interview will take 1-2 hours.

Thank you

RESEARCHER SIGNATURE…………………

DATE……………………

CAREGIVER'S CONSENT TO BE INTERVIEWED

I…………………………………….. (Spouse, parent, grandparent, adult child brother or sister) agree and volunteer to participate in this research. The purpose of the study has been explained to me.

CAREGIVER'S SIGNATURE

DATE…………………..

Appendix D2: Sepedi letter of consent for participants

LENGWALO LA TUMELO YA GO TSENELA NYAKISISO KA BA LAPA LA MOLWETSI

Thobela

Nna, Granny Shalate Baloyi ke kgopela gore o nthuse ka dinyakisiso tsaka tsa sekolo. Ke kgopela go go butsisa diputsiso ka ga leloko la gago. Leina la nyakisiso: Ke magato afe batho ba leloko ba a tseyang ge o mongwe wa lekolo la bona a na le bolwetsi ba monagano?Ga o gapeletswe go tsenela nyakisiso ena, o ka gana go tsenela ge o nyaka , goba wa emisa ka nako e nngwe le e nngwe. Re tlo tsea iri e tee goya go tse pedi.

Ka leboga

MOSAYENO WA MONYAKISISWA…………………

LETSATSI……………………

TUMELELO YA BA LAPA GO TSENELELA MO NYAKISISONG

Nna…………………………………….. (Molekani,motswadi,koko/rakgolo,Ngwana wa molwetsi yo mogolo, buti/sesi) Ke dumela go tsenelela nyakisiso ye. Ba nhlaluseditse moholwa wa nyakisiso.

MOSAYENO MUTSENELLI

LETSATSI…………………..

Appendix D3: Xitsonga letter of consent for participants

RITSALO FOMO RA MPFUMELELO YA MUNGENELERI

Avuxeni

Mina, Granny Shalate Baloyi ni kombela ku pfuniwa hi vulavisisi. Nhloko mhaka ya ndzavisiso: Ndzi lava kutiva kuri loko vanhu va dyangu vari na munhu loyi a nga na vuvabyi bya miehleketo va sungula va ya kwini loko va lava ku pfuneka hi swa vuvabyi bya miehleketo.Ndza swi twisisa leswaku ku nghenelela eka ndzavisiso lowu iku tsakela ka mina.Naswona dzi nga tihumesa eka swona nkari wun'wana na wun'wana handle ko hlamusela ku hikwalaho ka yini. Vito ra wena ringake ri humelerisiwe ka van'wana

Ndza Khensa

NSAYINO YA MULAVISISI…………………

SIKU……………………

MFUMELO WA NDYANGO KO NGHENELELA EKA VULAVISISI

Mina…………………………………….. (nsati/nuna, mutswari, nwana nkulu, sesi/) Ni pfumela ku ngenelela e ka ndzavisiso lowu.Ni hlamuseriwile hi ndzavisiso lowu.Na twisisa kuri wu vulavula hi yini.

NSAYINO YA MUNGHENELERI

SIKU…………………..

Appendix D4: Letter of consent for facility manager

LETTER OF CONSENT FOR PARTICIPANTS

PARTICIPANTS IN RESEARCH

Dear participant

I, Granny Shalate Baloyi request your participation in my study. The study is about health seeking behaviours among caregivers of patients with a mental illness. Participation is voluntary and you have the right to decline participation at any time before and at any time during the process of interview. Your name will not be in the interview guide. Your identity will be protected. The interview will take 30-60 minutes.

Thank you

RESEARCHER SIGNATURE…………………

DATE……………………

FACILITY MANAGER'S CONSENT TO BE INTERVIEWED

I…………………………………….. (Facility manager) agree and volunteer to participate in this research. The purpose of the study has been explained to me.

FACILITY MANAGERS'S SIGNATURE

DATE…………………..

Appendix D5: Sepedi Letter of consent of faith healers/Traditional healers

LENGWALO LA TUMELO YA GO TSENELA NYAKISISO KA NGAKA/MORUTI/MOPOROFETA

Thobela

Nna, Granny Shalate Baloyi ke kgopela gore o nthuse ka dinyakisiso tsaka tsa sekolo. Ke kgopela go go butsisa diputsiso ka ga leloko la gago. Leina la nyakisiso: Ke magato afe batho ba leloko ba a tseyang ge o mongwe wa lekolo la bona a na le bolwetsi ba monagano?Ga o gapeletswe go tsenela nyakisiso ena, o ka gana go tsenela ge o nyaka , goba wa emisa ka nako e nngwe le e nngwe. Re tlo tseya metsotso e 30 goya e 60.

Ka leboga

MOSAYENO WA MONYAKISISWA…………………

LETSATSI……………………

TUMELELO YA NGAKA/MOPOROFETA/MORUTI

Nna…………………………………….. (moruti/moporofeta/ngaka) Ke dumela go tsenelela nyakisiso ye. Ba nhlaluseditse moholwa wa nyakisiso.

MOSAYENO WA MUTSENELLI

LETSATSI…………………..

Appendix D6: Xitsonga letter of consent for Traditional healers/faith healers

RITSALO FOMO RA MPFUMELELO YA MUNGENELERI

Avuxeni

Mina, Granny Shalate Baloyi ni kombela ku pfuniwa hi vulavisisi. Nhloko mhaka ya ndzavisiso: Ndzi lava kutiva kuri loko vanhu va dyangu vari na munhu loyi a nga na vuvabyi bya miehleketo va sungula va ya kwini loko va lava ku pfuneka hi swa vuvabyi bya miehleketo.Ndza swi twisisa leswaku ku nghenelela eka ndzavisiso lowu iku tsakela ka mina.Naswona dzi nga tihumesa eka swona nkari wun'wana na wun'wana handle ko hlamusela ku hikwalaho ka yini. Vito ra wena ringake ri humelerisiwe ka van'wana

Ndza Khensa

NSAYINO YA MULAVISISI…………………

SIKU……………………

MFUMELO WA MFUNDISI/N'ANGA KO NGHENELELA EKA VULAVISISI

Mina…………………………………….. (Mfundisi/n'anga) Ni pfumela ku ngenelela e ka ndzavisiso lowu.Ni hlamuseriwile hi ndzavisiso lowu.Na twisisa kuri wu vulavula hi yini.

NSAYINO YA MUNGHENELERI

SIKU…………………..

Appendix E1: Letter of assent form for patients

ASSENT FROM PATIENTS

Dear Patient

I, Granny Shalate Baloyi request your consent to discuss your personal information. The study is about health seeking behaviours among caregivers of patients with a mental illness. This is a voluntary and you have the right to decline that your information be shared at any time before the interview and during the process of interview. The interview will take 1-2 hours.

Thank you

RESEARCHER SIGNATURE…………………

DATE……………………

PATIENT'S CONSENT FOR INTERVIEW

I……………………………………..allow my caregiver to discuss my circumstances with the researcher

PATIENT SIGNATURE

DATE…………………..

Appendix E2: Xitsonga letter of assent for patients

RITSALO FOMO RA MPFUMELELO RA MUBABYI

Avuxeni

Mina, Granny Shalate Baloyi ni kombela ku pfuniwa hi vulavisisi. Ni kombela ku vutisa va ndyango ya wena swivutiso hi wena. Nhloko mhaka ya ndzavisiso: Mfambelo ya rihanyo ra dyango ra mhunu lowo a nga na vuvabyi bya miehleketo.Ndza swi twisisa leswaku ku nghenelela eka ndzavisiso lowu iku tsakela ka mina.Naswona dzi nga tihumesa eka swona nkari wun'wana na wun'wana handle ko hlamusela ku hikwalaho ka yini.

Ndza Khensa

NSAYINO YA MULAVISISI…………………

SIKU……………………

MFUMELO WA MUBABYI KO NGHENELELA EKA VULAVISISI

Mina…………………………………….. Ni pfumela kuri ndyango wa mina o ngenelela e ka ndzavisiso lowu.Ni hlamuseriwile hi ndzavisiso lowu.Na twisisa kuri wu vulavula hi yini.

NSAYINO YA MUBABYI

SIKU…………………..

Appendix E3: Sepedi letter of assent for patients

LENGWALO LA TUMELO YA GO TSENELA NYAKISISO LA MOLWETSI

LENGWALO LA TUMELO YA GO TSENELA NYAKISISO

Thobela

Nna, Granny Shalate Baloyi ke kgopela gore o nthuse ka dinyakisiso tsaka tsa sekolo. Ke kgopela go butsisa ba lapa la gago dipotsiso ka ga wena. Leina la nyakisiso: Ke magato afe batho ba leloko ba a tseyang ge o mongwe wa lekolo la bona a na le bolwetsi ba monagano?Ga o gapeletswe go tsenela nyakisiso ena.O na le toka ya go gana gore ba arabe dipotsiso ka ga wena. O ka emisa ka nako e nngwe le e nngwe ge o kwa gore ga o rate ko dipotsiso di yago gona. Leina la gago le kase ngwadiwe. Ke tlo dira gore go sa tsebega gore ke mang a arabileng dipotsiso. Re tlo tsea iri e tee goya go tse pedi.

Ka leboga

MOSAYENO WA MONYAKISISWA…………………

LETSATSI……………………

TUMELELO YA BA LAPA GO TSENELELA MO NYAKISISONG

Nna…………………………………….. Ke dumela gore ba lapa laka ba tsenelele nyakisiso ye. Ba nhlaluseditse moholwa wa nyakisiso.

MOSAYENO MOLWETSI

LETSATSI…………………..

Appendix F: Hospital letter of permission

P.O BOX 10064

Bakenberg

0611

George Masebe Hospital

Private Bag X2201

Suswe

0612

Dear Sir/Madam

I am currently doing my master's in public health at the University of Limpopo. I am requesting permission to conduct the study at George Masebe hospital. The title of my study is: Health seeking behaviours among caregivers of patients with mental illness at George Masebe hospital, Waterberg District, Limpopo province.

Attached please find my research proposal for the study and consent form.

I hope my request will be considered

Yours faithfully

Baloyi G.S

Appendix G: Gantt chart

Appendix H: Trec letter

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 4713, Fax: (015) 268 2306, Email: moore.hutamo@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE

ETHICS CLEARANCE CERTIFICATE

MEETING: 09 JANUARY 2023

PROJECT NUMBER: TREC/42/2023: PG

PROJECT:

Title:	Health Seeking Behaviours among Caregivers of Patients with Mental Illness at a Hospital in Waterberg District, Limpopo Province.
Researcher:	GS Baloyi
Supervisor:	Dr TJ Mashamba
Co-Supervisor/s:	N/A
School:	Health Care Sciences
Degree:	Master of Public Health

PROF D MAPOSA
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) **This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.**

ii) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.**

iii) **PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.**

Finding solutions for Africa

Appendix I: Department of Health permission letter

LIMPOPO

PROVINCIAL GOVERNMENT

REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF

HEALTH

WATERBERG DISTRICT

ENQ: RAMALIVHANA M.C
EMAIL: Mukhethwa.Ramalivhana@dhsd.limpopo.gov.za
TEL: 014 718 0623

TO: BALOYI GRANNY SHALATE

RE: PERMISSION TO CONDUCT RESEARCH: YOURSELF.

The above bear's reference:

1. The office of the District Executive Manager, hereby confirm receipt of your request to conduct research on Health Seeking Behaviours among Caregivers of Patients with Mental Illness at Hospital in Waterberg District , Limpopo Province.

2. Permission is hereby granted as per approval by the acting HOD.

3. You are further requested to notify this office on when you are going to start with the research and make sure that there is no action that disturbs service delivery.

4. This permission is **Only for George Masebe Hospital at Waterberg District.**

5. The approval is only valid for a 1-year period.

6. If the proposal has been amended, a new approval should be sought from the Department of Health.

7. Kindly note that, the Department can withdraw the approval at any time.

Your support and cooperation in terms of the above will be highly appreciated.

______________________________ 29/03/2023
Ms. Bulannga N.G **DATE**
DISTRICT EXECUTIVE MANAGER

100 Nelson Mandela Drive & Thabo Mbeki Street Modimolle 0510, Private Bag X 1026 Modimolle 0510 Tel: 014 718 0600. Fax: 014 718 0675 Website: www.doh.limpopo.gov.za

APPENDIX J: CODING CERTIFICATE

Coding Report

For: Baloyi Granny Shalate

Research Topic: HEALTH SEEKING BEHAVIOURS AMONG CAREGIVERS OF PATIENTS WITH MENTAL ILLNESS AT HOSPITAL IN WATERBERG DISTRICT, LIMPOPO PROVINCE

By: **Prof . PM** Mamogobo

Date: 2023/08/ 31

The method used for data analysis:

The coding and further analysis of the transcripts of verbatim conversations that the principal investigator coded and found were further analyzed by the independent coder/intercoder using the Tesch data analysis method as indicated by Creswell (2009) that integrates the Tesch approach as a method of data analysis, and also as described in Botma, Greef, Mulaudzi, and Wright (2010).

Related to the role of an independent coder/ intercoder, the principal investigator transcribed verbatim individual one-to-one interviews including typing up field notes. The principal investigator subsequently forwarded digitally recorded data, including transcribed scripts of individual participants for the independent coder to analyse and reflect on study findings independently. Once the independent coder has coded the verbatim data and completed the coding and organization of data, the independent coding was shared with the principal investigator to compare and share similarities and differences between themes and sub-themes.

- The independent coder first read through each transcript to get a sense of the whole, writing down ideas as they come to mind on the margins of each transcribed transcript.
- The independent coder then picked up one of the transcribed interesting transcripts from the pile previously read, to carefully read through the

transcript to make sense of the meaning of the information shared by study participants. The independent coder continued to write down the meaning derived from the transcript on the margins of each transcript.

- The independent coder wrote down a list of topics based on information obtained from collected data to group similar topics together in columns of either major topics, unique topics, or those that could be classified as leftovers.
- The independent coder further went back to the transcribed verbatim transcripts with topics written in columns and organized them into codes also writing these codes next to the segments of the transcribed text wording related to the phenomenon under study. The independent coder then circled and highlighted significant words emanating from the data shared by study participants. The independent coder also tried to find wording that best describes what the study participants shared, so that the underlying messages of portrayed data may become clearer. The independent coder then drew lines between the categories to show the interrelationship between these categories.
- The independent coder then made a final decision on each category including writing the categories.
- The independent coder assembled each group of coded segments belonging to designated categories and started performing an analysis of the collected data.
- The independent coder continued to recode the existing data as the need arose during the analysis of data, also with a one-to-one consultation with the principal investigator to be able to be able to reach a consensus.

The following are the Themes and sub-themes that were derived from the excerpts of one-to-one interviews and human stories shared by individual study participants, based on their experiences related to the phenomenon under study.

Theme	Subtheme
Theme 1. Caregivers have poor knowledge of primary care and signs of	5.2 Caregivers lack knowledge of early signs of mental illness. 5.3 Family members unable to share

mental Illness.	and disclose individual mental illness and necessary care required. 5.4 Poor knowledge results in a delay of appropriate care interrupts treatment and leads to and relapse of mental health care users. 5.5 Minimal discussion between healthcare workers and caregivers on the actual nature of the mental illness to cope with the necessary care 5.6 Caregivers use traditional and spiritual healers to establish supernatural causes of individual mental illness.
Theme 2: District Hospitals easily accessible as the first point of healthcare versus clinic services	2.1 Clinic-based services are not visible for caregivers to use for consultations. 2.2 Caregivers predominantly use district hospitals to access treatment and needed emergency care. 2.3 The triage process used in the hospital to prioritize violent patients makes it easier for caregivers to be assisted without stigma
Theme 3: Patterns of health-seeking behaviour include both modern, traditional, and spiritual care	3.1 Caregivers consult in the hospital to calm the violent patient and encourage adherence to treatment 3.2 Once calm traditional and spiritual are sought. 3.3 Social workers used to access social

grants and some personalized care

Verbatium transcript No 08

RECORDING NO 08

Age: 72 years

Gender: Female

Duration: 21:52

Researcher: My name is Granny Shalate Baloyi I am asking that you help me with my research. The name of the research: I want to know what are the steps that you take to get help when your family member has a mental illness. I want to know when your family member has a mental illness, where do you first go?

Participant: We went to the hospital.

Researcher: We will go to that I still have to explain. I understand that my participation is voluntary. This one is explaining that you agreeing to participate you are not forced to participate. I can stop anytime when I am not feeling comfortable. Your name will be kept confidential. This means that after we done with our conversation I wont write that you the one who talked to me. I will just write your name on the agreement form only to show that you spoke to me only

Participant: Yes

Researcher: The form shows that you spoke to me, and you agreed to speak to me. Can you please sign here for me

Participant: where do I sign

Researcher: Can you write

Participant: Yes I can write. But I won’t write all of it

Researcher: Yes, You just sign

Researcher: The first question is what the health are seeking behaviour a caregiver. Where do you go when your family member start showing they have a mental illness? Where did you first go?

Participant: I took him to the ..hospital

Researcher: You took him to the hospital

Participant: Yes

Researcher: The hospital only

Participant: Yes the hospital only

Researcher: You didn't take him elsewhere?

Participant: I went to our church

Researcher: Which church

Participant: ZCC

Researcher: He is your child

Participant: Yes, He was a twin with another, a girl. but the girl died 2 days after birth. My family were not considering it. They were old fashioned people. I don't understand what is going on. When they buried him they didn't take the one who is alive and put him on the grave or find a traditional healer to perform ritual. While I was sleeping they buried the baby in the yard. I cannot show you where they buried the baby. This because they cleaned up and no evidence of the burial was left.

Researcher: Yes

Participant: Then this child grew…While doing his studies…He would turn his back from the chalkboard he continued doing that till standard four. They called me at school and told me that your child when we speak to him he doesn't listen. When others write he looks the other way. He didn't want to sit with others he wanted to sit

alone. When I consulted with spiritual people. They told me that no ritual was done so when he is sitting he thinks of his deceased twin.

Researcher: mmh

Participant: yes. He still thinks of his deceased twin. We should be patient with him. I then went to school I explained to them that he had a twin they shouldn't be surprised when he likes sitting alone and doesn't understand when you talk to him. They understood me. And time went by. The other time when I was with him in Johannesburg. He left and came back home to Limpopo?

Researcher: How did he come back

Participant: When his uncle's gave him money he was saving it so that he can come back home

Researcher: To come back home.

Participant: Yes to come back home. One day when I woke up, I saw him leaving. I didn't think much of it because he always went to the shops he will come back. I saw it was getting dark and he was not coming back. I started calling relatives. I told them he hasn't come back home since leaving in the morning. My older daughter then called neighbours back home and asked them who is at our home. Then they told her they are seeing her younger brother he is walking around. Then she called me and told me that he is at home.

Then the next morning I came back home and asked him why he left. He told me he wanted to come back home. Then I asked him why he didn't tell me. He told me that he didn't want to bother me. That thing bothered me, and I no longer enjoyed my job then I came retired early in 2012. I saw that he was too much, sometimes he speaks when I am with him, sometimes he doesn't speak. Sometimes he eats sometimes he doesn't eat. He wants to just roam around. I thought this thing of him always roaming around will lead to people killing him. Then I had a thought and took him to the hospital. Then I told them. Then they examined him. They said he will be seen by the doctor.

Researcher: What did the doctor say

Participant: He asked his who his mother is, and he told him, Who is your father and he said he don't know. Sometimes when they asked him questions he responded sometimes he said he doesn't know those things. Then we took him to a psychologist. The psychologist also asked a lot of questions. Some he knew. Some he didn't know. Then the doctor asked where the child was born. Then I told him he was born at that hospital. Then doctor ££££ asked me what they gave him when he got home. I told him they didn't do anything to him. He told me the problem started there

Researcher: Who was saying that

Participant: Huh?

Researcher: Was it Dr £££££?

Participant: It was doctor £££££ while he was still in the hospital.

Researcher: mmh

Participant: Yes then he told me to take him and apply disability grant for him. Because the way he is he won't be okay. And he is not okay. Sometimes he wakes up and speaks alone. He speaks alone too much

Researcher: He speaks alone?

Participant: Too much. And because we are used to him we don't respond to him when he speaks. The day when he is better is better. Yes…sometimes he drinks pills sometimes he doesn't

Researcher: mmmh

Participant: When he is angry we leave him alone. There are days when he gets very angry we don't respond to him. We keep quiet

Researcher: What did you see that showed you he has a mental illness

Participant: We saw things he was doing which we were not understanding where they stem from

Researcher: mmh

Participant: Yes…you see

Researcher: mmh. When did he start showing he has a mental illness

Participant: in 2012 he had it but we didn't think it's a mental illness. When he was doing things we would get angry at him. I started noticing when I was staying with him that something is not right.

Researcher: What did the Doctor say was the name of the mental illness?

Participant: He just said that he was mentally ill. This child was mentally ill. And he said that if she were another person she would sue the hospital. Because after she gave birth to twins the hospital should have done something to him. And he asked what they did to him. Then I said nothing. He said they are wrong they should have done something to him. This something I don't know what it is. He is a doctor he knows. He didn't explain.

Researcher: mmh

Participant: He said you can sue us.

Researcher: mmh

Participant: Then I kept quiet. Then he said yourself if you want you can sue us because you gave birth to this child here and they gave him to you in that condition and they didn't check what. He knows what they were supposed to check on him. He said they were supposed to check his mental state. To see if he was fine. So, they didn't check him.

Researcher: Where did you first take him when he showed he had a mental illness

Participant: I took him to the hospital; he was seen by psychologists in the hospital. Then they gave him papers. You know when he gets to them they give him papers to write. To see if he can write. A person who deals with mental illness and another…Yes I took him here. They told me to leave. I left and they remained with him there. Yes

Researcher: Do you know any other place where people with mental illness are taken when they start having a mental illness

Participant: I don't know…I didn't take him anywhere. I took him to my church. And they told me that child is ill. He is an ill person.

Researcher: At church what are they saying is the cause

Participant: They said according to your tradition they should have cured him. Yes and they didn't do that. They said to him if you knew where the other twin was buried you will make him sleep on the grave. Then wake him up after. Then I said I don't know where the baby was buried because I was in the house sleeping.

Researcher: What do you think caused the mental illness?

Participant: I don't know what caused it because when I gave birth to him at 9 months. It was time for me to give birth

Researcher: mmmh

Participant: Yes, in 1982

Researcher: Okay…I don't remember if I asked. Its saying what do you know of other places people go to when their family member has a mental illness.

Participant: I didn't take him anywhere. I only took him to the church we went. Then I took him to the hospital so that they can explain to me. That's where people are taken. I never took him to traditional healers. But my custom is my custom. At church they told me to go and buy a goat and do a sacrificial ritual for him. And we did that. We did the ritual. When they did the ritual he was not speaking.

Researcher: They told you to do the ritual at church

Participant: Yes. They told us to do the ritual. When we did the ritual he was not speaking. There was a time he couldn't speak. When the time was exactly 10 o'clock he would stop speaking he would speak at 12 o'clock again. He kept quiet when he tried to speak it will be like his mouth gets shut. And they said when you do the ritual for him he would be fine. That's what made him speak again.

Researcher: The ritual?

Participant: Yes

Researcher: After the ritual

Participant: Yes after the ritual he could speak. At exactly 12 o clock he would stop speaking

Researcher: mmmh

Participant: Yes, we didn't know what was causing that. That's when we realised he was ill.

Researcher: mmmh

Participant: right

Researcher: mmh. Where are you staying are there clinics or doctors or hospitals where they treat people with mental illness?

Participant: I've never taken him. I only took him here only. I didn't take him elsewhere. I only took him to church only and did all they said, Then I took him here only

Researcher: How long did it

Participant: Did it take

Researcher: How long did it take to seek health after showing he has mental illness

Participant: Here in the hospital

Researcher: Yes

Participant: I'm sure from 2012 till now. Even now, He is still taking pills

Researcher: Oh, you started in 2012…You started realizing in 2012

Participant: Before

Researcher: Then you took him there in 2012

Participant: Yes I took him in 2012. I asked permission to leave from where I was working so I could stay with him at home. Even when I was working my siblings were telling me.

Researcher: It took years

Participant: Yes it took years, a lot of years

Researcher: For you to seek health what had happened?

Participant: what made me seek help, is when I had he was no longer staying at home.

Researcher: mmh

Participant: Someday when I got home. I found he had cooked but have not eaten. He had cooked with all the pots, but the food was not eaten. That's when I saw that he was ill

Researcher: mmmh

Participant: mmmh

Researcher: This one is saying tell me what you think of clinics and hospitals

Participant: Then I took him to the clinic

Researcher: This is another one. Its asking…..It is saying tell me what you think of hospital and clinics

Participant: I think of taking those who are ill there. Clinic helps people. I took him to the clinic. I consulted the clinic for a long time taking him there. Then the clinic referred us to the hospital. That's where we met doctors. It was after we consulted the clinic for a long time

Researcher: mmh

Participant: Yes, after consulting at the clinic for long they took us to the doctors

Researcher: mmmh

Participant: Yes

Researcher: The other one is saying tell me what you think of other places where people with mental illness can be taken. Tell me what you think about other health seeking pathways when a person has a mental illness

Participant: I only want him to be healed…I only want him to be healed… Taking him to far away hospitals will not be helpful because it will give me stress

Researcher: Tell me how other people are treated at health facilities. How do they treat people at health facilities?

Participant: At other places they don't treat other people well… At other places they don't treat people well. Some day when he speaks alone….when he doesn't want to drink pills…..they held him and beat him up

Researcher: Who beat him up…oh you mean

Participant: Those from the hospital

Researcher: They beat people

Participant: Some they beat people.. When they beat him, and you find they beat him won't you have stress as a parent?

Researcher: mmmh

Participant: yes. At home he is not troublesome. Even when you pass him by the street you won't believe that he has a mental illness

Researcher: mmh..

Participant: We know him as his parents and family that he is ill. But he is not ill to the point of bothering other people. Sometimes when he goes to my family home he refuses to eat their food. He says I don't eat food from people who are not my family. You want to bewitch me. You see

Researcher: mmh

Participant: He is old now because he is 34 years old. He was born in 1982. We are used to him. My daughter in law is used to him, her children are used to him. If we take him far it will be stress.

Researcher: Explain your experience (**word experience said in deep Tsonga)

Participant: I don't know what experience is

Researcher: Tell me how you are helped when you come to the hospital

Participant: How they treat us when we come to the hospital?

Researcher: Yes

Participant: Even now his card is in the hospital. They took it…They took it from him

Researcher: in the hospital

Participants: Last month she came to the hospital. There are times where he would go to the hospital alone to take pills. Last month his card was full. I told him your card is full now, go to the hospital and take mine. Collect my pills for me. Then they took both of the cards. They gave him pills but didn't give him the files that we keep at home. I came and collected mine and they opened a new one for me. When I went to them they told me that they didn't see the file. The file that stays in the hospital they have it. Mine and is lost. This means when the pills are finished I have to go with him to the hospital to open a new file. If I'm sick what am I supposed to do. They are not treating us well.

Researcher: Before he had a mental illness what did you know about mental illness?

Participant: I didn't know anything because I haven't come across someone with that kind of illness in my relatives.

Researcher: mmh

Participant: Yes, from my relatives

Researcher: mmmh

Participant: mmh

Researcher: Do you know other mental illness

Participant: I don't know them

Researcher: Tell me what you think of workers from clinics and hospitals

Participant: Adah

Researcher: Those who help the public in general

Participant: Ah they should help up. As we are here, they do help us, but they are not the same…they are not the same sister.

Researcher: Some treat others well

Participant: *interrupts* Some treat people well some don't treat people well. When you ask them something they scold you and you wouldn't understand how you should respond to him

Researcher: mmmh

Participant: Yes… They are helping us

Researcher: mmh

Participant: yes

Researcher: Then tell me what you think of workers who help people with mental illness only

Participant: Ah… they must have patience at them. They must have patience

Researcher: mmmh

Participant: Yes

Researcher: I mean psychologists and social workers; I am asking what you think of them

Participant: Those ones they treat us well

Researcher: They treat you well

Participant: Yes they treat us well

Researcher: They don’t have a problem

Participant: They don’t have a problem they treat us well. It’s just that we can’t be the same as people. They are treating us well

Researcher: mmmh

Participant: Where we are …..the illnesses that we have. They are caused by them. When they are checking us doing everything? They could see we are sick when we thought we are not sick. And they would say that the headache you are having……You have a certain illness, you must take these pills to get better. They are treating us good.

Researcher: mmmh

Participant: Yes

Researcher: That’s all I wanted to ask. That is all