The cultural and spiritual factors influencing the health-seeking behaviour of the Xhosa people in Johannesburg

By

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DECLARATION OF ORIGINALITY

Declaration of originality Name of the student: Sipokazi Somzana

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ABSTRACT

Title: The cultural and spiritual factors influencing the health-seeking behaviour of the Xhosa people in Johannesburg.

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Cultural and spiritual factors served as an important tool in determining the factors that influence the health-seeking behaviour of Xhosa people in Johannesburg, the tool illustrated an important aspect of the tribe while noting the kind of influence they have on everyone.

The purpose of the study was to establish and understand the cultural and spiritual factors influencing the health-seeking behaviours of the Xhosa people in Johannesburg. For this particular purpose a qualitative approach was employed, a case study research design, with an instrumental case - study as a sub-type. The study consisted of ten individuals, both male and female who served as participants in the study process. The data collection technique used in gathering the information was the semi-structured interview.

The research findings indicate that within the Xhosa tribe several factors have a great influence on the health-seeking behaviour of the Xhosa people residing in Johannesburg as per the study. Furthermore, the research reflects that although spiritual and cultural factors were the main enquiry within the study, other factors were revealed. A recent effort considering those factors revealed during the study was made by the Department of Health and other concerned departments considering those factors revealed certain challenges still prevail among the health sector in Johannesburg as experienced by the Xhosa people.

By researching the relationship between spiritual and cultural factors and the health-seeking behaviour of the Xhosa people residing in Johannesburg, it became evident that these factors could not be ignored and needed in-depth understanding by social workers

and health practitioners within the health care field. The tribe is excluded from certain health care resources due to cultural factors and health care challenges as revealed by participants during the study. It can be concluded that the cultural and spiritual factors that exist within the Xhosa tribe affect the health-seeking behaviour of the Xhosa people residing in Johannesburg.

Therefore, it is recommended that the Department of Health together with the Department of Social Development's diverse health strategy plan take into consideration these factors to develop treatment plans that cater for the members of the tribe to ensure adherence to proper and safe health-care avenues, health service delivery is improved and the healthcare facility structures upgraded to ensure they serve the community efficiently. The study recommended that the related Departments to develop awareness campaigns across the country about issues of health care influenced by culture and spirituality or religion.

LIST OF KEYWORDS:

Health, Health-seeking Behaviour, Influence, Spirituality, Cultural, Xhosa

LIST OF ACRONYMS

ARV: Antiretroviral drugs

ATM: African Traditional Medicine

HBM: Health Belief Model

HIV/AIDS: Human Immunodeficiency Virus/Acquired Immunodeficiency syndrome

HIV: Human Immunodeficiency Virus

HSB: Health-seeking behaviour

OPRS: Office for the protection of Research Subjects

SSI: Semi-structured Interviews

STD: Sexual Transmitted Disease

STI: Sexually Transmitted Infection

TAM: Traditional African Medicine

US: United States

WHO: World Health Organization

PA: Physical Activity

CONTENTS

CHAPTER 1
BACKGROUND AND STUDY ORIENTATION

1.1 INTRODUCTION

Musinguzi, Anthierens, Nawaha, Van Geertrudyden, Wanyenze and Bastiaens (2018:2) explain that health-seeking behaviour has been defined as any activity undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy. The health-seeking behaviour of a community determines how health services are used, and in turn, the health outcomes of its population (Musoke, Boynton, Butler & Musoke, 2013). Shaikh, Shaikh and Hatcher (2005:50) add that health-seeking behaviours are influenced by various individual and collective factors, including demographic, socio-economic, political and cultural factors. Culture is an important factor, which refers to the customs, habits, skills, technology, arts, values, ideology, science and religious and political behaviour of a group of people in a specific time (Barker, 2014:103). Nayak, Sharada and George (2012:61), emphasise that every society has its own traditional beliefs and practices related to health care. Some practices are effective, whereas others may be harmful or ineffective. These beliefs and practices are linked to culture, environment and education.

Visser (2012:166) states that cultural factors will influence the domains of among others, social behaviour, personality, emotion and health-seeking behaviour. It is obvious that Spiritual factors are the aspects directly linked to spirituality. Spiritual factors include motivation, attitude, belief, judgement, practice of, and behaviour directly linked to spiritual content or religious processes (Schaefer, Blazer & Koenig, 2008:509). There is increasing recognition within contemporary western medicine of the significant links between spirituality, religion and health (Rumun, 2014:39). Thus, there is a growing need for health professionals to understand their patient's spiritual beliefs and practices, which needs to be integrated into the community's cultural life (Rumun, 2014:39). The study focuses on the cultural and spiritual factors influencing health-seeking of the Xhosa people in Johannesburg.

1.2 KEY CONCEPTS

The following key concepts used in the study are defined below:

- **Health**:

Svalastog, Done, Kristoffersen, and Gajović (2017:432) state that health is a relative state in which one is able to function well physically, mentally, socially, and spiritually to express the full range of one's unique potentialities within the environment in which one lives. In the context of the conducted study health refers to the individual's health state in all spheres and what factors affect those areas in relation to their spiritual and cultural standing.

- **Health-seeking**:

Oberoi, Chaudhary, Patnaik and Singh (464:2016) define health-seeking as "any action undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy". In the conducted study health-seeking refers specifically to the behaviour displayed by Xhosa people seeking medical assistance, taking into consideration the time in which such assistance is required, that is, at what point the action to seek assistance takes place.

- **Behaviour**:

Bergner (2011:147) states that behaviour is essentially observable physical activity. For this study, behaviour will refer to the way the Xhosa people conduct themselves in response to their cultural or religious standing in relation to health care.

- **Health-seeking behaviour** (HSB):

Musinguzi et al. (2018:2) explain that health-seeking behaviour has been defined as any activity undertaken by individuals who perceive themselves to have a health problem or to be ill to find an appropriate remedy. In this study, health-seeking behaviour refers to any action displayed by the Xhosa people in seeking health assistance.

- **Influence**:

According to the University of Nebraska-Lincoln (2007), influence is defined as a force a person (the agent) exerts on someone else (the target) to induce a change in the target, including changes in behaviour, opinions, attitudes, goals, needs and values, and the ability to affect the behaviour of others in a particular direction. In this study, influence refers to the force that exerts change within the Xhosa people thus affecting how they respond to health issues.

- **Spirituality**:

Pillay, Ramlall and Burns (2016:1) refer to spirituality as a personal connection with God or a supreme being, as a journey towards transcendental consciousness and connectedness with one's inner life force; spirituality is commonly used interchangeably with religious influence. In the study, the researcher seeks to understand the link between Xhosa people's spirituality or religious influence and their health-seeking behaviour. This will allow the researcher to get an idea of how the relationship between Xhosa people and the higher being or force influences their behaviour to health-seeking. For the purpose of the study, spirituality refers to an expressed belief in a greater power (this can be God, a supernatural force or the ordered universe) and action is based or guided upon that belief. Spirituality is not necessarily tied to a formal church doctrine (Wood & Hilton, 2012:30).

- **Xhosa**:

Graham, Gwyther, Tiso, and Harding (2013:387) define Xhosa people as an ethnic group constituting 18% of the national population, comprising many large family clans and lineages. They are concentrated in South Africa's Eastern Cape, with 7.9 million speaking isiXhosa as their home language.

1.3 THEORETICAL FRAMEWORK – SOCIAL LEARNING THEORY AND HEALTH BELIEF MODEL

The study had its premise in the Health Belief Model, a model that stems from the social learning theory. Social learning theory means learning by individuals that takes place in social settings and/or is socially conditioned; for others, it means learning by social aggregates. (Lindley, 2015:52). Chironda, Bhengu and Manwere (2019:55) explain that the Health Belief Model is the most widely used social cognitive theory in health psychology; it predicts and explains health behaviours and that behaviour change is based on the balance of the barriers and benefits of health action. This in a

way indicates that each person whether influenced by cultural or spiritual factors in adhering to a healthy life contributes in one way or another to the outcome that needs to be beneficial to the individual. This still does not eliminate or deny the fact that culture and spirituality may influence people's health-seeking behaviour but rather acknowledge the possibility of contributing factors of a person's intended outcome in their chosen health action.

The Health Belief Model (HBM) is most appropriate in this study as it helped the researcher establish and explain the cultural and spiritual factors that influence the health-seeking behaviour of the Xhosa people. The theory is enhanced further in its application when combined with the social learning theory. The reason for this great collaboration mostly stems from the fact that one is a model and the other a theory that originates from the existence of the other; hence they have a lot in common and complement each other.

Champion and Skinner (2008:47) assert that the perceived benefit as indicated by HBM is the fact that even if a person perceives personal susceptibility to a serious health condition (perceived threat), whether this perception leads to a behavioural change will be influenced by the person's belief regarding perceived benefits of the various available actions for reducing the disease threat. The model has been used in most studies as a tool to help health practitioners understand the illness or health from an individual level. It has been a tool to help explain behaviour in terms of an individual's change experienced and maintenance in their health. Hence it was the most appropriate model in my study as it served as a guiding framework in understanding each individual's experience in healthcare.

Tarkang and Zotor (2015:1) state that HBM was one of the first theories developed to explain the process of change in relation to health behaviour. When used appropriately, it provides organised assessment data about clients' abilities and motivation to change their health status. Hence it was an appropriate theory to use in the study. The model enabled the researcher to establish and define the health-seeking behaviour and the spiritual and cultural factors that led to such behaviour of the Xhosa people in Johannesburg. Allowing her to gain a vast and in-depth understanding of the phenomenon. This provided more understanding in terms of

health barriers and benefits that influence these specific health behaviours displayed by this particular tribe. This understanding will help them to know the motivation of non-adherence and be able to provide more tailored health services.

1.4 PROBLEM STATEMENT AND RATIONALE OF THE STUDY

The cultural and spiritual factors influencing health-seeking behaviours differ from one culture to another. Social workers in health care need to understand the cultural and spiritual context of their service users to understand their health-seeking behaviours. This will also help them to render the appropriate intervention. Health-seeking behaviours have been researched, but a gap exists in the diverse cultural and spiritual factors influencing health-seeking behaviours. Xhosa people have been studied; however, the focus was on specific issues like circumcision and HIV (Froneman & Kapp, 2017; Venter, 2011; Beck, 2004) and not much attention has been given to cultural and spiritual factors affecting their health-seeking behaviour. This particular focus in the study will allow practitioners within the health care field to have a wider and informed understanding of the people and be more effective in rendering the appropriate services that will ensure adherence. The researcher grew more interested in focusing her study on this particular tribal group in South Africa due to wanting to understand in depth what and how specifically their culture and spiritual background affect their health-seeking behaviour.

The researcher cannot ignore the fact that the tribe over centuries has expanded, evolved and a lot of changes might have taken place in their culture and spiritual facets. The individuals within the tribe might have been influenced by the larger community in one way or another taking into consideration that their tribe now forms part of individuals who are highly educated, have travelled all over the world and married into other cultures or religions.

Hence, the study will be of great importance as it will narrow down some important issues on this tribe in Johannesburg that the health system needs to understand in ensuring that their health needs are more understood. The research question for this study is as follows: **What are the cultural and spiritual factors influencing health-seeking behaviours of Xhosa people in Johannesburg**?

1.5 GOAL AND OBJECTIVES

The goal for this study is:

To explore the cultural and spiritual factors influencing health-seeking behaviours of Xhosa people in Johannesburg.

The objectives are as follows:

- To conceptualise and contextualise cultural and spiritual factors influencing health-seeking behaviour from a health belief perspective.
- To explore and describe cultural and spiritual factors influencing health-seeking behaviour of Xhosa people in Johannesburg.
- To make suggestions to improve social work services in health care, taking into consideration the factors influencing health-seeking behaviour in diverse cultures.

1.6 RESEARCH APPROACH

The study employed a qualitative research approach that is explorative, descriptive and contextual in nature mainly to gain an in-depth understanding of Xhosa culture and spiritual factors influencing health-seeking behaviour. The nature of the study allowed the researcher to explore the phenomenon as there is limited information on it. It further allowed the researcher to give meaning to the phenomenon as a description of the phenomenon investigated was done. Most importantly the researcher was able to gain an in-depth understanding of the phenomenon studied and discover participants' experiences (Rahman, 2017:104). This, in turn, resulted in the researcher establishing a broader understanding of the phenomenon. This keeping in mind that to gain a better understanding of health and spiritual seeking behaviour within the of cultural and spiritual beliefs systems of the Xhosa people, the researcher appreciated and respected the uniqueness of the culture and its spirituality.

Creswell, Ebersohn, Eloff, Ferreira, Ivankova, Jansen, Nieuwenhuis, Pietersen and Plano-Clark (2016:53) state that qualitative research is naturalistic, that is, it focuses on natural settings where interactions occur, in other words, viewing social life in terms of the processes that occur rather than in static terms. This meant it was of significance to ensure that an in-depth understanding is gained from the participants, to ensure and allow participants to feel free and comfortable enough to share their experiences concerning the phenomenon. This approach in this regard was most appropriate.

1.7 LIMITATIONS OF THE STUDY

The first limitation was the laziness displayed by the participants in conversing in English during the interview process. The second limitation was the fact that the interview schedule had quite a number of questions, which seemed to overwhelm some participants and decrease their eagerness to participate.

The last limitation of the study is that the data or results cannot be generalised nationally due to the small sample that was used during the study. The sample consisted of ten Xhosa participants who reside in the Johannesburg area.

1.8 CHAPTER OUTLINE

Chapter 1: Introduction and background to the study

The researcher will give a broad overview of the cultural and spiritual factors influencing the Xhosa people's health. This will highlight how this topic fits in what has already been researched by other researchers and illustrate the background to the rationale of the study.

Chapter 2: Literature Review

The researcher has provided some literature on the topic to inform the readers where the study fits in the broader context. This section focused on what other researchers have done concerning the topic to establish the gaps that exist within this particular study.

Chapter 3: Research Methodology and Empirical Findings

This section will indicate the type of research approach that has been employed by the researcher as well as the type of research design, research methods, ethical considerations, empirical findings and interpretation and a recap on the research questions. The section will interpret and describe the importance of the findings established from the study taking into consideration what is already known about the study, explaining new findings to the study and a new understanding received as a result.

Chapter 4: Summary, conclusions and recommendations

The section will summarise the key findings of the study, restate the topic as well as summarise the main points, content and purpose of the study. The researcher will also make recommendations for future work by the researcher or other researchers.

The following chapter details an in-depth literature review on the Xhosa people and their health-seeking behaviour.

CHAPTER 2
LITERATURE REVIEW ON XHOSA PEOPLE AND THEIR HEALTH-SEEKING BEHAVIOUR

2.1. INTRODUCTION

The purpose of the review is to familiarise the researcher with the scope of the field of study (Polit & Beck, 2008:137). The literature review is an important step to ensure that an understanding of the factors that influence health-seeking behaviour among various populations is achieved. The literature review provided the researcher with a broader understanding of the study.

The chapter will provide a broad summary of the cultural and spiritual factors that influence the health-seeking behaviour of people from across the globe, the African continent, South Africa and more specifically the Xhosa tribe in Johannesburg, South Africa. Therefore, this chapter will present the related literature through studies that have been conducted by other researchers in similar studies over the years.

2.2 CONTEXTUALISATION OF HISTORY OF XHOSA PEOPLE AND THEIR HEALTH-SEEKING BEHAVIOURS

According to Elphick and Gilliomee (1989:2), the term Xhosa is derived from the Khoisan (Khoi and San) tribe who were occupiers of the Cape Colony when the 1652 settlers landed in South Africa. They were also referred to as Kosa, meaning angry men, sometimes known as the Black people or Bantu-speaking people with the characteristic click sounds in their language (Elphick & Gilliomee, 1989:2-3).

Pinnock (1994:1) in Sotewu (2016:1) states that the Xhosa ethnic group forms part of the Nguni people of Southern Africa. He further explains that the Xhosa ethnic group is further divided into various tribes that include “Mpondo, Bomvana, Bhaca, Thembu, Mpondomise, Xesibe, Mfengu, Hlubi, the Xhosa proper and others, which were bound century after century by ties of marriage, as well as by diplomatic, military and political alliances”.

The Xhosa people historically fall within the racially segregated and oppressed South Africans discriminated against during apartheid governance. A diverse range of spiritual beliefs underpin the Xhosa culture including African traditional healing

methods and medicines, other forms of worship, including magic and witchcraft along with Christian and Islamic atheist, and agnostic beliefs (Campbell et al., 2017:1).

2.3. CULTURAL AND SPIRITUAL PRACTICES OF XHOSA PEOPLE WITHIN THE HEALTH SETTING

The need for extensive research and implementation of evidence-based culture-relevant and culture-response therapeutic techniques have been identified (Asmal, Mall, Kritzinger, Chilliza, Emsley and Swartz 2011:367).

The following are some of the cultural and spiritual practices of Xhosa people that in one way or the other form part of the health care system. These are some of the practices that have been explored a bit by other researchers in trying to gain a better understanding of the Xhosa people and how they perceive health.

2.3.1 MALE CIRCUMCISION AND SEXUALITY AND HOW IT RELATES TO THE HEALTH-SEEKING BEHAVIOUR OF XHOSAS

Kepe (2010:729) states that male circumcision, involving the removal of the foreskin, is practised in many cultures around the world for ritual, religious, medical and other purposes (e.g., the belief that it strengthens boys for warfare or enhances masculine virility). Venter (2011:560) states that male initiation is an important and deeply-rooted custom of various ethnic groups in South Africa, especially the amaXhosa.

He further states that it serves as a doorway through which the Xhosa adolescent male must step in order to become a respected member of society, or as it is called among the amaXhosa to attain manhood (Venter, 2011:560).

This is a must as without having performed this custom as a man you are not respected by the Xhosa people and regarded as a boy despite your age (Venter, 2011: 560). However, some associated risks have been reported during the practice of this custom over the years. Venter (2011:565) explains that even if his life is in danger, it is considered to be the last resort for the initiate, the *ikhankatha* and the boy's family, as seeking medical help means that they have given up on preserving the cultural tradition. Gittings, Hodes, Colvin, Mbula and Kom (2021:67) explain the term *ikhankatha* is a traditional caregiver, in simple terms, this means an initiate's guardian.

These are health risks that have been quite alarming to society at large. Complications that may arise during this season are dehydration, loss of appetite, weakness due to

blood loss, swelling of the limbs and times results in uncontrollable bleeding (Mavundla, Boitoman, Toth, Bottoman & Tenge, 2010:400). These symptoms at times lead to death as no medical attention is received. This mainly is because medical assistance is forbidden during the initiation school. They are high risks involved on the boy's perception of becoming a man if he calls for medical assistance as he will not be allowed to continue with the school afterward (Froneman & Kapp, 2017:5). Froneman and Kapp (2017:2) further share a discovery revealed in their study that seeking medical help is considered taboo and results in failed initiation. Furthermore, Froneman and Kapp (2017:2) state that the community perception is that death during initiation is a way for the ancestors to point out who would never become real men anyway.

Literature also reports on boys who "suffer severe emotional and spiritual confusion if they are not allowed to undergo this traditional practice" (Tenge, 2006:3 in Venter 2011:561). Mavundla's et al. (2010:4) study revealed that most participants underwent the initiation due to fear of social rejection and the pressure received from their friends, family and the community. They associated Acceptance into their community as a man was associated with being circumcised. Failing the test occurs when the ritual does not follow the prescribed traditional steps or a taboo is violated, such as hospitalisation. In the broad sense, the participants revealed that hospitalisation means the person is uninitiated (Mavundla et al., 2014:4). This clearly shows that not all who participate in this ritual do so freely and even if they are not forced by any person, circumstances and pressures from their communities make the final decision. In the Xhosa culture, male initiation is held in high regard, it is an important and deeply rooted custom as it serves as a rite of passage from a boy to manhood.

Kepe (2010:729) explains that the increasing number of injuries and deaths of initiates, has caused tension between the government and traditional leaders in the Eastern Cape Province. This has become a public health issue and the government has tried to avert the crisis through legislation and various other programs.

One of the participants, a chief, interviewed in Froneman and Kapp's (2017:2) study, criticised the Department of Health in its campaign against illegal circumcision and illegal traditional surgeons in 2006. The opinion he shared was that the ongoing deaths

showed that the ancestors did not approve of what health officials were doing (Froneman and Kapp, 2017:2).

According to Madunda (2017:1), traditional leaders fail to learn and adapt to the changing society, to remain relevant and align their processes and systems in accordance with the Constitution of the Republic of South Africa, something that has proven to be a challenge to the government. This is mainly due to the fact that traditional leaders are seen to be the custodians of culture and traditional practices, such as traditional initiation schools (Ntsebeza, 2006).

Ntombana (2016:632) clearly states that the reasons for such concerns by the community are the fact that many boys have died as a result of their guardians' negligence; something that was rare in the past. Another reason is that the behaviour of the initiated boys has become unacceptable. This means the boys who go through the initiation process come out unruly and at times cause unrest and havoc in the community being supported by the illusion that they are now greater than anyone else as they have now become men.

Ntombana (2016:632) explains that the initiation school has become a place where criminal activities are committed, and the practice of initiation no longer contributes to the building of society but instead contributes to the moral decline of the communities concerned. This means that enrichment is no longer brought on by this cultural practice within the community as a lot of fear has been stirred rather than lessons and growth intended by the actual practice.

In the Xhosa culture, circumcision is a social phenomenon of building masculine status and identity propelled by the individuals need to control and attain a range of masculine characteristics, which is impossible if one has not undergone the ritual (Mavundla, Netswera, Toth, Bottoman & Tenge, 2010:932). There is a widely held belief that encourages the practice of circumcision as a tool that can prevent HIV and AIDs amongst its partakers. This belief that rests within the community strongly suggests an influence in the health-seeking behaviour of men when it comes to sexual

health and matters pertaining to the use of available public health prevention methods for sexually transmitted disease (STD).

Froneman and Kapp (2017:1) suggest that traditional circumcision seen as a sacred religious practice, has been rationalised as a mechanism for the maintenance of social order and is believed to play a role in the prevention of HIV. Vincent (2008:85) states that a spate of recent research has argued that the higher prevalence of HIV in Africa is linked to a lack of male circumcision. Klausner, Wamai, Bowa, Agot, Kagimba and Halperin (2008:1) explain that the higher prevalence of HIV in Africa linked to lack of male circumcision could be mainly attributed to the fact that with circumcision the absence of the foreskin reduces the HIV infection through hetero-sexual intercourse. This is because the foreskin contains a large number of target cells such as Langerhans' cells, that are uniquely vulnerable to HIV infection (Klausner et al., 2008:1).

Gray, Kigozi, Serwadda, Makumbi, Watya, Nalugoda, Kiwanuka, Moulton, Chaudhary, Chen, Sewankambo, Wabwire-Mangen, Bacon, Williams, Opedi, Reynolds, Laeyendecker, Quinn and Wawer (2007:657) reveal that a number of ecological and observational studies, mainly from sub-Saharan Africa, have suggested that male circumcision reduces the risk of HIV infection in men. This means that men are more likely to participate in this particular practice due to the benefits that it offers, thereby influencing their health-seeking behaviour. Klausner et al. (2008:1) state that uncircumcised men are more likely to acquire certain sexually transmitted infections, particularly ulcerative ones such as syphilis and chancroid, which probably facilitate HIV infection, this being due to the fact that keratin, the protective coating covering most exposed skin, is largely absent from the inner foreskin and thus renders those target cells much more accessible to HIV.

Weiss, Halperin, Bailey, Hayes, Schmid and Hankins (2008:567) reveal in their study that several plausible biological mechanisms could explain the increased risk of HIV and other sexually transmitted infections (STI) in uncircumcised men, including microtears and lesions in the mucosal surface of the inner foreskin and the longer survival of pathogens in the warm, moist sub preputial space.

Regarding the information shed by literature, it is evident that the practice of circumcision does pose some great health benefits for the individual, however, studies

have also revealed that non-adherence to the practice has been linked to a high rise of sexually transmitted diseases within the community. This further suggests that this practice whether adhered to or not has a significant influence on the health-seeking behaviour of men within the community.

It is evident that circumcision within the Xhosa tribe largely influences the health-seeking behaviour of men, how they react to sexual health issues and what health care avenues to access, hence the fascination in fully understanding the phenomenon.

2.3.2 IMBELEKO/CHILDBIRTH AND HOW THIS PRACTICE LINK TO HEALTHCARE

Abid (2014:211) explains that childbirth gives social recognition and status to young girls navigating through pregnancy and delivery. This is because the birth ritual gives the mother of the child and the women involved an opportunity to participate in the sacredness and aesthetics of the amaXhosa ritual (Penxa-Matholeni, 2019:431). Henda (2021:3) states that when a nursing mother of the Xhosa tribe returns with a child to the people after ten days, a white goat is slaughtered, and that particular ceremony is referred to as *imbeleko* (meaning carry on your back). Bogopa (2010:2) explains that the ritual ceremony *imbeleko* relates to the birth stage, a stage when a woman who has a newborn baby is expected to stay in her house for a period of at least ten days partaking in various ritual ceremonies, after ten days she leaves the house and white goat slaughtered.

This strongly suggests that the next ten days after the birth of a child the woman and the child are not allowed to access any health-care services until the completion of the ceremonial process timeline. This clearly indicates that the health-seeking behaviour is largely influenced by the ceremonial tradition.

The birth of a child in the Xhosa tribe signifies an important occasion, not only for the family but for the entire community (Penxa-Matholeni, 2019:431). This is due mainly to the embedded belief that childbirth within any family ensures the continuation of a clan, hence the fertility of women in bearing children is of great paramount (Penxa-Matholeni, 2019:431). This assertion is further supported by Ntombana (2015:105) who defines *imbeleko* as a ritual that entails the inclusion of babies into the clan. Tonsti

(2019:72) explains that *imbeleko* in detail as a ceremony in the Xhosa culture which introduces the child to the ancestors by slaughtering a goat. This is mainly due to the fact that *imbeleko* is considered to be a rite of passage and said to be celebrated shortly after the birth of a child (Ramaube, 2018:68).

Penxa-Matholeni (2019: 430) explains that upon exiting the birth canal the baby usually cries symbolising the beginning of life, he further states that an infant is considered a baby when *inkaba* has fallen, signifying the shift from infancy to babyhood. Njwambe, Cocks and Vetter (2019:415) define *inkaba* as the umbilical cord and explains that it is buried at home after the birth and signifies a person's physical and emotional connection with their rural home It is evident in Xhosa culture that the birth of child holds a lot of importance and is a ritual that is not taken lightly, one in which certain procedures and processes need to be fulfilled in order to ensure the safe delivery of every child and his/her long life thereafter.

Abid (2014:211) states that within the Xhosa tribe, birth is not just carried out anywhere but rather carried out in a rondavel, this is a mud house with thatched roofs. Furthermore, the birth of the child carried in a space referred to as *efukwini,* the birth takes place *emva* kocango, Henda (2021:1) translates this term as behind the door, meaning a part of a birth rite within the Xhosa tribe occurs behind the door. This information suggests a strong connotation why certain mothers within the tribe continue to give birth at home, this information clearly shows the influence this cultural practice has on the health-seeking behaviour of an individual specifically the women. The cultural beliefs linked to the birth of a child within the tribe directly influences the health-seeking behaviour of the individual.

A woman about to deliver a child is usually assisted by experienced grandmothers, these grandmothers help with the process where the baby and the mother become isolated to ensure the cord of the child falls off (Abid, 2014:211). This reveals the fact that just like any other birth and delivery process there are individuals, experts in the field who are part of the process, this being clearly evident even in the Xhosa tribe. This suggests that tribal experts are more likely to be sought for assistance in matters pertaining to the child-birth or child-rearing and not necessarily any health-care services outside the borders of the tribe. These findings demonstrate that their health-

seeking behaviour is influenced by the culturally embedded perceptions of these tribal experts.

In ensuring that the cord of the child falls off, a particular process by these experts in the form of experienced grandmothers needs to be strictly followed. Abid (2014: 211) explains that these grandmothers help in this process by ensuring that they apply the specially prepared mixture of ash, sugar, and a poisonous plant called *umtuma* on the newly severed cord. Abid (2014) further explains that the day the cord falls off is the day the baby is introduced to the family and community members. In support of this Henda (2021:2) explains that the falling off the cord is called *ukuwisa* in Xhosa and that this time becomes an important event in which the mother buries the umbilical cord, signifying the transition from foetus to birth to babyhood. This means the healthcare of the members of this particular community is rooted in their customs and traditions, clearly showing the influence culture has on their health-seeking behaviour. In this regard Abid (2014:211) explains that within the Xhosa tribe a ritual termed *sifudu* is performed, which entails the burning of tree leaves which produces a very strong smoke, this is where the women gather and the baby is then passed over the smoke three times, this particular act said to bring about severe coughing and screaming by the baby. Abid (2014:211) states that the aim of this particular ritual is to ensure that the baby is strong, courageous and protected from any harm including the manifestation of evil spirits.

Abid (2014:211) explains that upon the completion of the *sifudu* ritual a bath ritual follows where the baby is bathed and then painted with a white chalk-like substance referred to as *ingceki* mixed with sweet-smelling ground wood termed *mtomboti*. The child is then breastfed by the birth mother who is called *umdlezana* a term that means a nursing mother (Maseko, 2017).

This process of this ritual suggests that the health-seeking behaviour of the mothers concerning their newborn babies is largely influenced by the activities that they partake in during and after childbirth. It further shows the major role traditions and customs play in the birth of a baby and child-rearing in its totality. Abid (2014: 211) explains that once all is done, it is not the end of all the rightful and significant customs performed

for the child, another major one is still to follow, this ritual is referred to as *imbeleko* which refers to a Xhosa birth rite that signifies the introductory birth of a child.

Ramphele, (2002:47), as cited in Allegritti and Gray (2005:3) state that *imbeleko* usually takes place a few months after the birth of a new child. Its purpose is to 'introduce' the young male or female to his or her ancestors and to cement the ties of the clan by linking together the newborn, parents and ancestors. The Xhosa people believe that not performing this ritual means disrespecting the ancestors and in doing that once risks a life of many misfortunes and lack of protection.

In support of this Bogopa (2010:2), explains that the performance of this ritual is based on thanking the ancestors for protecting the child and the mother, and therefore it is also believed that failure to perform it will have great consequences such as the child continually wetting the bed and being disobedient. According to Nortje, Jones-Bonofiglio and Sotomayor (2021:8), a person who disrespects and dishonours the ancestors is taboo and can be the cause of punishment. Abid (2014: 211) explains that *imbeleko* is a ritual done to welcome the child to the clan, a ritual symbolised by the slaughtering of a goat and the tribe is invited to the feast. The skin of the goat is considered sacred and therefore the baby will be covered by the skin, as this is said to also signify an attachment to his/her ancestors. This suggests that the way the tribe caters for the child's well-being and health needs, in general, is embedded in the culture and confirms that culture does influence their health-seeking behaviour.

Allegritti and Gray (2005:3) explain that the failure to participate in *imbeleko* is viewed in a negative light. It is believed to make the child, and later the adult, vulnerable to misfortune. These misfortunes can range from, being constantly sick or having problems in your relationship to being mistreated or not accepted by your in-laws. Ramphele (2002:48) explains that the importance of being properly introduced to your ancestors upon your arrival on earth is a requirement to ensure that the ancestors are able to protect you as their own. This clearly indicates that certain health issues that Xhosa people experience are explained by certain cultural rituals that one has not honoured. This suggests that an individual can assign a causal factor of illness to punishment by the ancestors and because of such a strong conviction their reaction

to an illness will be influenced by that cultural belief, further suggesting the type of health care assistance sought afterward in order to eliminate the illness.

Imbeleko is the first ceremony that is performed when the baby is born, a moment when the baby is introduced to the clan and the ancestors and a joyful moment for the parents of the child and the whole family. This practice suggests a great influence of health-seeking behaviour in issues pertaining to the well-being or the health of the mother or newborn child. This means the health-care avenues to whatever illness that can erupt will be mainly guided by the tradition and customs of the tribe.

2.4 ANCESTORS AND HOW THIS PRACTICE LINKS TO HEALTH CARE

According to Bogopa (2010:1), within the South African context, different terms are used by various cultural groups to refer to ancestors, for example, in the Sesotho language they are known as *badimo* and in isiXhosa as *izinyanya*. This means that within the South African context in different tribal or ethnic groups, the practise of ancestors does exist, but the only difference is the reference to it. In further highlighting the importance of a higher power that exists within different cultural groups, Wasti et al., (2011:39) explain that Nepalese people pray to various deities for protection from disease and illness, not only at times of stress but also for comfort and future wellbeing. He further reveals that there are specific deities to whom specific offerings are made by the Nepalese people.

This in a way affects the type of avenue that people might likely select when accessing a health service. Hence, Nuhu (2016:3) explains that traditional and herbal medicine has served the health needs of the people of Ghana long before the introduction of modern health services in the country and remain an integral part of the Ghanaian culture to date. This largely explains the fact that culture within a tribe whether regarded as ancient or newly found can influence the lives of individual and predominantly their choice of health approaches.

In support of this Bogopa (2010:2), explains that ancestors within the Xhosa tribe are very important and one of the reasons is their need for guidance and cooperation in ensuring the success of any ritual performed. This means within the Xhosa culture,

certain families that perform these rituals have to adhere to honouring their ancestors to ensure the success of the rituals performed. In this regard, Nuhu (2016:5) states that another first point avenue that healthcare consumers in Ghana resort to is faith healing, operated at many levels; from the individual level to small groups to prayer camps, shrines, mosques, churches, and in recent times through mass media (television and radio evangelism). He further explained that many faith healers are believed to have spiritual prowess and powers to cure all manner of diseases ranging from conditions thought to be due to curses and evil forces such as mental disorders through diabetes and hypertension to infertility.

This attests to the fact that spirituality does contribute to the perceptions and beliefs that individuals within a particular tribe or religious group hold about health care. This fully alludes to the perception that they can get healed without necessarily accessing modern health care avenues. According to a study conducted in Nigeria on the high mortality rate of babies, it was established that the mothers perceive child diseases to be caused by human agents (witchcraft activities), ancestral spirits, and the breach of taboos rather than by infection, that affected their response routes and thus leading to the high mortality rate (Ugwueje, 2012:14). This study illustrates the important fact that cultural factors that influence health-seeking behaviours can have a detrimental impact on the lives of individuals.

The question now remains, in what circumstances or situations certain tribes' traditional and spiritual experts seek out health assistance. In this regard, Abubakar, Van Baar, Fischer, Bomu, Gona, and Newton (2013:4) in their study "Cultural Determinants of Health-Seeking Behaviour on the Kenyan Coast: A Qualitative Study" discovered from participants that according to their belief and culture there are diseases/conditions that they regard as abnormal, take for instance, someone who sleeps well and at night gets ill and starts screaming and calling out to people no one else can see, they decide that hospitals cannot deal with such conditions, and they are taken to an expert (traditional healer) who can see what the person can see. This means an individual's contrast and understanding of what takes place around him/her is largely influenced by culture and spirituality.

In support of this notion, Bae (2007:11) states that a person's understanding of the world and universe is very closely linked to their identity, religious and cultural heritage. This truly illustrates the influence that culture and spirituality have on the health matters and health avenues of each person or tribe. This indicates that it is impossible to ignore culture and spirituality in a person's life. Culture and spirituality influence how a person perceive life, the decisions that one embarks on and the motivation to thrive in life (Venter, 2011:566). This ranges from how people view challenges associated with death, success and health in general. Hence, the need to understand the cultural and spiritual factors influencing the health-seeking behaviour of the Xhosa people. Cocks and Dold (2006:64), in this regard, explain that Xhosa people perceive and explain good health, disease, success or misfortune as something that is rarely considered to be coincidence but rather a result of active intervention by individuals or the ancestors. This means the basis of this particular study is not misplaced and therefore, the need to obtain in-depth information into the phenomenon is of great importance.

Hirst (2005:3) explains that ancestors are conceived as disembodied ghosts (*imishologu*) in the form of wind or spirit (*ngumoya*). They reputedly influence the lives of their descendants and communicate with them in dreams and omens (*imihlola*). Culture is a major factor, mainly due to the meaning and importance people ascribe to it, which it affects how people respond to challenges or problems to their wellbeing (health) (Herselman, 2007:62). How people view or understand the term health differs from person to person, tribe to tribe and race to race. Within the African context, sickness is understood within the contextual basis of a balanced relationship between people, the natural and supernatural and the fact that disruption of the relationship results in physical or emotional imbalances (Herselman, 2007:63). This clearly illustrates the fact that each person has his/her own understanding of what we mean by the term health and further that understanding potentially influences how one responds to it.

This means keeping in mind that each person though within the same tribe is in a way different, this is mainly due to their upbringing and background in terms of the family (nuclear or extended family). For instance, a person from a Xhosa ethnic group who has grown up in a Christian family might not know how a traditional Xhosa person who practises African traditional religion grieves (Yawa, 2010:3). As much as health and

health care facilities also need to be explored, a great gap would exist if people's understanding and views of what treatment means and entails for each individual when it comes to health challenges is not explored. This means exploring what also influences the understanding or meaning of treatment. This will further highlight the meaning they place on health challenges or sickness. The purpose of this is to establish which one might be that, explore and therefore discover whether that meaning influences the health-seeking behaviour of the Xhosa people. It is important to understand that the Xhosa people have not been explored deeply in relation to their culture and spirituality in understanding their health-seeking behaviour.

It has become evident through the study that although there is good evidence within literature across the world regarding health-seeking behaviour, there is still little research about cultural and spiritual factors. Regarding this particular study, a big gap still exists that needs to be explored further. It is of great significance that we understand that seeking health care is influenced by our understanding of what leads to health challenges in the way, the causal factors of the health challenges direct your treatment and from where you sought that kind of treatment. This means in understanding healthcare-seeking behaviour, the exploration of the causal factors to health challenges cannot be ignored. This keeping in mind that when we refer to health-seeking behaviour, we not only refer to sickness or diseases but rather any form of threat to the well-being of a person. This includes any form of abuse, abuse that has been mostly experienced by women, children, older persons, people living with disabilities and in a few reported cases, even men. This now leaves room for thoroughly exploring as to what could be cultural and spiritual factors that influence the health-seeking behaviour of these victims.

2.5 MENTAL HEALTH AND WITCHCRAFT AND HOW THE BELIEFS OF XHOSA PEOPLE IMPACT HEALTH-SEEKING BEHAVIOUR

Ugwueje (2012:16) explains that the economic choices and health practices of individuals are shaped and modified by the cultural beliefs, traditions and norms of society. In his study on "Cultural environment, health-seeking behaviour and survival chances of under five children in South East Nigeria" he discovered that in traditional culture, beliefs about disease causation result in customs and practices that have a serious impact on the proximate determinants of child survival because he had further

established that women and children suffered greatly the grave consequences of the traditional customs and practices.

This means everyone's beliefs are influenced by the belief of the larger group they are a part of. In this regard, Wasti, Randall et al. (2011:39) state that in Nepal illness is believed to be caused by a "supernatural attack" and, in many cases, demons or witches are sometimes believed to be the cause of illness. Similarly, health and ill health can be attributed to one's relationship with the spirit world of gods and anti-gods (demons).

In addition, Workneh, Emirie, Kaba, Mekonnen, and Kloos (2018:4) explain that most illnesses in Konso are believed to be caused by either supernatural forces or the natural environment. Many older, poorer, and less-educated people attributed illness to the wrath of supernatural and malevolent spirits, envious witchcraft, or intrusion of pathological agents. This means their reference to the causal factors is linked to a supernatural doing and one that plays a larger role in their health, therefore largely influencing their health-seeking behaviour. In certain cases, illnesses are also believed to be caused by being unclean, this idea was especially common among women (Workneh et al., 2018:5). This in a way reveals the importance of hygiene in certain tribes and the high esteem it holds within their health issues.

Workneh, Emirie, Kaba, Mekonnen, and Kloos (2018:1) state that the Konso worldview regarding health, illness, and health-care systems is closely linked to the culture of the people and their knowledge of the natural environment, plants, and animals. This in a way reveals a stance of being one with nature and all that forms part of it, therefore any imbalance might be referred to as being unhealthy.

Workneh et al. (2018:3) illustrate this in their study when one of the informants explained that health for the Konso encompasses receiving enough rain during the rainy season, having good harvests, and living harmoniously with the environment, *waaqa* (the indigenous god), and *karayitta* (ancestors).

Several health factors within the tribe that have been researched by other researchers explored the meaning that Xhosa people place on mental illness-specifically

schizophrenia (Campbell, Sibeko, Mall, Baldinger, Nagdee & Susser, 2017:7). The study on “The content of delusions in a sample of South African Xhosa people with schizophrenia” revealed that most people within the tribe believed that the mental illness was more than just an illness, rather something inflicted on the person by a witch as they believed that a someone was jealous of the person with the affliction. The literature revealed how diverse health is and how easy it is to only focus on one factor and ignore others. In this way an individual is at a disadvantage as attention to all spheres of an individual is to establish an all-round health diagnosis and ensure the person reaches his/her optimal well-being.

It is well acknowledged that cultural ideologies do influence families’ belief systems of schizophrenia and access to mental health care (Asmal, Mall, Kritzinger, Chiliza, Emsley & Swartz, 2011:368). The study by Asmal et al. (2011:368) looked at the attitudes and beliefs of the relatives of Xhosa patients with schizophrenia and found that 67% of their family members believed that witchcraft or possession by spirits was related to the onset of schizophrenia. This alludes to the fact that this factor influences how individuals access health-care for these particular health issues. Asare and Danquah (2017:1) clearly explain that within the African context spiritual belief is a major determinant to choice of treatment, they explain that this was held by indigenous Africans, however, these beliefs have been passed on from one generation to the next. This explains why its influence is still apparent within the lives of individuals even in this day in age.

This sheds some light on the findings by Campbell, Sibeko, Mall, Baldinger, Nagdee and Susser (2017:1) that although the relationship between cultural beliefs and schizophrenia has received some attention, relatively little work has emerged from the African context. It is likely that the widely accepted belief in the Xhosa culture that mental illness has its roots in witchcraft plays an integral role in the content of these delusions (Campbell et al. 2017:1). According to Campbell et al. (2017:1), these delusions consistent with international cross-cultural studies, persecutory delusions, including the belief that others are plotting against or planning to hurt the individual, appear to be the most frequently reported type of delusion in South African Xhosa people with schizophrenia.

Campbell et al. (2017:1) explain that bewitchment takes numerous forms, one of these is *isidliso* or poisoning by ingestion which may result in physical symptoms such as chronic coughing, chest pains and blood in the sputum. He further states that bewitchment also takes the form of possession by evil spirits, the manifestation of which may be consistent with mental illness. One example is *amafufunyana* which refers to a state of perceived possession by multiple spirits that may speak or communicate through the possessed individual.

Another state of bewitchment may involve the dirty spirit known as tikoloshe described as a small hairy man with a large penis that he carries over his left shoulder (Campbell et al., 2017:1). Burchardt (2017:87) describes a tikoloshe as a small, dwarf-like male with human features. He further explains that it is most popular amongst the Xhosa people and is considered to be a malicious agent operating on behalf of witches.

This illustrates the depth to which cultural ideologies may influence an individual's choice of treatment, thereby illustrating the importance of understanding the phenomenon of study. This particular belief has a great influence on people's health-seeking behaviour on issues pertaining to mental health in particular. This statement is supported in the study by Campbell et al. (2017:1) which revealed that the majority of the participants believed their state of schizophrenia to be due to bewitchment. This means access to Western medicine is less likely to occur as compared to traditional healers or faith healers. A study conducted in Gambia also noted that individuals infected by malaria attributed its cause to supernatural forces when the symptoms became evident, despite the availability of diagnosis and treatment for malaria in Gambia, thus directly influencing the choice to opt for traditional medicine (Oneil, Gryseels, Dierickx, Mwesigwa, Okebe, Alessandro and Grietens,2015:2). These studies show vast information on the importance of understanding the phenomenon.

In a study conducted by Niehaus, Koen, Muller, Laurent, Stein, Lochner, Seedat, Mbanga, Deleuze, Mallet and Emsley (2005:1), it was noted that clinicians are often confronted by patients who have a markedly different interpretation of their psychiatric symptoms compared to the clinicians. For instance, *ifufunyane* (plural) and *amafufunyana*(singular), a ritualised possession on state, often thought to result from witchcraft, is frequently reported by South African (Xhosa) patients with psychosis (including schizophrenia) and their families (Niehaus et al., 2005:1). In-depth

qualitative research undertaken to explore the health-seeking behaviour of Xhosa women with breast lumps and the factors that influence their health behaviour discovered or established that various cultural factors play a part in the health-seeking behaviour of the Xhosa women with breast lumps, these included their belief about the causal factor, fear of losing their femininity and the stigma attached to having breast cancer (Mdondolo, Villiers & Ehlers, 2003:8).

This alludes to the fact that an individual is prevented from receiving the appropriate assistance as a result of these factors, which have a major influence on their health-seeking behaviour. The results in the study by Mdondolo et al. (2003:8) further indicate that the Xhosa women conceptualised the cause of breast lumps in terms of the supernatural, sorcery or witchcraft. As a result, the results indicated that traditional and faith healers were perceived to be appropriate sources of health care for health problems caused by the supernatural (Mdondolo et al., 2003:8). Due to this belief and ideology, the affected women are said to have gone for medical treatment when breast cancer was already present (Mdondolo et al., 2003:8).

Witchcraft is an innate psychic power to cause illness or misfortune, Webb (2012:99) in his study investigated a sample of isiXhosa mother tongue-speaking science teachers', their learners', and adult local community members' awareness of Xhosa indigenous knowledge and what aspects of this knowledge they valued, and think should and could be integrated into the school science curriculum. The author found out that witchcraft, in general, was noted by 26% of those polled, with a further 11% specifically noting superstitious beliefs about lightning. Apart from being prevalent, similar examples of superstitious beliefs were mentioned across a wide geographic area. These included witches causing harm through spells that killed or made people ill and summoning lightning to kill people or destroy their property.

This alludes to the fact that individuals will seek help from a traditional healer of faith healer when experiencing any health issue that has its premise on witchcraft ideologies, which largely influences one's health-seeking behaviour.

Webb's study also reveals that Xhosa people also placed a great deal in the existence of witchcraft in their communities as a result of some health-related issues faced by people in the community and their loved ones. Moreover, Mdondolo et al. (2003:8) in

their study about cultural factors associated with the management of breast lumps amongst Xhosa women found out that the key informants conceptualised the cause of a breast lump in terms of the supernatural, sorcery/witchcraft and equilibrium explanatory models of illness. The possible causes mentioned were complaints by the ancestors (supernatural causation), the effect of witchcraft (sorcery causation) and other women's jealousy (disequilibrium with the social environment causation). This further shed some light on the possible reasons why some Xhosa people will rather approach other mediums of health as compared to the doctors, clinics and hospitals for assistance. Mdondolo et al. (2003:8) state that traditional and faith healers were perceived to be appropriate sources of health care for health problems caused by supernatural forces, sorcery or disharmony with the social environment.

Meel (2009: 61) explains that elderly women are at highest risk, as they are often identified as witches, placing them at risk of being murdered as a result of such accusations. This has caused a lot of fear among the elderly as they feel unsafe as they could be the next victim to the planned community cleansing of all the evil, which in this case are the elderly labelled as witches (Meel, 2009: 61). This reveals that such cultural perceptions have a large impact on societies and not necessarily health-ailments but rather people's safety too. This also explains how this can have a detrimental effect on an individual's mental health, constantly living under such conditions that evoke anxiety and fear due to an imminent threat of death. Meel (2009:62) explains that several deaths in rural areas of the Xhosa region have been attributed to witchcraft, an issue that cannot be proven at court. He further explains that women fitting descriptions of being dark, short and elderly are often labelled as witches and the community often targets them as a way of eliminating the problem within their community. Such incidents often happen when people die at a young and immediately such deaths are linked to witchcraft as a causal factor (Meel, 2009:62).

In support of this Kleibl and Munck (2017:212) explain it is nearly always elderly women who are accused of using witchcraft; women being the object of many of today's witch-hunts have been seriously hurt and at times assassinated by young men during the attacks denying these individuals of the right to life and safety within their communities; these cultural factors endanger the livelihood of individuals.

Meel (2009:62) clearly explains that there is even a criterion in place to identify who is participating in witchcraft practices and such a criterion is believed among the community and trusted by members of such a community, this criterion includes being a woman, dark and elderly. This criterion, therefore, casts most black women as potential witches and need to be eliminated from society on that basis. Osei (2003:41) defines a witch as a person believed to be capable of harming others supernaturally through the use of innate mystic power, medicines.

Osei (2009:43) explains that authors and researchers who studied and researched this phenomenon have not necessarily presented the views of those studied but of their own and as influenced by their religion, this has been evident through their view of it as a pathetic fallacy that needs to be phased or ruled out of society. Osei (2009) truly believes that such studies have denied the public of rich data that could have been made available to people and allowed them to make their own assessments and conclusions.

Therefore, it is important for the researcher to pay attention to such issues to ensure that the data presented fully reveals the views of the participants and not that of the researcher. The ideology side lines any biological or medical factor as a causal factor for an individual's the death revealing that certain illnesses that could have been treated are not due to the belief that their causal factor is of a supernatural nature in this case witchcraft. These rooted cultural ideologies encourage individuals to continue their focus on one health-care avenue, and in this case traditional healers.

2.6 DISABILITY AND HEALTH-SEEKING BEHAVIOUR OF XHOSA PEOPLE

According to Coleridge (2000:23) many traditional societies do not have an exact equivalent in their language for the word 'disabled', and they can seldom match the three-tier concepts in English of 'impairment', 'handicap' and 'disability' espoused by WHO and disability theorists; they usually do however have words for specific impairments such as 'deaf', 'blind', 'lame', and so on. Coleridge (2000:23) states that the way societies think about people living with disabilities is determined by a variety of cultural variables, including the nature of the impairment.

Wazakili, Mpofu and Devlieger (2006:8) state that the concept of ‘disability’ is often loaded with negative connotations including witchcraft, so that no human being would wish it for themselves or their offspring. This was proven in their study conducted in one of the Western Cape townships, home to Xhosa people in their attempt to discover their experiences and perceptions of HIV/AIDS, sexuality and disability among young people. This information reveals that a stigma around people living with disabilities is created amongst communities through ideologies or beliefs, which in turn, negatively influences the health-seeking behaviour of people living with disabilities or families that have members living with disabilities.

However, certain studies reveal that it is not a universal issue, Ghaly (2016:158) explains that available research results show an overall positive attitude towards people with disabilities within the Islamic tradition. This information rather speaks share different notions as compared to the former as within the Islamic religion, where people living with disabilities have no stigma attached to their existence. In understanding this ideology of disability Pardeck and Murphy (2012:xvii) explain that the moral/religious model of disability is the oldest model of disability and is found in a number of religious traditions, including the Judeo-Christian tradition. This means there is a religious connotation to what a disability is and why a person is living with a disability. This means spiritual factors have an influence on this particular connotation and therefore in people's health-seeking behaviour. Retief and Letšosa (2017:2) explain disability as one of the primary forms of moral and/or religious models of disability, meaning disability should be regarded as a punishment from God for a particular sin or sins that may have been committed by the person with a disability. Sometimes it is not only the individuals’ sin that is regarded as a possible cause of their disability, but also any sin that may have been committed by their parents and/or ancestors (Henderson & Bryan, 2011:7).

The relationship between religion and disability is a complex one. In many cases, the birth of a child with a disability may be seen (and continues to be seen) as either a curse or as a special gift from God, and both of these stereotyped ascriptions have been argued as ways in which parents of such children may be misrecognised and not properly supported (McDougall et al., 2006). At the same time, more studies support the fact that religion or spirituality have been at the baseline of how disability is viewed

and how people living with disabilities are assisted within communities. This largely has a direct impact on the health-seeking behaviour of people living with disabilities within our communities, on whether to access health assistance or shun away due to fear of stigmatisation because in the minority group model of disability, people with disabilities may be viewed as a socially stigmatised minority group subjected to stereotypes, prejudice, and institutional barriers similar to those of an ethnic minority (Eddey & Robey, 2005).

Gallagher, DiGiorgio, Bennett and Antle (2008:30) state that we live in a global society where the experience of disability is culturally bound and determined. To support this notion Chaturvedi (2019:67) states that it is argued that marginalisation of people living with disabilities is culturally as well as contextually determined. This means one way, or the other culture is a factor that cannot be ignored when understanding people living with disabilities in a society and how these particular factors influence their health-seeking behaviour. Gallagher et al. (2008:31) explain that western society has traditionally adopted a medical or clinical view of disability in which disability is a condition to be fixed or cured. In other cultures, disability may be viewed as punishment for a previous generation, the result of committing a sin or offence against the spirits, something that can be contracted or, in religious practice, as a gift. In support of this notion, Makamure (2019:111) established in his study in Zimbabwe that other Christian dominations still rejected, condemned and marginalised people living with disabilities. He further noted that certain married couples in Zimbabwe divorced after a woman gave birth to a child living with disability and communities accused each other of witchcraft after a baby is born with disability (Makamure, 2019:112).

Makushi, Makhubele, and Mabvuira (2019:108) in their study in a Zimbabwean community established that there were some traditional remedies that were meant to end disability, further noting the health consequences they possessed for the child considering hygiene and complications that may arise from taking the remedy in its concentrated form, confirming the fact that there still are communities and religious groups that reject and marginalise people living with disabilities and therefore such factors have a negative impact on their health-seeking behaviour as people living with disabilities. It is important that we note such cultural and religious factors prohibits the person living with a disability to access the necessary help when a need arises

Hopson (2019:23). People with disabilities themselves have a vital role to play in changing the cultural representation of disability. A study further highlighted that hiring people living with disabilities has great benefits in the improvement of profitability such as work ethics, loyalty, and the ability of awareness (Lindsay, Cagliostro, Albarico, Mortaji & Karon, 2018:6). This means just like any other individuals within the society they too have a role to play within society in improving it and influencing how people view people living with disabilities. This in a way might have a direct positive impact on the health-seeking behaviour of people living with disabilities within our communities.

Gallagher (2008:31) explains that the challenges that individuals with disabilities face are a function of society and disability studies examine solutions to break down the barriers that limit individuals' full participation in the community. Bezyak, Sabella and Gattis (2017:19) established in their study that despite legislation mandating accessible public transportation for individuals living with disability, the current transportation systems continued to present significant barriers for people living with disabilities in the United States. This suggests that within society there still are issues at play leading to limited participation of people living with disability and not only that such factors directly affect the health-seeking behaviour of people living with disabilities.

Wazakili et al. (2006:82) explain that in addition, cultural barriers play a significant role in denying participants access to sexual information. Young people with disabilities and parents alike reported that it is taboo in Xhosa culture for parents to discuss sexual matters with their children, whether with a disability or not. According to Wazakili et al. (2006:82) one of the reasons some parents did not bother to educate the children about sexual matters is based on a belief that because they are living with disabilities, they do not experience sexuality like other people. Wazakali et al. (2006:82) indicated that apart from the culture of silence over cross-generational sexuality talks, some parents held the belief that their disabled offspring were asexual. Gil-Llario, Morell-Menguel, Ballester-Arnal and Diaz-Rodriguez (72:2018) explain that people living disability have the same sexual needs as those without any form of disability, however, their sexuality is often restricted due to attitudes or fears based on irrational beliefs. This directly excludes the individuals from accessing health care in respect of their

sexuality, such beliefs have a direct influence on the health-seeking behaviour of a person living with a disability.

2.7 GENDER STEREOTYPES OF XHOSA PEOPLE REGARDING HEALTH-SEEKING BEHAVIOUR

Shaikh and Hatcher (2004:50) explain that men play a paramount role in determining the health needs of a woman. Since men are decision-makers and in control of all the resources, they decide when and where women should seek health care. This suggests that male dominance is still an aspect of society even in this technologically advanced era - an aspect that cannot be ignored as it still affects many people within particular communities or nations and affects some more than others, thus having a direct influence on their health-seeking behaviour. In addition, Abubakar, Van Baar, Fischer, Bomu, Gona, and Newton (2013:5) explain that almost half of the participants in their study had the view that fathers were the ultimate decision-makers in seeking treatment. They further noted that whenever the child required medication or was ill, the child's father was consulted, as noted by one participant mother in the study Abubakar et al., 2013:5). This perfectly illustrates that men in certain tribes still hold all the power and control over the majority, that is women and children. An influence that can either be viewed as positive or negative depending on the outcomes of its exercise.

This is perfectly illustrated in a study by Ugwueje (2012:17) in a discovery that parental differential value for different sexes among their children existed and therefore affected child care and child survival. For example, in Kenya, the girls are valued more because of the bride wealth they attract and as such the males are neglected and their mortality rate is higher than the females. This suggests that in each tribe or society, the sexuality aspect that differs does not necessarily refer to male dominance. In addition, Wasti, Randall, Simkhada and van Teijlingen (2011:40) explain that Nepalese culture is not open to discussion about sex and sexuality. For instance, Nepali people are bound by the culture of silence around sexual matters. This means any related matters to sexuality that might prepare the young for adulthood and certain cautions they may need to put in place to ensure safety is in a way denied.

Furthermore, Wasti et al. (2011:40) state that due to changing values and norms unsafe sexual practices exist and people are increasingly vulnerable to HIV/AIDS. In addition, there are also certain cultural traditions of the Badi and Deuki tribes in Nepal "approve the sale of girls and prostitution". This in a way also illustrates the difference and inconsistency in the treatment of each gender within these tribes. Lastly, Shaikh and Hatcher (2004:50) explain that gender disparity has affected the health of the women in Pakistan too by putting an un-rewarded reproductive burden on them, resulting in early and excessive child-bearing. This has led to 'a normal maternity' being lumped with diseases and health problems. Throughout their life cycle, gender discrimination in child-rearing, nutrition, health care seeking, education and general care render women highly vulnerable and disadvantaged, implying disparity or inconsistency amongst genders do not only exist in one tribe but seem to be relevant amongst different tribes and nations. Beck (2004:11) explains that traditional beliefs seem to be stronger among Xhosa men as compared to Xhosa women, the reasons for this have been linked to the fact that women tend to be more exposed to western medicine. This exposure is mainly due to their life experiences such as family planning, pregnancy and so forth. These allow women a chance to learn to trust such systems, unlike men who are not necessarily exposed to such hence their rigid stance in their traditional beliefs.

In Beck's (2004:11) study, it became evident that males were more susceptible to not receiving treatment when it came to an illness or chronic illnesses such as HIV/AIDS. This makes it hard to encourage the importance of seeking medical attention in dealing with the illness. Beck (2004:11) explains that as the older generations are often uneducated about HIV and place greater faith in traditional medicines than the younger generations, it is often unrealistic to rely on parental pressure as a means of increasing male clinic attendance. In this particular regard, the literature suggests that male supremacy within a community or a tribe can be an influencing factor to the health-seeking behaviour of an individual. This means their influence is likely to support or encourage action towards curbing the health issue or the opposite. This influence can decide what type of health care is accessed and which is deemed highly relevant for the tribe or community.

2.8 COMPLEMENTARY AND TRADITIONAL MEDICINE

According to the World Health Organisation (WHO) (2008), traditional medicine is often termed alternative or complementary medicine in many countries, including herbal treatments as the most popular form of traditional medicine and 70% to 80% of the region has used a form as primary health care. According to the definition of the World Health Organisation (2008) “Traditional medicine refers to the knowledge, skills and practises based on the theories, beliefs and experiences indigenous to different cultures, used in the maintenance of health and the prevention, diagnosis, improvement or treatment of physical and mental illness.”

Ali Arazeem (2011:115) In this regard states that:

> Traditional medicine (TM), variously known as ethno-medicine, folk medicine, native healing, or complementary and alternative medicine (CAM), is the oldest form of health care system that has stood the test of time. It is an ancient and culture-bound method of healing that humans have used to cope and deal with various diseases that have threatened their existence and survival. Hence, TM is broad and diverse. Consequently, different societies have evolved different forms of indigenous healing methods that are captured under the broad concept of TM, e.g. Chinese, Indian and African traditional medicines.

Elujoba, Odeleye and Ogunyemi (2005:46) state that traditional African medicine abbreviated to TAM is our socio-economic and socio-cultural heritage, servicing over 80% of the population in Africa, however, there has not been much progress on its development and utilisation since our ancestors. Mander, Ntuli, Diederichs, and Mavundla (2000:189) state that as much as almost every university in South Africa is involved in indigenous plant chemical research and/or seeking novel chemical products for new markets, there is still little research and development taking place in support of the existing traditional medicine trade in the country. In support of the above Mahomoodally (2013:1) states that the extensive use of traditional medicine in Africa is composed mainly of medicinal plants and has been argued to be linked to cultural and economic reasons.

Bhat (2014:292) explains that plants have played a great role in the history of humankind. He further stated that the Xhosa speaking people of Transkei use a wide range of remedies to treat disease and illnesses. This indicates an important part of the Xhosa culture and the value and trust they place in their medicine. This was confirmed in Bhat's research focusing on the Xhosa people within the Transkei area. Findings of the research was the fact that the identified plants and plant materials were referred to as *imithi* or *umthi* (singular) and these included remedies derived from trees, shrubs, herbs, leaves, barks, bulbs, and roots. The most interesting and important discovery was the fact that much knowledge about medicinal plants and phytomedicines was known by elders, herbalists and traditional healers within the tribe and not just anyone. Mahomoodally (2013:1) explain that the most common traditional medicine in practice across the African continent is the use of medicinal plants, as a result in many parts of Africa, medicinal plants are the most easily accessible health resource available to the community. Hirst (2005:1) states that it is by no means unusual for a diviner, after dreaming about a medicinal plant (*iyeza*) in the bush, to go and collect it in the place in which it was seen in the dream and to use it to treat (*ukunyanga*) a client or novice. Nor is it unusual for a diviner to dream about people with various afflictions coming for divination (*imvumisa, evumiso*) and treatment. In another study conducted by Webb (2012:98) he discovered that health-related issues such as traditional herbal knowledge, extraction of chemicals from plants, mixing of traditional medicines, and HIV/AIDS issues were mentioned by 20 % of the respondents.

Webb (2012:98) explains that in his studies it became evident that most people relied on the use of traditional herbal medicine that was either collected personally or obtained from traditional healers (sangomas). In the study and similar studies conducted by various researchers, it became evident that some Xhosa people identified some faith and confidence in their traditional health methods.

Mothibe and Sibanda (2019:1) postulate that African traditional medicine (ATM) has been used by African people for the management and cure of life-threatening health issues and diseases long before the dawn of conventional western medicine and continues being a major part of treatment for the majority of society. As a result, due

to the fact that South Africa is a member of the World Health Organisation, it has been handed the privilege to institutionalise the African traditional medicine.

Mothibe and Sibanda (2019:7) explain that many reasons exist for the use of traditional medicine, cultural practice being the main and common reason for use, however other reasons include affordability, availability, accessibility, spiritual and emotional reasons and a general desire for wellness. Furthermore, statics indicate that the trade in traditional medicines in South Africa is estimated to be worth R2.9 billion per year, representing 5.6% of the National Health budget. With 27 million consumers, the trade is vibrant and widespread, (Mavundla et al., 2000:189).

Mavundla et al. (2000:190) in their study findings further established that the diversity in consumers showed that consumption of traditional medicine is a common practice across most sectors of the Black African population and that traditional medicinal use is not confined to poor, rural, and uneducated users; therefore, the people and this case tribe's pursuit of the study are somehow influenced by the traditional or cultural medicines or remedies used by the tribe.

2.9 ROLE OF SOCIAL WORKERS IN ASSISTING XHOSA PEOPLE REGARDING HEALTH-SEEKING BEHAVIOUR:

This section details the roles of social workers that might be effective when employed in assisting Xhosa people regarding health-seeking behaviour that will be established through the conducted study within this particular tribe.

Parast and Allaii (2014:59) explain that social work differs from other professions in the health care system because its role is to accept the clients and embody a professional attitude that allows the social worker to assess their clients in three areas: the need for assessment, the condition of the client and lastly the interaction between person and community. The statement fully explains what social work roles entail within practice, and its vital importance to human well-being.

The roles of social workers are defined below.

i. Advocate: Hoefer (2006:8) defines social work advocacy as, "that part of social work practice where the social worker takes action in a systematic and purposeful way to defend, represent, or otherwise advance the cause of one or more clients at the individual, group, organisational or community level, in order to promote social justice". In simple terms, this means standing up for your patients and advocating for their rights to access culturally appropriate healthcare. This will ensure that some of the issues or challenges that they face such as financial resources and literacy can be overcome as you as a social worker will help healthcare practitioners understand some of the challenges faced by patients in adhering to treatment or clinic or hospital visits.

In support of this Rizzo and Seidman (2009) in their paper state that social workers can help to promote health by advocating for the development of employment opportunities that will improve the socioeconomic status of all segments of society and thus their access to health and preventive services. Lens and Gibelman (2000:614) explain that advocacy can be directly related to clinical work through a common goal, that is, "helping clients become independent and exercise influence and control over their own lives". Enabling the clients to be independent when it comes to their healthcare choices in general without their rights being infringed upon.

ii. Educator and counsellor: Zastrow (2004:79) states that the role of an educator within the social work field entails providing information to people, teaching adaptive skills and communicating the essential tools.

In support of this Rizzo and Seidman (2009) in their paper state that using education and counselling, social workers, on an individual basis, can help to address diseases, such as obesity, that are so prevalent in American society. This entails being in charge of patient education, by providing them with all information pertaining to their health and ensuring they understand things like discharge paperwork, know how to obtain and use their treatment and further teach the importance of follow-up visits and adherence to treatment. This will directly have a positive influence on the health-seeking behaviour of the Xhosa people residing in Johannesburg.

iii. Referrer: Zastrow (2004:39) explains that one of the roles of the social worker is to connect individuals with systems that provide them with resources, services and opportunities. In a study conducted amongst the elderly in the rural Central Otago, Aotearoa New Zealand, it was established that more people within the community were unaware of the role of social workers upon being referred for a particular service, the participants noted the importance of publicising the social work role as they believed it can serve greatly in meeting the needs of clients within their community (Diamond & Jaye, 2020:123). This means that social workers will fulfil the function of connecting people with whatever additional and necessary resources they may need to reach their optimal health status.

iv. Supporter: Sukmana and Abidin (2020:1318) explain that this role ensures that social workers provide the necessary psychological and emotional support that people will need. Kirst-Ashman (2010) explains that the role of a social worker entails counselling, providing guidance to clients and assisting them with a planned change or problem-solving. This can range from an individual being diagnosed with an illness or when they recover from illness, and the social worker steps in as a support system to help them adjust to changes in life. This kind of support can influence the health seeking behaviour of an individual.

v. Community worker: Rizzo and Seidman (2009) in their paper explain that social workers can be actively involved in social planning to ensure a safe and accessible community environment by working to reduce potential barriers to the promotion of health.

According to Parast and Allaii (2014:59), the rise in numbers of patients within the community demands the use of social workers to establish the root of illnesses and social problems employing a team effort approach, this is based on the fact that social workers are known for their application of distinguishing strategies such as community-based work, social objectives and the implementation of health programmes based on community.

This means taking an active role within the community setting and taking notes of all the needs of the members and together with the community finding ways to resolve the problem or finding a sustainable solution.

vi. Enabler: Sukmana and Abidin (2020:1322) in their study established that the role of a social worker as an enabler became extremely prominent in the field of practice during the COVID-19 pandemic. Zastrow (2010) defines it as a role that a social worker occupies in ensuring that individuals or groups are provided with a platform to express their needs as well as explain and define the need with the aim of improving their capacity to cope better with the problem. Zastrow (2004:77) explains an enabler as a social worker who articulates the needs of the people within a community and clarifies and identifies problems as well.

In this particular role, the social worker focuses on the needs assessment within the community, a role embedded within community work.

vii. Activists: Hyde (2021:1) explains that this role entails a commitment to social justice, including advocating on behalf of economically disenfranchised populations. As explained by Zastrow (2004:77) this means the role is one that encompasses seeking change within communities or people's lives, causing the necessary shift in power and resources to the disadvantaged individuals or groups.

This role can be simply defined as the fighter of the people, the one who ensures that people are afforded what they need and in no way are their rights denied in service delivery or assessing the necessary resources.

viii. Mediator: Roberts (2017) defines this role as an aid to joint decision-making in the context of a range of family disputes. He further states that it is seen as a process of intervention distinct from social work, drawing on a distinctive body of knowledge across fields including anthropology, psychology and negotiation theory. Zastrow (2004:78) refers to this social work role as one that entails providing interventions in disputes with the aim of finding a compromise, reconciling and reaching an agreement by playing a neutral role throughout.

This role will serve as an important factor in family conflicts regarding the choice of health care to embark on.

ix. Initiator: Sanzharovets, Petrenko, Mietule, Platash and Kostyk (2021) explain the role of a social worker as an initiator of innovation, the purpose is to create, modernise or maintain in a changed environment the material or spiritual value of people,

recognised as positive in its social value. Zastrow (2004:78) explains that this particular role entails a social worker calling attention to a problem or a challenge. Social workers are there within communities to note any issues that can impede on the people's well-being by bringing them to the necessary offices.

x. Empowerer: Strydom, Wessels and Strydom (2010:46) explain an empowerer as a social work role where a social worker spends little time trying to understand what caused the problem and rather focuses on identifying or uncovering people's strengths and creating a mindset to look at the positives. This is further supported by Zastrow (2004:78) when he states that the role of an empowerer as a social worker means providing help that increases strength by improving circumstances evident in people's lives or communities.

This means focusing on developing and growing people within their communities with the aim to improve their circumstances.

2.10 SUMMARY

As noted throughout this review, many authors have highlighted the importance of culture and spirituality to the tribes, ethnic groups they have studied across diverse nations or countries and the value they hold for it.

As much as a lot of similarities do exist in terms of culture and spiritual factors and how they influence health, a lot of differences also exist, and this is mainly affected by the different cultural practices and spiritual beliefs and influenced by the laws and regulations of the particular country. This reveals the fact that the tribe does place meaning on some health issues as influenced by their belief system, whether culturally or spiritually based. This indicates that further research needs to be done in every facet of health concerning the particular group of people being studied. This is to ensure that an all round in-depth understanding of the Xhosa culture and their spirituality has been explored and explored closely along the lines of the factors within their culture and spirituality that affect their people's health-seeking behaviour. No studies have solely explored both the cultural and spiritual factors influencing health-seeking behaviour within the Xhosa tribe in Johannesburg. Little information exists that would assist in understanding how cultural and spiritual factors that have been

studied influence the health-seeking behaviour of this particular tribe. A lot of research has mainly been done on the social and economic factors that influence health-seeking behaviour.

An in-depth understanding of the cultural and spiritual factors influencing health-seeking behaviour of the Xhosa people in Johannesburg will provide the health care system with a vast understanding of how to serve the needs of this particular group and ensure effective service delivery is offered.

In addition to helping the researcher realise what areas of the research need more focus, the literature review also helped to establish the research questions that the study was based on and further highlighted the areas of future research that need further investigations.

This succeeding chapter presents the research methodology and empirical findings.

CHAPTER 3
RESEARCH METHODOLOGY AND EMPIRICAL FINDINGS

3.1. INTRODUCTION

The purpose of this chapter is to present, explore and interpret the empirical findings of the study. The study aimed to explore the cultural and spiritual factors influencing the health-seeking behaviours of the Xhosa people in Johannesburg. In understanding this phenomenon, the study was guided by the goal of the study and objectives as steps to understand the phenomenon in further detail. The researcher ensured that every action and step taken during the study was directed and guided to answer the research question.

Primarily the chapter details the discussion of the research approach, research type, research design and the research methodology that was employed during the study. It further depicts information on the pilot study and the ethical considerations that were followed. The personal information of the participants was detailed, followed by the emerging themes with their sub-themes from the interviews conducted during the study and supported by relevant literature. It then closes off with detailed information on the limitations of the study as identified by the researcher during the study.

3.2. RESEARCH APPROACH, RESEARCH TYPE AND RESEARCH DESIGN

3.2.1. RESEARCH APPROACH

Silverman (2020:3) in simple terms defines qualitative research as the type of research that finds out about people's experience, therefore helping us understand what is important for people, creating a successful research application. Qualitative research focuses on understanding a research query as a humanistic or idealistic approach, this means a method used to understand people's beliefs, experiences, attitudes, behaviour and interactions generating non-numerical data (Pathak, Jena and Karla, 2013:192).

Marczyk, DeMatteo and Festinger (2005:17) define qualitative research as an approach that involves studies that do not attempt to quantify their results through statistical summary or analysis. In addressing the objectives of the study outlined the

researcher employed a qualitative method or research approach that is explorative, descriptive and contextual in nature mainly due to the fact that the researcher attempts to gain an in-depth understanding of Xhosa culture and spiritual factors influencing their health-seeking behaviour. This particular approach typically involves interviews and observations without formal measurement in its studies (Marczyk, DeMatteo & Festinger, 2005:17). Hence, the data that was received as a result of this particular method was very rich as it is generally grounded from the participants' views and experiences since it allowed an in-depth understanding of the case studied.

3.3. RESEARCH TYPE

The purpose of applied research is to increase what is known about a problem to create a better solution (Purdy, 2010:35). The study embarked on used the applied research type as it allowed the researcher to ask questions designed to provide data that could be used to improve a situation or solve a problem (Creswell, 2016:9). This research type was explorative in nature and enabled the researcher to gain in-depth information as well as understand the cultural and spiritual factors influencing health-seeking behaviours of Xhosa people in Johannesburg. Hence, the applied research focuses on real-life problems, which require action prior to a policy decision being taken, and it may end up making a scientific contribution to the development of the theoretical knowledge (Das, Tarafder & Nahar, 2016:7). Therefore, allowing the findings of the study to assist with providing recommendations for social workers in practice, the Department of Social Development, Department of Health and any related field or department. The recommendations will further serve as a basis for informing the policy makers and suggest strategies to social workers and health-related practitioners on ways to intervene in detrimental health factors that influence health-seeking behaviours.

3.4. RESEARCH DESIGN

According to Creswell, Ebersohn, Eloff, Ferreira, Ivankova, Jansen, Nieuwenhuis, Pietersen and Clark (2016:72), a research design is a plan or strategy that moves from the underlying philosophical assumptions to specifying the selection of participants, the data-gathering methods to be used and the data analysis to be done. This means the selection of a research design is of utmost importance in any research. It enables easy outlining of issues such as how the study will be carried out and ensuring that

the research objectives are achieved. Yin (2003:13) defines a case study as an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident. Schwartz-Shea and Yanow (2012:2) explain that research designs are about making choices and articulating a rationale for the choices one has made. Hence within this very study, a case study research design was selected to conduct the study, with an instrumental case study research design as a sub-type, due to its congruent nature with the research question.

3.5. RESEARCH METHODS

This particular section deliberates on the practical activities undertaken throughout the study such as sampling, data collection, data analysis, data quality and the pilot study (Carter & Little, 2007:1318).

3.5.1. STUDY POPULATION AND SAMPLING

The study population consisted of individuals selected from the Xhosa people residing in the Johannesburg area. Individuals who formed part of the tribe that the study focused on, a sample of people that ensured a true representation of the experiences by the tribe. Ten people comprising of six females and four males were interviewed for the actual study excluding one person who participated in the pilot study. The number of the participants selected for the study, proved to be the perfect number of selection as they provided data that was rich and relevant to the study, in other words, data provided adequate insight for meaningful and relevant results. Taherdoost (2016:23) explains it is where the researcher includes cases or participants in the sample because they believe that they warrant inclusion.

A non-probability purposive sampling method was employed to collect data. This type of sampling method proved to be very suitable for the study as it was able to explore and understand Xhosa culture and spiritual factors influencing health-seeking behaviour. It ensured that the participants had the characteristics and knowledge needed by the researcher (Babbie &Mouton, 2001, De Vos et al., 2002, Struwig & Stead, 2001). The researcher approached one Xhosa person who referred her to other potential participants, the initial participant was able to share with the researcher the

contact details of potential participants who were interested in being part of the study. This is the snowball sampling, a recruitment technique in which research participants are asked to assist the researcher in identifying other potential subjects who qualify to provide the information relevant to the study. Therefore, the participants were able to provide the data required for the study adequately.

The researcher reached a point in the study where no new information could be obtained from the participants achieving data saturation. Moser and Korstjens (2018:11) describe this process as a collection of qualitative data to the point where a sense of closure is attained because new data yields redundant information.

In support, Guest, Bunce and Johnson (2006:65) define data saturation as a point in data collection and analysis when new information is said to produce little or no change to the codebook. This means the researcher reached a point in her data collection and analysis of data where little new information could be produced by the data at hand, confirming data saturation had been reached.

3.5.2. DATA COLLECTION

The data collection technique that was used in gathering the information was a semi-structured interview. This type of interview proved to be most appropriate in achieving the goal of the study and that was to gather an in-depth understanding of the phenomenon. Adams (2015:493) states that semi-structured interviews are superbly suited for several valuable tasks, particularly when more than a few of the open-ended questions require follow-up queries. He further explains that this is used specifically in situations where you need to ask probing, open-ended questions and want to know the independent thoughts of everyone in a group (Adams, 2015:494).

To truthfully represent this, in-depth understanding needed to be gained, and in-depth information or data needed to be received in the most accurate manner, hence the use of a recorder during each interview. The use of the recorder led to the need for and importance of ensuring that each interview's data/information was transcribed and analysed. The data has been stored for the purpose of serving as evidence of research done and as per the departmental requirement.

De Vos et al. (2011: 359) explain that a recorder allows the researcher to concentrate on how the interview is proceeding and where to go next. Each participant was interviewed individually to ensure confidentiality was maintained, this meant that the interview was one-on-one, consisting of the researcher and the participant. The recorder was used for each interview conducted and consent to record the interview was received from each participant (see appendix C for the consent form). The process of the recorder proved to be very efficient and less time-consuming keeping in mind that if the researcher had to write down notes during the interview process it would have taken more time and may have caused slight distractions as the researcher would have lost the opportunity to listen attentively and observe the participant during the study.

The researcher employed the use of an interview schedule (see appendix D for the interview schedule) that served as a guide with a set of predetermined questions as drafted; however, flexibility was the order of the day as the researcher was able to probe and had the opportunity to get clarity with certain answers that the participants providing repeatedly for each question.

3.5.3. DATA ANALYSIS

Flick (2013: 4) explains data analysis as a process describes a phenomenon in some or greater detail, with a comparison of several cases on what they have in common or on the differences between them. Graue (2015:8) explains that the phenomena under study need to be described precisely, meaning the researcher needs to be able to interpret and explain the data.

The generated data was analysed using the eight steps as suggested by Tesch (1990:142-145) cited in Creswell (2009:186).

- **Preparation of data**

The researcher transferred all the recorded data word for word on paper. The researcher further took time to go through all the transcripts by rereading all. This was intended to gain a sense of understanding about the gathered data from each participant. In support of this process followed, Theron (2015:7) states that this refers

to the transcribing of the interviews and the sorting and arranging of the data if different sources of information are used.

- **Defining the unit or theme of analysis**

According to Tesch (1990:142-145) cited in Creswell (2009:198), this process entails picking one transcript document, the shortest one on the top of the pile, reviewing it, asking yourself, what it was about. A process of not thinking about its substance but the underlying meaning and noting it down in the margins.

The researcher took time to divide the data into units, this was guided by the similarities found in each transcript or paragraph. These units were ones that were meaningful to the study, not just units like because or what. These themes were then outlined and grouped to make sense of the data received. The process was to ensure the essence of the interview was established and notes were included in the side margins.

- **Developing categories and coding schemes**

Tesch (1990:142-145) cited in Creswell (2009:198) explains that when you have completed this task for several participants, make a list of all the topics, clustering together similar topics forming them into columns. In this step once the themes were established the researcher arranged them, further listed them and then sorted them according to the similarities they possessed. The researcher then proceeded to table the themes, creating main and sub-topics.

In support of this Theron (2015:7) states that the researchers need to identify prominent themes, recurring ideas and patterns of belief that link people and settings together.

- **Pre-testing the coding schemes on sample**

Tesch (1990:142-145) cited in Creswell (2009:198) explains that in this step you take the list and go back to your data, abbreviating the topics as codes and writing the

codes next to the appropriate segments of the texts. He further states that this preliminary organising of schemes should be tried to see if new categories and codes emerge.

This served as an important step in the analysis as it was conducted to ensure consistency when the researcher went through the process of coding all the existing information to establish whether the level of consistency was not low. It was also important that she became aware of the fact that a re-coding will have to be employed all over again to maintain a state of constancy across.

- **Coding all text**

According to Tesch (1990:142-145) cited in Creswell (2009:198) this step is about finding the most descriptive wording for your topics and turning them into categories, grouping topics that relate to each other. This was achieved by going through all the data that was received, thoroughly labelling and organising the information received from all transcripts.

This process was followed to ensure that themes emanated from the data. Common themes were established, these were important or recurring words or phrases. It is the process of organising the data into chunks of information and writing a word that represents a category in the margin (Theron, 2015:7).

- **Assessing the consistency of coding employed**

Tesch (1990:142-145) cited in Creswell (2009:198) explains that this step is about making a final decision on the abbreviation for each category and alphabetising these codes. This is the step in which the data was also checked to see if re-coding was necessary and the process of analysis was then finalised (Creswell, 2009:186).

This was the step that demanded out of the researcher a validity and reliability check. This process was taken after the researcher had ensured that all the information or data was fully coded.

- **Drawing inferences based on coding or themes**

According to Tesch (1990:142-145) cited in Creswell (2009:198) this step entails assembling the data material belonging to each category in one place and performing a preliminary analysis. This is the step in which the researcher drew inferences on the basis of the codes and categories generated from the data. This meant the researcher had to take time and thoroughly go through each interview recording and each interview sheet. This served as the most important step in the process of data analysis. It enabled the researcher to make or draw interpretations and conclusions that stem from the basis of the collected data in this particular study.

- **Presentation of results**

Tesch (1990:142-145) cited in Creswell (2009:198) explains that this step is all about recode of your existing data. The researcher then took the time to present the findings or data under each theme with conclusions and made use of tables and graphs to clearly depict the results with clear and concise understanding. In support of this process Theron (2015:8) states that this is often done in a narrative passage to convey the findings of the analysis.

3.5.4. DATA QUALITY

Ensuring trustworthiness in data was imperative to ensure the success of the study, to do that the researcher took into consideration the following aspects.

3.5.4.1. Credibility

Smyth (2006:139) states that the credibility of research is most appropriately established by making judgments about the worth of unstructured data by evaluating its consistency. This means credibility refers to the truth of the data or the participant's views and the interpretation and representation of them by the researcher (2012, Polit & Beck). This required the researcher to establish a link between the findings in the study and that of the real world to indicate the truth of the study findings. In this regard, Smyth (2009:139) explains that when a close connection with the environment can be sustained over the life of the project, a researcher demonstrates credibility. Firstly, this meant examining why the study was initially conducted, how the data was collected from participants and whether participation was voluntary. This, in turn, guided the researcher in ensuring the credibility of the study.

One of the strategies employed was the technique of peer debriefing, Hail, Hurst and Camp (2011:83) define this strategy as discussing reflections and perceptions with a disinterested peer to see a situation more clearly, as it is a tool that is utilised to strengthen the data. In adhering to the advice that the literature suggested, the researcher made use of the peer debriefing strategy. The researcher employed the critical detective method and reflections of a peer in assessing the study, in this way the researcher was able to enhance the credibility of the study. In support of the benefits of the application of the strategy, Simoni, Beima-Sofie, Amico, Hosek, Johnson and Mensch (2019:2186) explain that peer debriefing involves discussing experiences and findings with other interviewers or research teams throughout the process of gathering interview data, to enhance the interviewers' self-reflection and build confidence in the data collected.

This means the researcher was able to create space for this particular qualitative research technique in her study. Triangulation is defined as a method that is used to increase the credibility and validity of research findings, mainly due to the fact that it explores and explains complex human behaviour using a variety of methods to offer a more balanced explanation to readers. (Noble & Heale, 2019:67).

In this particular study, the social worker employed the use of theory triangulation to ensure the credibility of the research findings. Carter, Bryant-Lukosius, DiCenso, Blythe, and Neville (2014:545) explain theory triangulation as triangulation that uses theories to analyse and interpret data. The researcher made use of this triangulation type in the study; this took place when upon receiving the data from the study, she employed the health belief model in an attempt to make sense of the findings of the study.

3.5.4.2. Transferability

Transferability is used to provide evidence to the reader to assess the integrity of research outcomes (Cope, 2014:89). In an attempt to indicate that the research findings would be applicable to other contexts or populations, the researcher will provide evidence that will establish that the research findings could be applicable. To conduct this process, the researcher maintained her guide by Guba's model. It is imperative that we remain aware of the fact that this particular study is done on a small

scale as compared to quantitative studies that can easily be generalised to a wider audience.

However, in this particular study, it became evident that certain findings can be applied to members of the same tribe who are traditionally guided in their day-to-day living, whereas other findings can serve as a guide for dealing with individuals in general and as a simple guide in further research. In other words, a qualitative study is considered transferable if the findings have meaning to individuals not involved in the study or the readers of the research can associate the findings with their own experiences (Cope, 2014:89). In this regard, Hannes (2011) explains that it also requires a detailed description of the context of the study, sample characteristics (e.g., demographic data) and the participants' experiences. Thus, it was crucial that the researcher clearly indicates the degree to which the findings may or may not be apply to other environments or contexts (Moon, Brewer, Januchowski-Hartley, Adams &Blackman, 2016:19).

Ferrando, Hoogerwerf and Kadyrbaeva (2019:1) in their study ascertained that the transferability model is extremely important as it had the ability to provide knowledge and essential insights for policy makers and service providers, this is evident in their study.

3.5.4.3. DEPENDABILITY

This can be achieved when another researcher concurs with the decision trails at each stage of the research process (Cope, 2014:89). An important question had to be asked and answered by the researcher and that question was whether the research findings proved to be consistent and reliable. Moon et al. (2016:18) state that dependability refers to the consistency and reliability of the research findings and the degree to which research procedures are documented, allowing someone outside the research to follow, audit, and critique the research process. To establish that the researcher employed an audit trail technique, the researcher ensured that a track was available for the next person to follow, facilitating future studies. This means dependability is established when there is consensus because this demonstrates that the researcher and the researched have understood their communications (Smyth, 2006:141).

Moon (2019:103) explains that to ensure information derived from the study accurately reflects the truth about the phenomena under investigation, the use of triangulation is one method that helps increase confirmability in a study. To ensure this, the researcher made use of the triangulation method, allowing her to confirm the findings by examining the phenomenon from different perspectives.

3.5.4.4 Conformability

This was of importance, as it was imperative that the researcher established that the findings of the study were solely of the participant's accounts and not that of the researcher. In establishing that the findings were shaped by the participants and not the researcher, an audit trail technique was employed. This refers to a detailed, comprehensive accounting of all data collection and data analysis activities that were completed (White, Oelke & Friesen, 2012:251). The audit trail was not once-off but rather a process as it stems from the identification of the problem or the particular study to embark on until the very end, and not a process that just emanates from the analysing of data collected.

This is because the audit trail technique involves the systematic recording and presentation of information about the material gathered and the processes involved in a qualitative research project (Bowen, 2009:307). Bowen (2009:307) states that it is a record of the research process as well as the theoretical, methodological, and analytical choices made by the researcher. This is mainly due to the fact that confirmability is "concerned with establishing that data and interpretations of the findings are not figments of the inquirer's imagination but are clearly derived from the data (Tobin & Begley, 2004:392).

3.6. PILOT STUDY

A pilot study is performed reflecting all the procedures of the main study and validates the feasibility of the study by assessing the inclusion and exclusion criteria of the participants (In, 2017:601). This process was conducted prior to the actual study to establish the factors that might affect the study. The researcher ensured that the participants in the pilot study presented with the same characteristics as with the participants who would form part of the actual study.

According to Kim (2010:2), the principal benefit of conducting a pilot study is that it provides researchers with an opportunity to make adjustments and revisions to the main study. This ensured that the researcher clearly tested the interview questions scheduled for the study and took note of the advantages and disadvantages that were identified to rectify or improve the study. The researcher conducted a pilot study with two participants who served as the basis for the coming interviews, the information received was stored and the research made reference to it. It also served as a training ground for the researcher as it prepared her for the actual study by improving her interviewing skills, an aspect that is vital to the success of the study, Strydom (2011:115) clearly explains that this was something to be expected when a researcher embarks on a journey of testing the study.

3.7. ETHICAL CONSIDERATION

The protection of human subjects through the application of appropriate ethical principles is important in any research study (Arifin, 2018:30). The researcher ensured that all the specified, chosen and detailed ethical standards set by the generic research ethics were honoured at all times throughout the study. In ensuring that this was honoured, all participants participated voluntarily without any coercion. Every participant gave their consent to partake in the study and as well as being recorded while being interviewed, this was through a signed consent form provided by the researcher. All information pertaining to their participation in the study was clearly explained and shared with every participant involved.

3.7.1 AVOIDANCE OF HARM

Bell and Bryman (2007:68) state that in social research, the possibility of harm is arguably considerably less, but social scientists still have the capacity to wrong research participants. He further explained that wrongdoing in research involves a failure to treat research participants as important in themselves, researchers instead view them as a means to an end (Bell & Bryman, 2007:68).

The signing of informed consent forms by participants was one of the techniques employed in the avoidance of harm that could have potentially taken place during the

study. The researcher further ensured that each participant was aware of the fact that they had a right to withdraw from the study at any time and that should they require any counselling as a result of the study they will be referred to a reliable professional for assistance.

3.7.2 INFORMED CONSENT

Kanuka and Anderson (2007:24) explain that informed and voluntary consent must be obtained from all participants. This means before the commencement of a study, participant's consent must have been obtained and without any coercion. The researcher ensured that the process of the study, what it entailed and what will be expected from the participants was clearly explained to all participants before engaging in the study.

Klykken (2021:2) states that facilitating free and informed consent is a key ethical standard to consider when conducting social research. This means one cannot ignore this aspect in the process of conducting research. The researcher ensured that each participant was informed about all the details pertaining to the interview.

Klykken (2021:2) further explains that an important criterion for consent's validity is that an individual's decision is voluntary and based on clear, unambiguous information about what engagement in the research will entail. This was a process where the researcher took time to explain the purpose of the study and clearly indicate that the study was voluntary and there was no sort of remuneration for participation.

The researcher provided each participant with an informed consent document that further explained all in detail (see appendix for informed consent). All the participants indicated their willingness to be part of the study, this was not only verbal responses, they also appended their signatures to the form (informed consent form). The researcher ensured that she sought permission from each participant to digitally record the interviews, before proceeding with the interviews and the recording of the interviews. The researcher informed the participants that the data collected will be stored at the University of Pretoria for a period of 15 years.

3.7.3. VOLUNTARY PARTICIPATION

Arifin (20:30) explains that to participate in a research study means, participants need to be adequately informed about the research, comprehend the information and have the power of freedom of choice to allow them to decide whether to participate or decline.

To ensure the manifestation of this the researcher informed all the participants that their participation was voluntary and that they were not compelled to participate or continue with the study. The participants clearly consented to being part of the study by appending their signatures on the consent form provided by the researcher.

In this regard, Spruce and Bol (2015) explained that voluntary participation in data collection is of critical value as it ensures and confirms the success and accuracy of a study or research. This means involuntary participation in a study would prove bias as it will render inaccurate findings, as they would not necessarily be a true reflection of the participants. Therefore, participants' voluntary involvement in a survey is a decisive factor in determining the margin of error (Chesney & Penny, 2013). Therefore, it is clear that voluntary participation serves a great benefit to the study and its success.

3.7.4. VIOLATION OF PRIVACY OR ANONYMITY/CONFIDENTIALITY

One of the key issues in the ethical conduct of research is the confidentiality of both the participants' identities and the findings gained (Giordano, O'Reilly, Taylor &Dogra, 2007:264). Saunders, Kitzinger and Kitzinger (2015:617) explain that confidentiality' is a generic term that refers to all information that is kept hidden from everyone except the primary research team. This means anyone outside this team has no clearance in any information pertaining to the participants. The researcher ensured that each participant's privacy or anonymity was respected by ensuring that in the presentation of data their real names were not used but participants were referred to, for example, as P1 or P2, in this way only the researcher was aware of the true identities of each participant.

They further stated that anonymity is one form of confidentiality that entails recording participants' identities secretly (Saunders, Kitzinger & Kitzinger, 2015:617). However, confidentiality also includes keeping private what is said by the participants, something only achievable through researchers choosing not to share parts of the data

(Saunders, Kitzinger & Kitzinger, 2015:617). This means what was shared with the researcher needs to be safeguarded. In ensuring this all information collected from the participants in the form of recordings, and transcripts were stored in a place that will not expose them or violate their privacy or anonymity/confidentiality.

To further ensure their privacy, the researcher ensured that the interview dealt with follow up questions that were relevant to the study and necessary, without imposing on their privacy.

Walford (2005:83) states that researchers should give anonymity to research sites and the individuals involved in research. This means a site or location of the interviews for the study can possess a threat to the anonymity of participants. The participants were all interviewed in locations or environments they had personally chosen and felt comfortable with and this provided them with their own guaranteed anonymity.

3.7.5. PUBLICATION OF FINDINGS

Proper publication of findings ensures that findings are not manipulated to prove the researcher's ideas but rather the ideas and views of the participants (Strydom, 2011:126). Throughout the process, the researcher ensured that the study was protected by constantly taking into consideration the research ethics principles. The researcher aimed towards mutual respect, fairness and to safeguard the participants and their information.

This was to ensure the results of the study could be published in an unbiased manner and made available to participants and the public without compromising their privacy or anonymity or harming them in any way. In its most basic form, publication bias exists when a set of published studies is not representative of all available or possible studies (Findley, Jensen, Malesky &Pepinsky, 2016:5). This is due to publication bias of the findings which is a great threat to the validity of qualitative and quantitative published inferences (Jacobs, 2019:2).

3.8. EMPIRICAL FINDINGS

Reay (2014:100) explains that the overall purpose of the discussion section is to build a theoretical story of your work, where you compare and contrast your empirical findings with the established literature. This means that you explain how your findings are similar or different from the literature that you reviewed in the literature review

section. This section details the research findings from the study. The section will firstly present the biographical information of the participants who formed part of the study. This will be followed by the presentation of the research findings through an orderly demonstration.

SECTION A: Biographic details

3.8.1. Biographical Information of the Xhosa people residing in Johannesburg area.

Participant	Age	Gender	Marital Status	No of children	Religion	Home language	Highest Qualification
1	19	Female	Single	None	Christianity	IsiXhosa	Grade 12
2	32	Female	Single	2	Christianity	IsiXhosa	Bachelor of Social Work
3	31	Female	Single	1	Christianity	IsiXhosa	Bachelor of Social Work
4	24	Female	Single	1	Christianity	IsiXhosa	Grade 12
5	40	Male	Single	2	Christianity	IsiXhosa	Diploma in Sound Engineering
6	28	Male	Single	None	Christianity	IsiXhosa	Diploma in Public Management
7	42	Female	Single	2	Christianity	IsiXhosa	Bachelor of Social Work
8	48	Female	Married	3	Christianity	IsiXhosa	Bachelor of Social Work & Bachelor of Education
9	25	Male	Single	None	Christianity	IsiXhosa	National Diploma in Civil Engineer
10	29	Male	Single	2	Christianity	IsiXhosa	Bachelor of Social Work

The table above summarises biographical information of all ten participants who voluntarily participated in the study. Their biographical information is decomposed into, age, gender, marital status, number of children, home language and their highest qualification obtained.

The purpose of this is to outline the participants' similarities and differences. From the table below, the majority of the participants were females (seven) while only three were males.

The oldest participant was aged 48 and the youngest was 19 years old, in terms of their level of education, the lowest level was a matriculation (grade 12) national certificate and the highest a Bachelor's degree. Thus, the majority of the participants were graduates and employed in different companies.

In terms of religion, the majority of the participant were migrant Christians attending different church denominations. By virtue of that, the members were not fully committed to the activities of the different churches. Nonetheless, the participants belonged to the same tribal group and resided in Johannesburg.

3.8.1.1 AGES OF PARTICIPANTS

Figure 1: Age of the participants

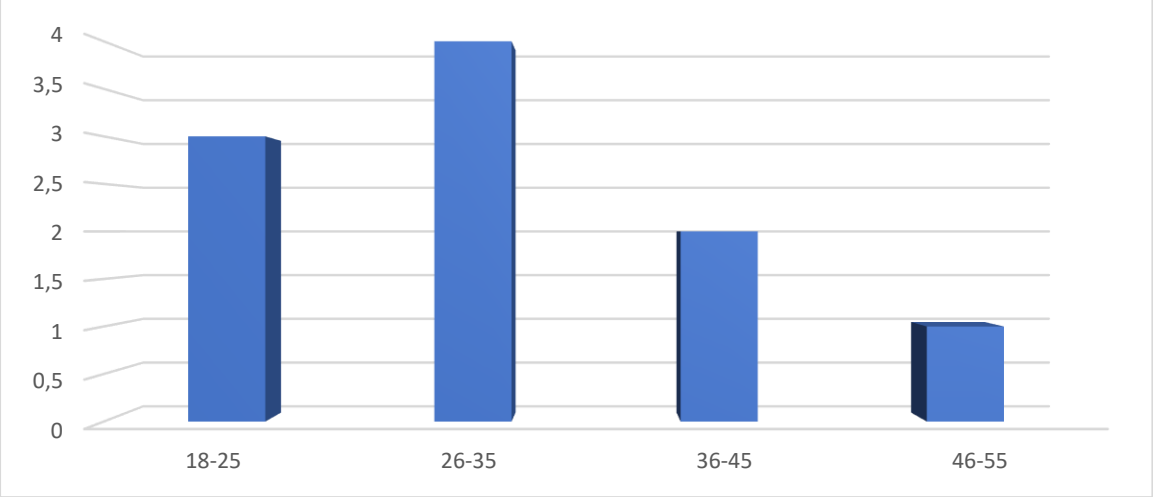

Figure 1 shows the age of the participants. The majority (four) of the participants were aged between 26-35 years, three were aged between 18-25 and two were between the age group 36-45 years. Only one participant was in the age range 46-55 years.

3.8.1.2 GENDER OF PARTICIPANTS

Figure 2: Gender of the participants

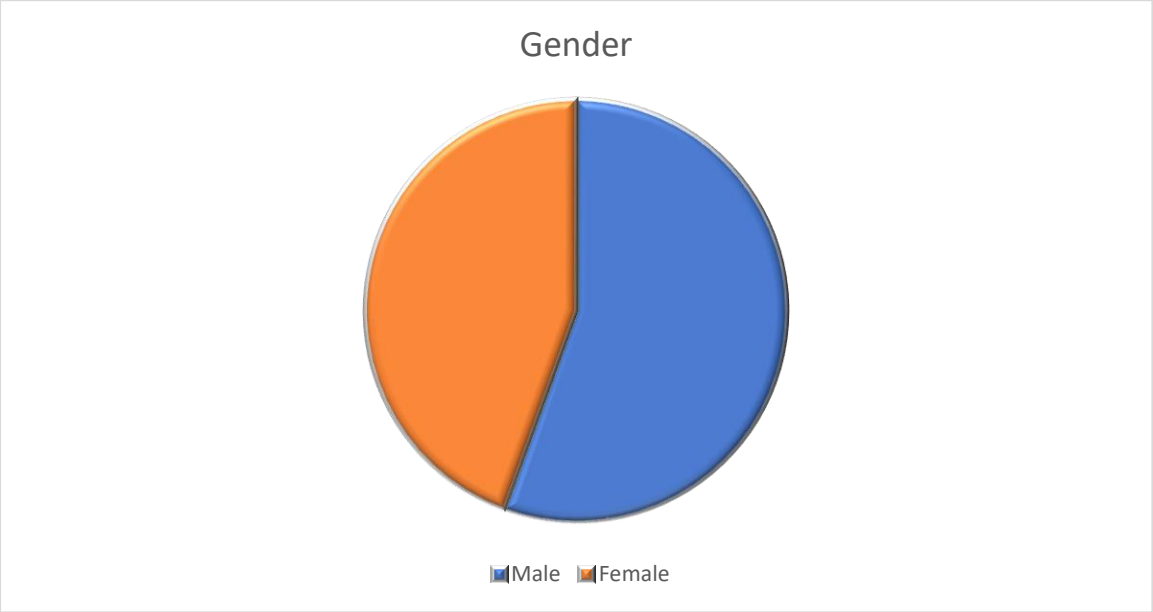

Figure two presents the demographic characteristics of the sample by gender. The figure shows that seven participants were females while three were males suggesting that the sample was not balanced in terms of gender.

3.8.1.3 MARITAL STATUS OF PARTICIPANTS

Figure 3: Marital Status of respondents

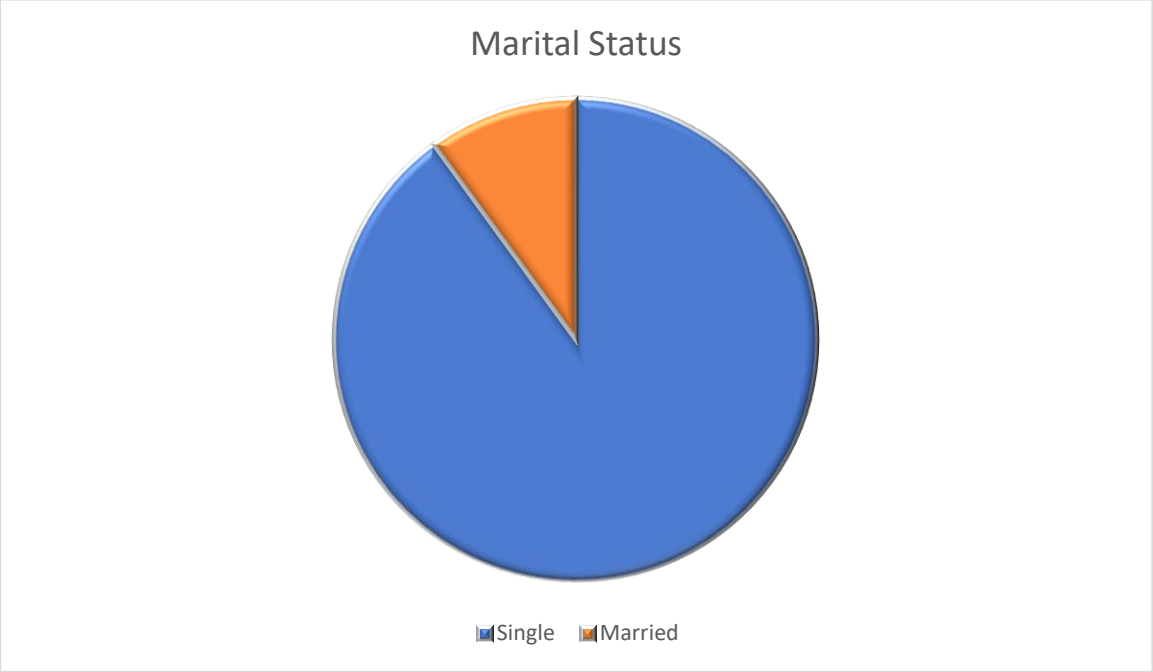

Figure 3 illustrates that majority of the participants that formed part of the study were single and only 1 participant was married.

3.8.1.4 NUMBER OF CHILDREN OF PARTICIPANTS HAD

Figure 4: The number of Children of the participants

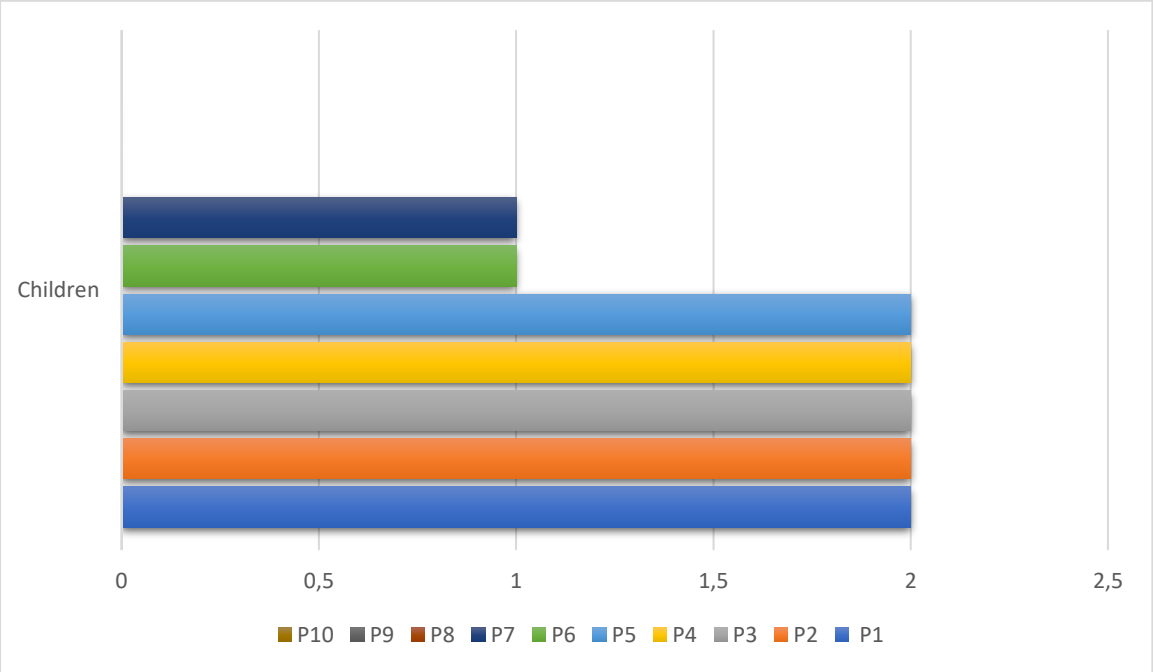

Figure 3 presents statistics of the number of children that the participants have. Figure 3 indicates that majority of participants (5) had 2 children, 2 participants had 1 child, and 3 participants had no children. This indicates that majority of participants within the study where parents, either father or mother.

3.8.1.5 QUALIFICATION OF PARTICIPANTS

Figure 5: Participant's education level

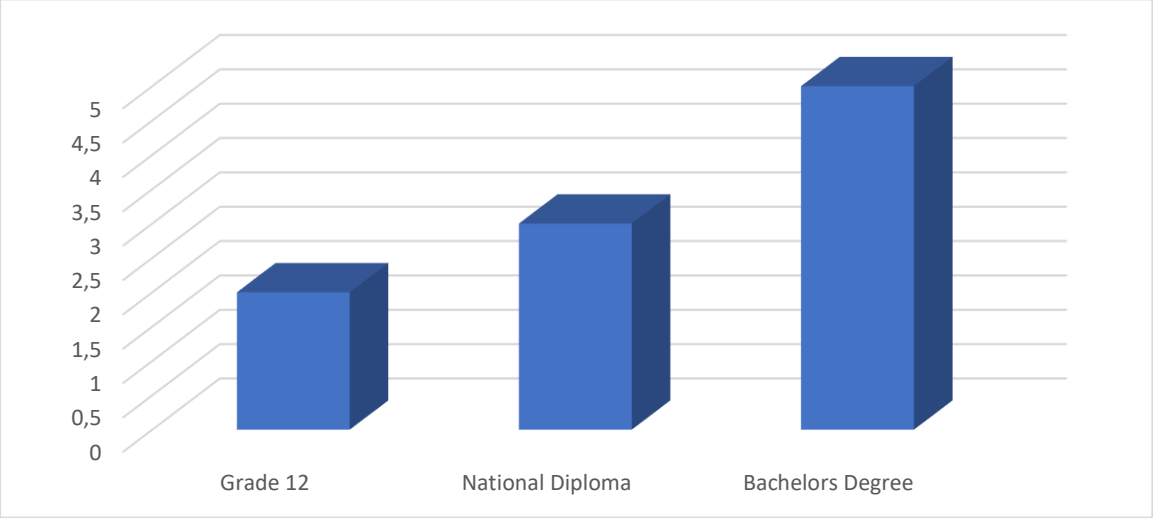

Figure 5 indicates that all participants involved in the study had a minimum of a grade 12 certificate and the majority (50%) attained a Bachelor's degree. Thirty percent of the participants had a National Diploma and 20% of the participants had a Grade 12 certificate.

3.8.1.7. EMPLOYMENT STATUS OF PARTICIPANTS

Figure 6: Participant's employment status

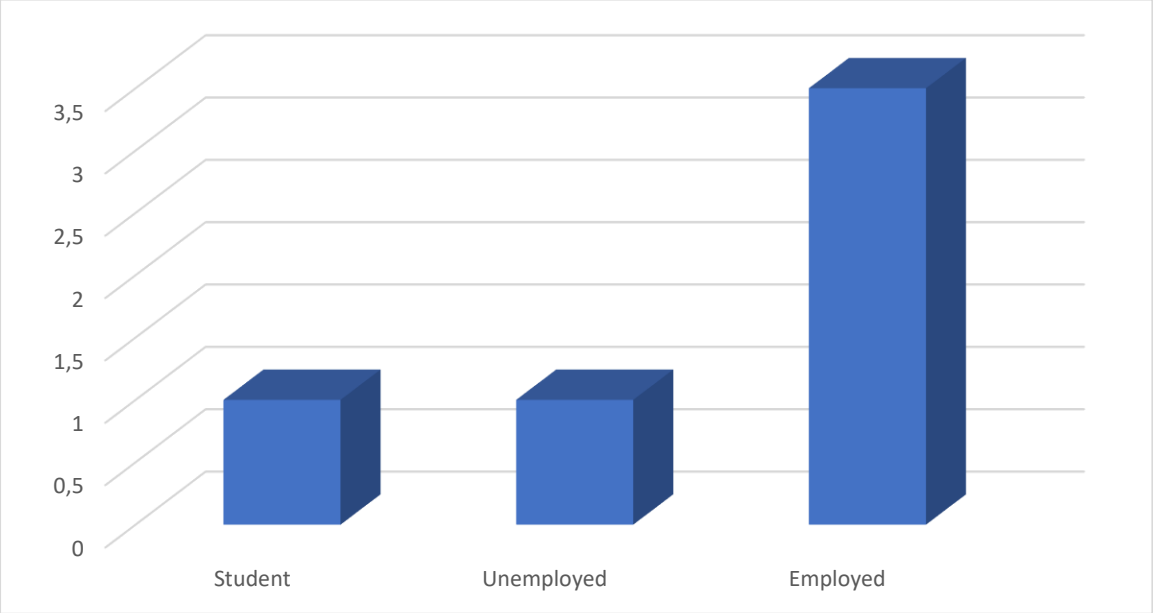

Figure 6 depicts that the highest number of participants that were employed, one participant unemployed and one participant a university student.

SECTION B: Presentation of themes and Sub-themes

3.8.2 PRESENTATION OF THEMES AND SUB-THEMES

This section discusses the themes and sub-themes that stemmed from the responses of the participants together with the literature findings that supported the findings.

THEMES	SUB-THEMES
1. Knowledge and description of health-seeking behaviour	1.1. General understanding of health-seeking behaviour.
2. Financial and Socio-economic factors as influencing factors to health-care.	2.1. Financial constraints 2.2. Poor service delivery 2.3. Poor planning and development 2.4. Limited health-care resources 2.5. Gender-based health-care attention
3. Health-care approaches employed by Xhosa people.	3.1. Home-made concoctions 3.2. Indigenous Xhosa medicine 3.3. Spiritual/religious exercise

	3.4. Health and fitness
4. Support Systems that impact health-seeking behaviour of the Xhosa people residing in Johannesburg.	4.1. The impact of family and traditional support 4.2. The impact of Spiritual/religious support
5. Social Implications to choice of health-care by Xhosa people residing in Johannesburg.	5.1. Strained relations
6. Non-adherence to health-care influencing factors.	6.2. Prolonged health-care attention 6.2. Lack of regular health-care check-ups
7. Diversity within the Xhosa tribe as a contributing factor to the type of health-care.	7.1. Cultural diversity 7.2. Spiritual diversity
8. Physical and Psychological Implications of non-adherence to health-care.	8.1. Death 8.2. Depression 8.3. Suicidal attempts
9. Health-care resources within the Xhosa community in Johannesburg.	9.1. Traditional healers 9.2. Pastors or prophets 9.3. Clinics and Hospitals
10. Support services to ensure adherence to health-care by Xhosa people.	10.1. Education and awareness 10.2. Social work services

3.8.2.1 THEME 1: KNOWLEDGE AND DESCRIPTION OF HEALTH-SEEKING BEHAVIOUR

This theme emerged from the descriptions the participants gave about their knowledge and understanding of the term health-seeking behaviour. From this particular theme, one sub-theme emanated.

Sub-theme 1.1. General understanding of health-seeking behaviour

The participants shared different opinions or responses to their understanding of health-seeking behaviour. These were the direct quotes from the participants:

"The word health-seeking behaviour its, it basically means, seeking help, it's seeking help, it's a way of seeking help". **Participant 1**

"I think it's self-explanatory...aaaah! as a person it's just a matter of aaaah! You…you…you…as a person you get to to to know…understand that when you need to get to to get assistance in terms of your health as a person then you go out there and seek for assistance in terms of your health so I think that what it actually means to me as a person". **Participant 2**

"Well, basically for me it means eeeh! Seeking that well-being from within, before eeeh! Maybe I can get it from elsewhere". **Participant 3**

"Oh! For me is typically a perceived approach obviously of finding the problem that is health-related in order to find remedy for that particular health-related eeeh! problem or illness". **Participant 4**

"Alright to me health-seeking behaviour means that me going to actually look who am I whose the first person that I go to look for help regarding my health." **Participant 5**

"I believe it involves behaviour that affects your health as an individual behaviour that might affect your life, and how you chose to live your life basically." **Participant 6**

"Okay, to me the word mean action that someone is taking when is feeling sick in order to get medical help." **Participant 7**

"*According to my understanding, it means, its whereby I …you go out any public or private centre to find help in terms of your sickness that you have it can be physical or…emotional…yah that's where you need help, it's a process of getting help."* **Participant 8**

"Health-seeking behaviour I think it means maybe you concerned about you're your well-being, your health you might as well to do maybe after working hours extra training to make sure you keep your physic fit and in a healthy way and again we are to consider the mental health also if you may be under any stresses or depression, you also want to associate with people around you within your cycle or perhaps if that's not the case you do want to consult a professional maybe like a psychologist or the counsellors, people who can console you, who can be your sole compensation into whatever problem you might be facing seeing that it might affect your health state or your mental health state, eeeh! Which is maybe might help in the long run the detrimental effect affecting you in a working environment or within your surroundings, eeeh! That's basically what I can eeeh! Explain with the term." **Participant 9**

"Eeeh! Right, eeh! Okay, my understanding health-seeking behaviour is when I, I …you acknowledge that you are sick, and you require medical attention." **Participant 10**

In support of the responses shared by the participants in sharing their knowledge and understanding of the term health-seeking behaviour. Latunji and Akinyemi (2018:52) explained health-seeking behaviour as an illness behaviour or sick-term behaviour. They further explained that it is situated within the broader concept of health behaviour, which encompasses activities undertaken to maintain good health, to prevent ill health, as well as dealing with any departure from a good state of health.

Oberai, Chaudhary, Patnaik and Singh (2016:2) define healthcare-seeking as any action undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy. Taking into consideration the health belief model, one can suggest that one's understanding of the term can trigger an action, as determining one's definition will in a way predict why one will take action to prevent, screen for, or to control an illness or condition or why one will not,

as the seriousness, benefits and barriers to behaviour are weighed by the individual prior to action taken for their health status (Champion &Skinner, 2008:47).

3.8.2.2 THEME 2: FINANCIAL AND SOCIO-ECONOMIC FACTORS AS INFLUENCING FACTORS TO HEALTH-CARE.

This theme focuses on the financial and economic factors that were highlighted by the participants during the study. Therefore, the sub-themes for this particular theme will be based on the financial and socio-economic factors as expressed by the participants, with five sub-themes that emerged from the theme.

Sub-theme 2.1: Financial constraints

The participants during the study expressed financial challenges as one of the factors impacting their health-seeking actions. Figure 6 revealed a variation of participants by employment status. Despite the fact that only a small percentage of the participants was unemployed, the research findings depicted finances as a challenge for both employed and the unemployed individuals.

The following are participant's quotes:

> *"I would say it's money right. Since I [am] unemployed and I'm not working I'm still looking for work I took, it becomes a challenge for every time I need to consult aaa let's say, yah! Every time I need to go, money is a problem because I'm unemployed."* **Participant 5**
>
> *"It's gonna need money and most of the people in the location are not working they are unemployed so now it makes it difficult for them to access those resources."* **Participant 8**
>
> *"For an example, if I don't have money to see a a doctor or private, a private health clinic then that could be another factor because usually, the clinics are very full, the hospitals are very full…… So that's another thing money."* **Participant 10**

The responses of the participants suggest that poverty and unemployment are aspects that cannot be ignored, as they are factors that are seen as influences to accessing health-care by individuals, families or communities seeking health care.

In support of the information revealed by the participants during the study, Harris, Goudge, Ataguba, McIntyre, Nxumalo, Jikwana and Chersich (2011:102) explained that more than a billion people, mainly in low- and middle-income countries, are unable to access needed health services as these are unaffordable. This notion was further supported by Nicholson, McDonnell, De Brún, Barrett, Bury, Collins, Hensey, and McAuliffe (2020:2) when he stated that other pragmatic concerns that influence patients can be costs associated with certain services within the health systems and the availability of transport to and from healthcare services

Regarding this notion, Luquis and Kensinger (2017) explained that previous data analysis by the authors showed that having health insurance was the main factor in receiving preventive services such as wellness check-ups and blood pressure and cholesterol screening. This illustrates the fact that finances are an influencing factor in seeking health care within communities and are not necessarily fixed only to the participants within the study.

The behavioural evaluation in this particular case concerns the financial constraints (costs) as barriers to accessing health-care services, a notion that the health belief model is based on (Abraham and Sheraan, 2005:28). This means the financial constraints that participants experience influences their health behaviour negatively.

Sub-theme 2.2.: Poor service delivery

This particular sub-theme emerged from the two participants who indicated poor service delivery as one of the influencers to health care. These were the participants' direct responses:

> *"We facing a lot of challenges when it comes to public hospitals, as they are sometimes, their service is bad, their service is bad sometimes it takes time for a person to be assisted."* **Participant 1**
>
> "*Quite difficult to help people with most necessary urgency so that the is no long ques, long back longs of people for people standing in the queue for more than 3 hours and which is actually then the reality in the current time period*." **Participant 4**

Literature suggests that in South Africa particularly, health-care access for all is constitutionally treasured; yet, significant disproportions and imbalances remain, this is said to be largely due to distortions in resource allocation (Cherish et al., 2011:102). This was further supported by Fokunang et al. (2011:286) who revealed that in some urban areas the average waiting time at a hospital or clinic for patients to consult a doctor can be as much as eight hours. This means what was shared by participants during the study denotes real issues faced within their communities when it comes to the healthcare centre. Hence, sub-themes that emerged from the theme spoke to one of the prevalent challenges faced, this was narrated by three participants in their responses during the study.

The diverse range of challenges pertaining to the health care service delivery influence an individual perception. This social influence has a major influence in the individual's motivation to stay healthy. In this particular case, the poor service delivery in the health-care system reduces the individual's motivation to stay healthy (Abraham & Sheraan, 2005:30). This supports the notion by the health belief model that benefits, or efficacy recommends health behaviour (Abraham & Sheraan, 2005:28).

Sub-theme 2.3.: Poor planning and development

The information received stemmed from five of the participants of the studied population and not just a small fraction but half of the respondents. The quotes further illustrate an issue that exists within their community that could potentially have a negative effect on its population receiving the necessary health care assistance as required.

These were the direct quotes from the participants:

> *"The clinic closes at 17:00, the surgery at 18:00 so if someone is in trouble then it means they have to travel all the way to hospital, which is like 45 minutes away so that will be like one of the biggest challenges and doesn't get help with the medical facilities."* **Participant 6**

> *"The challenges are we've got Medi-cross whose close by us is closing by 7 o'clock and the other hospitals whose opening 24 hours is a little bit far, so when someone is sick, so it takes time to go there to the to the hospital."* **Participant 7**

> *"I'm staying in a township so the most challenge we have is when a person gets sick at night, and we call for an ambulance then it take[s] hours to come sometime[s] it doesn't even come."* **Participant 8**
>
> *"… like here where I stay there is no gymnasium."* **Participant 9**
>
> *"The problem is aaah! it is servicing a lot of people you see…… they servicing most people so we then spend hours in queues."* **Participant 10**

Out of the 10 participants in the study, 5 indicated the issues that arose within their communities due to poor planning and development. Answers that directly linked limited health care resources to poor planning and development within the health-care sector.

Heywood (2014:8) explained that there is a particularly crucial need in South Africa for government to improve infrastructure in rural communities, where some primary healthcare centres even lack piped water – a clear sign that the public health system is overburdened and incapable of providing consistent quality care. The South African Medical Association (2015:42) agrees that the current physical state of public facilities is disgraceful and not favourable to the delivery of quality health services.

The issue of poor planning and development taking note of the health belief model, translates into a perceived barrier to health care and has the effect to influence a person whether to take action or not to prevent or improve health behaviours (Luquis & Kensinger, 2018:38).

Sub-theme 2.4: Limited health-care resources

The information received stemmed from the participants of the studied population These are the direct quotes:

> *"Well, the only one that I have encountered would be is… a… less a… what are less a… staff as far as the facilities or institution is concerned so obviously which now then doesn't make ratio of patients against the ratio of you know eeeh! nurses whether doctors whether its nurses or securities at the door right,*

which then now the only problem is the ratio which then make it you know aah!" **Participant 4**

"Shortage of nurses, right the shortage of nurses we have in our community its its it's terrifying." **Participant 5**

"The challenges are we've got medi-cross whose close by us is closing by 7 o'clock and the other hospitals whose opening 24 hours is a little bit far, so when someone is sick, so it takes time to go there to the to the hospital." **Participant 7**

"I'm staying in a township so the most challenge we have is when a person gets sick at night, and we call for an ambulance then it take[s] hours to come sometime[s] it doesn't even come." **Participant 8**

"… *like here, where I stay there is no gymnasium."* **Participant 9**

Literature supports the information revealed by the participants during the study, that one of the major weaknesses in sub-Saharan African health systems is the short supply of human resources (Maphumulo & Bhengu, 2019:2). Barron and Padarath (2017:4) further noted that health problems faced in South Africa are worsened by the unequal distribution of health professionals that exist between the private and public sectors, tied with unequal distribution of public sector health professionals among the provinces.

Moosa and Gibbs (2014:147) further emphasised that there have been anecdotal difficulties around clinical quality, the role of the increasing the number of doctors and the value of family medicine as a new speciality in Johannesburg since these changes. This further confirms what was shared by the participants in the study. Drawing from each participant's response this appears to be one of the most frustrating and overwhelming challenges experienced by the health care facilities within their communities. Moosa and Gibbs (2014:147) state that Primary Health Care in Gauteng suffers from poor communication, fragmented health services and a hospicentric focus. These contribute to poor service delivery at the clinic level and as a result many patients seek out doctors, bypassing the clinics and the referral system, thus overloading central hospitals.

In this particular case, the notion of the health belief model that asserts perceived benefits and barriers emerged to be strong predictors of engaging in the health behaviour was demonstrated (Luquis & Kensinger, 2018:38). Despite the challenges experienced within the health-care facilities individuals still made means to try and access those services due to the perceived benefit of the health behaviour.

Sub-theme 2.5.: Gender-based health-care attention

These responses come from the majority of the male participants within the study, this in a way established a clear understanding and belief amongst the males in this particular regard. From each response, it is clearly indicated that culture and tradition were the major influences in their stance.

> *"In terms of us the Xhosa, the is this custom that we do have which is uLwaluko that I mentioned earlier, eeeh! There initial[ly], and in some cases even now people are not allowed to go to doctors or approach social workers because of our cultural knowledge and background beliefs."* **Participant 3**

> *"You maybe require medical attention you actually restricted into taking the medication if you actually through that process of becoming a man."* **Participant 9**

> *"Anything that has to do with manhood we are told not to go and seek a doctor about it and then you can rather go to a traditional healer."* **Participant 10**

The notion shared by participants within the study was further highlighted in detail by Beck (2004:11) who stated that what emerges is a picture of a Xhosa man that is both bound by expectations of responsibility and raised on beliefs that resist help-seeking. This construct, if left unchallenged and intact, is irreconcilable with sickness and asking for help. He further explained that traditional beliefs, for reasons unknown, appear to be stronger among men than women in the Xhosa culture (Beck, 2004:11).

Many literature sources support the notion of gender-based health-care attention. Froneman and Kapp (2017:5) explain that although boys were encouraged to visit the

clinic to exclude any illness before the circumcision, receiving medical assistance during the ritual was strictly forbidden and seen as cheating. Vincent (2008:82) further explained that hospitalisation is thus strongly resisted by many who see themselves as champions of threatened cultural legacies.

Beck (2004:22) explained that in pursuing cultural expectations, a barrier was recognised in the shape of rigid roles and responsibilities inherent in being a Xhosa man. These expectations led men to outwardly convey a picture of health and ability, and therefore inhibited men from seeking help. In regard to this notion the health belief model as explained by Luquis and Kensinger (2019:46) state that the results of this study suggest that perceptions of susceptibility and seriousness of health outcomes are related to individual's characteristics (i.e. gender, age) and that those perceptions might influence the utilisation of preventive services among those with healthcare coverage.

3.8.2.3 THEME 3: HEALTH-CARE APPROACHES EMPLOYED BY XHOSA PEOPLE.

This theme focuses on the preferred health care approaches employed by the Xhosa people in the Johannesburg area. The sub-themes of this will therefore be based on the health-care approaches employed by the Xhosa people. Four sub-themes emanated from this particular theme.

Sub-theme 3.1: Home-made concoctions

Four participants revealed that they use home-made concoctions as a health care approach in dealing with sickness or an ailment. These were direct quotes from the participants:

> *"I first try home remedies before I go to the doctor."* **Participant 1**

> *"Home remedies where I, where I feel I'll be ok."* **Participant 2**

> *"Firstly, I get to seek you know home remedies, so which obviously eeeh!"* **Participant 4**

> *"For me going to eeeh! Clinics and hospitals is not my thing so usually, I do home-made remedies."* **Participant 10**

The information revealed by the participants spoke to the trust that individuals had in their own home-made methods or home potions that involved home essentials or essentials off their kitchen cabinets and being part of their health journey in dealing with a particular health ailment. In support of this notion Boyd, Taylor, Shimp and Semler (2000:342) explain that many ethnic minority patients utilise both "scientific" and folk medical systems. He further states that the use of home and herbal remedies by some specific ethnic groups has been well documented, which suggests that this is a health-care action that has been socially learned by an individual, supporting the notion of the social learning theory (Lindley, 2015:52). This explains one of the factors that lead to individuals not accessing health-care facilities for a health condition.

Hardon (2019:1) in a study conducted on sexual and reproductive practices indicated that the use of self-care was frequent among women and girls in communities with modern medicines and these reported a high number of complaints of pelvic pain and vaginal discharge, they further established that there was a need for women to feel and look attractive to their partners and as a result employed the use of home-made concoctions. This testifies to the fact that even though these communities have access to modern health-care, their health-seeking behaviour is still very much influenced by their homes, communities and ancient use of folk medicine or home-made concoction.

The issue of relying on home-made concoctions was also evident during the outbreak of the COVID-19 pandemic, Vijay, Kena, Sruja and Ranjit (2020:1) established that during the COVID-19 outbreak people turned to unverified home remedies for the prevention of the disease. This suggests that there is a certain safety net or trust that individuals and communities have on home-made concoctions and as a result, an influence in their health-seeking behaviour is largely expected.

Based on the health belief model in this particular regard, perceived susceptibility refers to beliefs about the likelihood of getting a disease or condition (Champion and Skinner, 2008:47). This means that vulnerability that is perceived guides each individual's action towards the step to take in dealing with the ailment and that is closely linked to their belief about the probability of getting the diseases.

Sub-theme 3.2: Indigenous Xhosa medicine

This sub-theme emerged from the response of participants that indicated they still employed indigenous Xhosa medicine as an approach to health care in their everyday lives.

These are the direct quotes from the participants:

> *"… get the help from maybe it's a traditional medication that myself I actually believe, it heals if you feel the pains kills things like umhlonyane we maybe umhlonyane when you coughing you know, you don't even need to to go to a to maybe chemistry to seek for, for medication you can just go and know roam around the terrains in the mountain or maybe bushes you can easily find this herb, you know and it helps."* **Participant 9**

> *"Because you know mosi, Xhosa's do believe in traditional medicine, yes ...most of the cases I use traditional practitioner more than the aaaah! Health practitioners."* **Participant 10**

These participants demonstrated that they still trusted in and relied on the use of indigenous or traditional (natural) medicine as one of the ways in dealing with physical ailments that they faced in their day to day living.

In this regard, Fokunang, Ndikum, Tabi, Jiofack, Ngameni, Guedje, Tembe- Fokunang, Tomkins, Barkwan, Kechia, Asongalem, Ngoupayou, Torimiro, Gonsu, Sielinou, Ngadjui, Angwafor, Nkongmeneck, Abena, Ngogang, Asonganyi, Colizzi, Lohoue and Kamsu-Kom (2011:284) explain that traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being.

Guma and Mokgoatsana (2020:1) explain that South African traditional medicine is based on centuries-old cultural heritage, yet it remains popular today used by a significant percentage of the population. Thus, confirming the findings from the participants' responses, that traditional medicine still holds a high value within society,

as much as times have changed, despite the technological advancement, migration from one province to another and level of education, the traditional medicine has adapted and is still in use by individuals, in this particular case, the Xhosa people residing in Johannesburg.

Beck (2011:22) The significance of traditional medicine and the role of the sangoma, or traditional healer, were explored, revealing that men often consider a sangoma the first port of call in times of sickness. Some attributed this to a belief that western medicine treated symptoms, while the sangoma addressed the underlying cause. It was also suggested that a sangoma should be able to meet all the health needs of an ideal Xhosa man and defecting to a western doctor indicates weakness.

The use of this particular health approach speaks directly to the notion of the social learning theory, that individuals are socially influenced, as they learn from their social settings, this means even the use of medicine, in this case, the use of indigenous medicine, medicine that was part of the Xhosa culture for years. Therefore, in this case, the use of indigenous medicine has a greater perceived benefit for the individual as informed by their social background (Rostami-Moez, Rabiee-Yeganeh, Shokouhi, Dosti-Irani & Rezapur-Shahkolai, 2020:6).

Sub-theme 3.3: Spiritual/religious

This sub-theme emerged from participants' responses that indicated spiritual or religious practices or activities as an approach to health care. Four participants expressed spiritual or religious exercises as one of their approaches.

These are the direct quotes from the participants:

> *"When in times of trouble or in times of need, I know who to turn to, my God and I know that when I pray things get better."* **Participant 1**

> *"While my mom is sick, the only thing that I would do is to actually pray and be closer to God and try and ……ask Him to intervene on whatever the situation"* **Participant 2**

> *"… and spiritually I do take time to seek that spirituality and eeeh! And maintain a good relationship with a Jesus Christ……. The first factor is prayer, my wuuuu…would be favourable when I'm seeking spiritual healing I pray."* **Participant 3**

> *"Well, personally when I speak of health, I don't only speak about my physical health but also spiritual health, so I pray a lot to make sure."* **Participant 6**

It appears that participants still valued spirituality in their lives and held it in high regard despite the changing times. The participants highlighted that certain health issues are not necessarily limited to physical ailments and needed divine intervention and not merely the use of man-made products. There is clear evidence in the literature that suggests spirituality as one of the coping mechanisms of health-related issues. In support of that notion Arrey, Bilsen, Lacor, and Deschepper (2016:1) state that spirituality/religion serves an important role in acting as a coping mechanism, survival and maintaining overall wellbeing within African cultures and communities.

According to the health belief model, Rostami-Moez et al. (2020:6) state that if people perceive the benefits of a healthy behaviour higher than the barriers of it, they will engage in that healthy behaviour. This means there are more chances of a healthy behaviour when benefits are higher than the barriers, this supports the idea of the health belief model that individuals weigh benefits and barriers to health-care (Chironda, Bhengu & Manwere, 2019:55).

Sub-theme 3.4: Health and fitness

The participants indicated another approach in curbing certain health issues faced and clearly revealed how much of a role exercise and balanced played in their positive health maintenance. The following are participant's direct quotes:

> *"The actions I take to maintain good health; I eat healthy, I exercise and yah! That's basically it."* **Participant 1**

"Well, I do exercise, eeeh! Regularly physically." **Participant 3**

"You know eating of keeping up with you know, your health requirements either consuming a certain type of food and and and eeh! Obviously, part of that keeping up with exercising." **Participant 4**

"You need to exercise more, you need to make sure that you eat clean food, a balanced diet so that you can actually maintain a good health." **Participant 5**

"One of the things I do is that I exercise, I drink a lot of water." **Participant 6**

"I believe in you have to eat proper food, eeeh! you do exercises." **Participant 8**

"To make sure that you have daily programs where you enlist yourself with training and make sure that you, you know, you … you stay healthy, you eat healthy diet food, you eat you know too much of your fruit, vegetables eeeh!" **Participant 9**

"I would say that going to gym regularly, yah taking walks, yah!" **Participant 10**

The participants indicated a high level of enthusiasm when it came to physical health, fitness and healthy eating plans as part of their everyday life in ensuring positive overall health. Anderson and Durstine (2019:6) state that physical inactivity is associated with increased chronic disease risk. They further indicated the support that literature provides in this regard, information that lower morbidity and mortality rates are associated with maintaining moderate levels of physical activity (PA) and physical fitness.

This means there is a great benefit for this particular behaviour for one's health state and thus the importance in engaging in one. Champion and Skinner (2008:47) explains that even if a person perceives personal susceptibility to a serious health condition

(perceived threat), whether this perception leads to behaviour change will be influenced by the person's beliefs regarding perceived *benefits* of the various available actions for reducing the disease threat. Regarding the notion expressed by the participants, literature of the health belief model suggests that change of behaviour of an individual is mainly influenced by the person's belief in the perceived benefit, meaning should the belief be that the perceived benefit is not that effective compared to the former, change in behaviour will not take place.

The health belief model suggests that this type of behaviour is to be expected as it is encouraged by the benefits of healthy behaviour and in this particular instance health and fitness (Rostami-Moez et al. 2020:6). This is largely influenced by learning through observations people have made about this behaviour within their surroundings, which informed them about its benefit. This suggests that behaviour is influenced by learning within one's social settings or surroundings (Lindley, 2015:52).

3.8.2.4 THEME 4: SUPPORT SYSTEMS THAT IMPACT THE HEALTH-SEEKING BEHAVIOUR OF THE XHOSA PEOPLE RESIDING IN JOHANNESBURG

This theme focuses on the support systems that impact the health-seeking behaviour of the Xhosa people residing in Johannesburg that were highlighted by the participants during the study. Therefore, the sub-themes for this particular theme will be based on the support systems factors. The two sub-themes emanated for the theme are as follows:

Sub-theme 4.1: The impact of family and traditional support

This sub-theme emerged from the participant's responses to the type of support received from family, another family support with a traditional quotation or influence was mentioned as a factor in influencing health-seeking behaviour.

These are the direct quotes from the participants:

> *"Okay I would say…my family, the love I have for my family, it encourages, encourages…me to seek help and also my daughter cause, yaah!"* **Participant 1**

"I would safely say my mom mostly, I think in most of the things she is the one who actually gives me guidance and also with my … my, with me seeking guidance." **Participant 2**

"In regard to cultural issues is the person who guides me is my father." **Participant 1**

"Culturally, the elders at home are the ones who guides me." **Participant 7**

Menon, Entwistle, Campbell, and Van Delden (2020:27) suggest that family involvement in healthcare decision-making for competent patients occurs to varying degrees in many communities around the world.

Therefore, it is evident that individuals are more likely to seek medical attention when health benefits surpass barriers, a notion stemming from the health belief model. In support of this Luquis and Kensinger (2018:37) explain that individuals who perceive high susceptibility and seriousness would be more likely to take actions toward preventing the disease as long as the health benefits surpass the barriers, and they feel they have the capability to engage in the behaviour.

Sub-theme 4.2: The impact of Spiritual/religious support

Indicate the assertion of the participants. This particular sub-theme emerged during the study as some of the support factors that influence health-seeking behaviour. These are the direct quotes from the participants:

"Spiritual issues I would say the person who guides me is God and my pastors." **Participant 1**

"Well, eeeh! Firstly, I do, I look at my spirituality that's the first thing…….. well in most cases it's … it's … it's those who are ahead of me spiritual, like your Pastors and eeeh! Prophets, I check with them if I'm within my community." **Participant 3**

> *"Spirituality, it helps me to deal with life challenges, yes especially if you have spirituality, you always have hope."* **Participant 7**

Literature, as mentioned by Djurović, Sovilj, Djokić, Brdareski, Vukomanović, Ilić and Milavić-Vujković (2017:69), suggest that religious support, in terms of clinical medicine, is spiritual support that religious patients obtain from religious and trained medical workers. Deschepper et al. (2016:2) support the notion that spirituality acts as a support during health-related issues experienced by individuals when he suggested that spirituality or religion can influence the way patients perceive health and disease and their interaction with other people.

Toledo, Ochoa and Farias (2021:3017) in their study established that religion or spirituality supported women in their psychosocial adjustments to breast cancer by offering them a sense of purpose and meaning in life, as it made them make sense of their treatment as they persisted with it despite experiencing adverse side-effects. This indicates that spirituality can serve as a support mechanism during pain or health ailments experienced by an individual as mentioned by participants during the study.

This particular sub-theme rests on the concept of perceived benefits because the participants believe in the action to be taken and the positive results will prevail upon application (Champion & Skinner, 2018:48).

3.8.2.5 THEME 5: SOCIAL IMPLICATIONS TO CHOICE OF HEALTH-CARE

Regard this particular theme, some participants mentioned experiences of family conflicts and negative outbursts amongst family members and such reactions were as a result of the choice of their health approach.

The sub-themes relating to the social implications experienced by participants are strained relationships, the one sub-theme that emerged from the theme.

Sub-themes 5.1: Strained relationships

The sub-theme emerged as one of the factors mentioned by participants as social *implications to their choice of health-care.*

> *"The consequences in most cases would be squabbles and quarrels and months of not talking to one another and stuff like that."* **Participant 3**

"Most of the time is for family members to split……. it might have an end product of a family not getting along." **Participant 5**

"Of course, it's gonna cause division among family members, there will be fights because now we have, we are facing a misunderstanding some believe in this and some believe in this, which make, which will make aaa a misunderstanding, eeeh! and yah! Some fights…you know what I mean…" **Participant 8**

"… It might have an end product of a family not getting along." **Participant 5**

"It can create aaaah! Aaa tension within the families because of different you know ways you know of thinking, thoughts you know and believing you know in that way." **Participant 9**

The involvement of family members in one's decision in what type of treatment to embark on was supported by the literature. Singapore Medical Council (2016b) explained that there are particular tensions and challenges around family involvement where healthcare professionals and patients may wish to give more weight to family perspectives than the law and professional codes allow. This was further elaborated on by Menon et al. (2020:32) when he stated that in many countries, family involvement in treatment decision-making can generate tension in interactions between patients, family and healthcare professionals.

In this regard, Champion and Skinner (2008:47) explained that the health belief model states that feelings about the seriousness of contracting an illness or of leaving it untreated include evaluations of both medical and clinical consequences (for example, death, disability, and pain) and possible social consequences (such as effects of the conditions on work, family life, and social relations).

This means the influencing factors are not mainly limited to clinical consequences but also to social consequences as revealed during the study through participants' responses. This means the health motivation is influenced by family involvement whether positively or negatively. As mentioned by Champion and Skinner (2008:48) the health behaviour of the individual, in this case, the participants is based on the balance between perceived barriers and perceived benefits. This clearly explains the

result of strained relationships within a family due to the choice of health action to embark on, as there is the weight between the two from the affected individual and his or her family.

3.8.2.6. THEME 6: NON-ADHERENCE HEALTH-CARE INFLUENCING FACTORS

The particular theme emerged because it became evident from the participant's responses that factors were affecting each person when it came to adhering to health care assistance. The two sub-themes that emanated from the theme are prolonged health care attention and Lack of regular health-care check-ups.

Sub-theme 6.1. Prolonged health care attention

The sub-theme reflects the non-adherence to health-care influencing factors in more detail. This factor emanated from five participants within the study. These where their direct quotes.

> *"It depends on the sickness I have; I don't immediately go and consult."* **Participant 1**

> *"It might be something that I have that I know it's not supposed to be there on my body, however, I always procrastinate, and I always postpone to go, so basically, I don't go like the first time I see something is* wrong." **Participant 2**

> *"Eeeh! It depends on, depends on the severity of the situation."* **Participant 3**

> *"No, I just don't go, I, it depends on the seriousness of the illness or … and maybe after four days if the illness is serious and then I have to go to the doctor."* **Participant 7**
>
> *"Oh! Sometimes it took me long enough because you know, ……haha haha, aaah! For me going to eeeh! Clinics and hospitals is not my thing."* **Participant 10**

Prolonged health care attention emerged because five of the participants indicated that they took a long time in attending to their health once stricken with an illness as compared to immediately attending to it.

This displayed a lack of urgency that participants had regarding their health care. During the interviews some participants indicated that until there was visible proof that the ailment was serious it was not worth attending to or getting it checked.

In support of the notion as shared and expressed by the participants, Beck (2004:14), his study, established that men used the clinics as a last resort, and this was mainly when all else has failed. It was further confirmed by health workers in his study that men typically arrived at clinics very late in the disease process, complicating treatment. This was further supported by Taber, Leyva and Persoskie (2014:290) in one study, where 17% of the patients diagnosed with rectal tumours reported that they waited a year or more, with some waiting up to five years, to seek medical consultation after noticing symptoms.

This supports the notion by the health belief model that individuals are motivated to take action to improve their health as per perceived benefit or barrier (Chironda, Bhengu & Manwere, 2019:55). This is further supported by Luquis and Kensinger (2018:37) who explain that the constructs of perceived seriousness, susceptibility, benefits, barriers, cues to action and self-efficacy can be used to explain whether a person takes actions to prevent, screen for or improve health behaviours.

Sub-theme 6.2. Lack of regular health-care check-ups

The participants reflected the lack of regular health-care checks-ups as one of the factors contributing to non-adherence to health-care. Therefore, this particular sub-theme emerged as a result of the non-adherence to health-care influencing factors. These are the direct quotes from participants:

> *"How long, I don't take, I would say every 6 months I go consult a health care."* ***Participant 5***
>
> *"It takes like three months or something, three to four months because I only go visit a doctor only when maybe it's a change of season, then that's when I start getting flu or my skin peeling off or something like, so I don't regularly visit the doctor."* **Participant 6**
>
> *"The value of spirituality in my community differs because some people don't believe in God, for example, there are people who believe in traditional healers,*

> *there are people who believe in God so I can say half of them, okay I can say spiritual, the spiritual culture is important only those who believe…because is not everyone who believes in the spiritual life as I mentioned some people believe in their gods, so it's important to some, to those who believe, but is not important to those who doesn't believe."* **Participant 8**

Taber et al. (2014:290) supported the views of the participants within the study, explaining that people often avoid seeking medical care even when they suspect it may be necessary; and the fact that nearly one-third of respondents in a recent national United States survey reported avoiding the doctor's consultation.

Taber et al. (2014:290) in their study further identified factors such as low trust in doctors, low perceived severity of symptoms, emotional factors (e.g., denial, avoiding worry, embarrassment), practical barriers, and prior negative experiences as contributing to avoidance. Therefore, substantiated evidence from literature in regard to this notion by the participants was found. This basically speaks to the tangible psychological cost or the analysis that occurs where individuals weigh the action's expected benefits with perceived barriers, this could be the belief that it could help, but it may have negative side effects, be unpleasant, inconvenient, or time-consuming (Champion & Skinner, 2008:49). This little by little leading to an individual never accessing the required health-care on time as mentioned by the participants and confirmed by literature.

3.8.2.7. THEME 7: DIVERSITY WITHIN THE XHOSA TRIBE AS A CONTRIBUTING FACTOR TO THE TYPE OF HEALTH-CARE.

Participants within this study highlighted the importance of diversity within the Xhosa tribe as a contributing factor to the type of health-care provided. Therefore, the sub-themes for this particular theme will be based on the Diversity within the Xhosa tribe as a contributing factor to the type of health-care.

Sub-theme 7.1: Cultural diversity

This sub-theme emerged as a result of reporting in detail the differences that exist amongst the Xhosa tribe as revealed by the participants during the study.

"We are different we've got different belief systems." **Participant 2**

"The same case to my parents or my sibling you understand, so because we've got different beliefs system you know and and and which then that make us diverse." **Participant 4**

"We quite diverse so people associate with different cultures and and and which then bring about different understanding, different approach." **Participant 4**

"We might be a family, but we are different people, person is a person individually so what we what we could do to a family is family not getting along, right because there is a person that believes in spirituality more the person that believes in cultural and there's a person that you know what the doctor can do this better." ***Participant 5***

"Us as a family as we are a family right, we believe in different things, right obviously we are different human beings so I would have my mother believing in cultural things most of the time right and you would have me believing in spiritual in spirituality most of the time eee and you will have my father saying just go to the doctor." **Participant 5**

"Aaaah! With my culture, aaaah! We do have cultural medicine, but it goes with with… with that particular household, how, how they take it how that they believe in but with me, I don't believe in the traditional medicine, so I normally consult western medicine, and with my religion, my religion is not eeeeh! We don't do the traditional medicine, if I don't get better with, If I don't get better then I would consult western medication which will be better." **Participant 6**

"We don't do this thing of consulting traditional medicine or traditional healer." **Participant 8**

"The family actually in actual fact …is fragmented you know based on the roles, cultural roles you know, how we do things, how we believe like if you my sister I'm your brother you my cousin you know it all goes like that and maybe you don't believe in Christian you know you believe in Muslim, you believe in traditional way of doing you know in that way we, we become defragmented it actually affects the family the family in that way, believing into different things…" **Participant 9**

Nkosinkulu (2015:19) in his attempt to explain the diversity and unique identity of the Xhosa tribe, explains that the historical background shows how the cultural identity of Xhosa people has been shaped by western influences, civil wars and trade. He further stated that in the age of globalisation, technology has made the spread of cultures truly boundless (Nkosinkulu, 2015:142). Therefore, the literature supports the notion that there is wide cultural diversity within the Xhosa tribe.

The indigenous cultural knowledge accompanied by the cultural belief system serves as a perceived benefit for the individual and therefore affects or influence the action to take regarding one's health status (Champion & Skinner, 2008:49).

Sub-theme 7.1. Spiritual diversity

This particular sub-theme emerged as a result of reporting in detail the differences that exist amongst the Xhosa tribe as revealed by the participants during the study.

> *"Within the family, we believe in different spiritual backgrounds and beliefs and believing in a lot of things."* **Participant 3**
>
> *"There are many different types of religion that people believe in, so my spiritual life is what I chose."* **Participant 8**
>
> *"We've got different religions some people are Christians you know some people they go into into into Muslim."* **Participant 9**
>
> *"However, there are different spiritualties, eee! Some believe in certain spirituality, and some believe in certain spiritualties."* **Participant 3**

In support of the responses shared by the participants, Sesanti (2009:44) in his study, noted a woman by the name Salamntu who is a Xhosa-speaking African Muslim born in the New Brighton township in Port Elizabeth. In his study, Sesanti (2009:36) noted that one of the Xhosa-speaking women interviewed had reverted to Christianity after years of being a Xhosa-speaking Muslim. Therefore, spiritual diversity is something that exists within the Xhosa tribe and is not just an assumption.

The indigenous religious knowledge accompanied by the religious belief system serves as a perceived benefit for the individual and therefore affects or influence the action to take regarding one's health status (Champion & Skinner, 2008:49). This

means one's spiritual stance can serve as a triggering mechanism to the type of action to take regarding health.

3.8.2.8 THEME 8: PSYCHOLOGICAL IMPLICATIONS OF NON-ADHERENCE TO HEALTH-CARE.

This theme focuses on the physical and psychological implications of non-adherence to health-care factors that were highlighted by the participants during the study. Therefore, the three sub-themes for this particular theme will be based on the physical and psychological implications of non-adherence to health-care factors.

Sub-theme 8.1: Death

This sub-theme emerged as a result of reporting in detail the physical implications of non-adherence to health-care as revealed by the participants during the study.

> *"It would save more lives for instance in terms of us the Xhosa, the is this custom that we do have which is uLwaluko that I mentioned earlier, eeeh! There initial[ly] and in some cases even now people are not allowed to go to doctors or approach social workers because of our cultural knowledge and background beliefs now if that were to be integrated it would eeeh! Help save many lives."*
> **Participant 3**

> *"You know hurt deep down in the heart you know, you know if maybe they lose you through that process of initiation and maybe you you don't make it maybe you end up dying you know, in that way they they they, it's a loss for them you know it's a pain you know, it's a permanent pain in their hearts."*
> **Participant 9**

The notion expressed by participants was supported by Mavundla, Netswera, Bottoman and Toth (2016:2) when he stated that in the areas where Xhosa male circumcision is practised, there have been reports of botched circumcision and hospital admissions due to various complications ranging from poorly performed operations to gangrenous penises, as a result of infection. Furthermore, deaths resulting from complications have also been reported.

Therefore, fully supporting the notion as expressed by the participants that at times during the circumcision rites, young men lose their lives due to complications encountered. In this particular theme taking into consideration the health belief model,

one would suggest that the individuals within this tribe should take action to prevent possible death during initiation rites as influenced by their perceived susceptibility to the seriousness or perceived severity (Champion & Skinner, 2008:46). This means they should take actions towards preventing death if their perceived severity outweighs their perceived benefit of fully engaging in the Xhosa initiation rite.

Sub-theme 8.2: Depression

This sub-theme emerged as a result of reporting in detail the psychological implications of non-adherence to health-care as revealed by the participants during the study.

> *"… which makes them sometime have mental breakdown, which might lead to depression."* **Participant 6**
>
> *"You can get depressed; you can be stressed out you know."* **Participant 9**

Literature supports the notion that very few acknowledge the emotional or psychological impacts as a result of cultural obligations. Beck (2004:11) explains that throughout the course of his discussions with men, only one man consciously acknowledged the pressure and expectations placed on him as a man.

Even though only a small percentage acknowledged the pressure and expectations placed on men, there is a need to report on such findings. This particular sub-theme speaks to the combination of perceived susceptibility and perceived severity, resulting in perceived threat as defined by the health belief model (Champion & Skinner, 2008:47). This meaning a personalised risk based on a person's characteristics or behaviour and thus the evaluation of possible psychological and social consequences (Champion & Skinner, 2008:47), in this case, the social consequences of losing the reputation as a Xhosa man (the defining traits of a Xhosa man) within one's community or tribe. Therefore, this largely suggests that the non-related perceptions, such as pleasing a family member by seeking a particular health approach, may also influence behavioural decisions (Champion & Skinner, 2008:47).

Sub-theme 8.3: Suicidal attempts

This sub-theme emerged as a result of reporting from the participants during the study, stemming from the psychological implications of non-adherence to health-care as revealed by the participants during the study. These are the direct quotes from the participants:

> *"You can get depressed; you can be stressed out you know you can even sometimes people they kill themselves you know for that matter you know."*
> **Participant 9**

In support of the notion shared by the participants, Koenig (2012:5) states that those who are depressed, without hope, and with low self-esteem are at greater risk for committing suicide. This in a way fully explains what was shared by the participants in their responses during the study. Therefore, in taking into consideration the health belief model, one would suggest that the individual had high or greater perceived benefits in honouring their culture and therefore the individual felt threatened by their current behavioural patterns (perceived susceptibility and severity) and believes that change of a specific kind will result in a valued outcome at an acceptable cost (perceived benefit) in this situation ending all their pain by taking their lives (Champion & Skinner, 2008:50).

3.8.2.9. THEME 9: HEALTH-CARE RESOURCES WITHIN THE XHOSA COMMUNITY IN JOHANNESBURG

This theme focuses on the health-care resources within the Xhosa community in Johannesburg as highlighted by the participants during the study. Therefore, the three sub-themes for this particular theme will be based on those specific health-care resources mentioned.

Sub-theme 9.1: Traditional healers

This sub-theme emerged as a result of specific health-care resources mentioned by the participants during the study.

> *"(laughing) … Alright! a … like okay, there are ……anything that has to do with my manhood then would say that I have to go and see a traditional healer.*"
> **Participant 10**

"Yes, there are traditional healers, yes we believe that they do help." **Participant 9**

Kahn and Kelly (2001:38) explain that there are three main types of healers in traditional Xhosa culture, and these consist of 'diviners' (*amagqira*), 'herbalists' (*ixhwele*) and 'faith healers' (*umthandazeli*). In support of this notion, Kahn and Kelly (2001:40) discovered that 80% of the respondents believed that their ancestors have been given traditional healers healing powers.

Almost half of a sample in which 90% were urban black South Africans and members of Christian churches had performed traditional rituals, and as many indicated that they would consult traditional healers in a crisis (Kahn & Kelly, 2001:41). The response of the participants together with the literature indicates a high level of perceived efficacy of individuals in relation to this particular health care resource within their communities, meaning a high confidence in one's ability to take action regarding their health-care.

Sub-theme 9.2: Pastors or prophets

This sub-theme emerged as a result of specific spiritual health-care resources mentioned by the participants during the study. These were the participants' direct quotes:

> *"My spiritual father at church is the one who guides me through the bible."* **Participant 8**

> *"Well in most cases, its its its those who are ahead of me spiritual, like your pastors and eeeh! prophets, I check with them if I'm within my community…… I go to my personal pastor but if I'm in another community I would go, I would check with the facts and beliefs of that pastor as to do my background search to to to see that a Pastor is real Pastor or a fake Pastor because there are fake prophets and a a a true Prophets but they do guide my spiritual eeeh! Guidelines…guide eeeh! Something like."* **Participant 3**

> *"Aaah! Spiritual issues I would say the person who guides me is God and my pastors."* **Participant 1**

"Something that had to do with witchcraft which they consulted with a prophet, aaaah! they consulted with a prophet who tried to assist me, help my nephew." **Participant 1**

"Well, there are resources in terms of both physical and spiritual because at the end of the day there are eeeh! Congregations and churches all around the place." **Participant 3**

"The fact that my pastor normally motivates us to exercise so that because we young, be fresh…….. so yaah!" **Participant 6**

"Church, hospitals and clinics, surgeries." **Participant 8**

In support of the notion by the participants during the study, Eckersley (2007:54) explained that religious belief and practice enhance health and wellbeing, although aspects of this relationship are contested. This was further supported by Schaefer, Blazer, Koenig (2008:511) when they established in their study that attendance, regular religious practices, and religious experiences were linked to decreased posttraumatic stress. Arias, Taylor, Ofori-Atta and Bradley (2016:2) also discovered that many patients and their families seek relief from mental health disorders at prayer camps, predominately Christian facilities run by faith healers where patients seek spiritual healing for their illness; such camps have been documented in Nigeria, Togo, and Ghana.

In regard to this, the health belief model would suggest that perceived benefits are at play, meaning even if a person perceives personal susceptibility to a serious health condition (perceived threat), whether this perception leads to behaviour change will be influenced by the person's beliefs regarding perceived *benefits* of the various available actions for reducing the disease threat (Champion & Skinner, 2008:47).

Sub-theme 9.3: Clinics and Hospitals

This sub-theme emerged as a result of specific health-care resources mentioned by the participants during the study. These were direct quotes from the participants:

"We have hospitals, we have clinics, yaaah! Hospitals and clinics…" **Participant 1**

"Aaaah! In my community there's aaaah!... there's clinics……and there's a mini-hospital as well aa and there are consultation rooms like for doctors, like surgeries aaaah!" **Participant 2**

"There are hospitals, clinics all around the place because we are in the CBD." **Participant 3**

"Yah! Well, we have basic health care resources we've got a clinic right, so of which when one is [struck]with flu or any less or more complicated you know health-related illness, that's the most available health available facility." **Participant 4**

"Resources like clinics, we have clinics, we have hospitals." **Participant 5**

"In my community, we do have a clinic, we have a clinic, that has enough mid-wives and nurses, we also have a surgery just to be accessible, so I think that's enough." **Participant 6**

"We've got clinics, we've got hospitals, we've got clinics inside iDischem, we've got a private hospital as well." **Participant 7**

"Church, hospitals and clinics, surgeries. **"Participant 8**

"Hospitals if you severely sick." **Participant 9**

"Aaah! We've got a 24-hour clinic… eeeh! Yah, we've got a hospital that is a bit far from where we stay, but it's not a problem because you can go to the ……eee clinic and they can transport you." **Participant 10**

In support of the statements shared by the participants, Moosa and Gibbs (2014:147) explained that South Africa is striving towards a strong primary healthcare system. This suggests that the country and the healthcare system are aware of the issues on the ground. They further mentioned that since 2007, departments of family medicine have been established in Gauteng to improve quality of care through improved access to doctors, the coordination of health services and better referrals Moosa and Gibbs (2014:147).

Regarding this particular sub-theme, perceived benefits were evident, meaning the belief in the efficacy of the advised action to reduce risk or seriousness of the impact of an illness was associated with accessing clinics and hospitals (Champion & Skinner, 2008:47). Meaning the participants trust in the action of accessing those particular health-care facilities.

3.8.2.10. THEME 10: SUPPORT SERVICES TO ENSURE ADHERENCE TO HEALTH-CARE BY XHOSA PEOPLE

The researcher established a trend during the participant's responses, where participants indicated a need for support services, a trend that led to the evolving of the following two sub-themes:

Sub-theme 10.1: Education and awareness

This particular theme emerged due to the low number of responses from the participants about accessing social work services or any related services. These were the direct quotes from the participants:

> *"I would really recommend them to open up, there are spiritual groups that do deny people access to to such assistance because of their belief, cultural or spiritual but I'm not going to mention spiritualties or something, but they are, and I would do recommend to approach eeeh! Public servants or social workers or practitioners like your GPs for assistance because they do become a hindrance."* **Participant 3**

> *"Comes to health understanding and of course when no one gets to understand you know the stand that I have as far as being aware of anything outside my*

spiritual formation, then it allows the social worker to either educate me right and make me understand there's more important things beyond what I understand, which in that instance I will be open up and have a little bit of a clarity as to life is not necessarily limited to what my spiritual formation educates me". **Participant 4**

"*We get introduced to new things every day. What can actually help are those in that problem in that situation is I would recommend that people being taught right because people lack the information, people lack information, people lack the reason why they should do something right. So, what can happen, people they have to be taught right, people need to be taught, people need to be told why they actually doing what they doing, why they actually have to do what they have to. Yah what they have to do."* **Participant 5**

"It is important to consult the doctor or medical practitioner when you get sick because in my, there are some people who are sick, for example, people who are HIV positive who do not want to take the ARVs because they believe that God will save them or they believe in ancestors things like that, yes….I will tell those people that it is important to go to the doctor to get medical help because even if their belief in God or in their cultures because those people are trained, they will get help." **Participant 7**

"I think people in the community they must know that a even though you believe in this type of belief a for instance as Christians some of us we have a tendency of exaggerating things because there are some of us Christians who believe even though they feel that they are sick but they will tell you, me I don't go at all to the doctor and the is nothing in the bible that disallows that so what I can say is people they must know that to be spiritual doesn't mean that when you are sick you cannot go to the doctor". **Participant 8**

In support of the view shared by the participants, Jeihooni and Rakhshani (2018:6) explained that the value of an education depends on its effectiveness as well as change with health behaviours. Meaning that educational effectiveness depends on the proper use of behavioural science theories, in this particular case, the health belief

model. Jeihooni and Rakhshani (2018:11) in their study established that educational intervention had the potential to increase preventive behaviours and decrease the risk for skin cancer among farmers. This was through the education based on the health belief model and social support construct that had led to the fact that with an increase in the mean of the constructs, the subjects in the experimental group performed better to prevent skin cancer.

Concerning this particular notion, the health belief model is one model that fits the criteria, mainly because the Health Belief Model (HBM) is one of the many models in health education that can be used as the basis for health promotion programs (Luquis & Kensinger, 2018:37).

Sub-theme 10.2. Social work services

This sub-theme emerged from the participant's responses during the study. These were the participant's direct quotes:

> *"I would also advise the community to consult with [a] social worker and psychologist to ....to speak…with the…to …I will also encourage them to go for therapy when they have health issues, their emotional or psychological."* **Participant 1**

> *"As a way of health-seeking behaviour because yah, counselling because whenever I get sick emotional the only way that I think its gonna help me is to go for my fellow social workers or psychologists to seek for counselling or therapy as a way of healing".* **Participant 8**

Jeihooni and Rakhshani (2018:10) established during his study that social support affects the disease control through two major processes: (1) direct impact of social support through health-related behaviours, such as encouraging healthy behaviours, and (2) moderating impact of social support that alleviates the effects of acute and chronic stress on health and increases the adjustment with the mental pressure caused by skin cancer. This means social support through the aid of social workers, or any professionals trained toward health care issues would prove to be vital in the

individual diagnosed with a health ailment, as they would take the role of supporting, advising and advocating for individuals (patients) rights.

Therefore, the health belief model applied to a range of health behaviours can provide a basis for shaping public health behaviour and training health care professionals to work from their patients' subjective perceptions of illness and treatment (Abraham and Sheraan, 2005: 29).

The next chapter presents key findings, conclusions and recommendations.

CHAPTER 4
KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

This particular chapter reviews and presents in detail how the goal and objective of the study were met by illustrating the key findings of the study. The conclusions are further made from the study and the recommendations from the study are detailed.

4.2 GOALS AND OBJECTIVES

The goal and objectives of the study were met to a certain degree and are presented as follows:

4.2.1 GOAL

The goal of the study was to explore the cultural and spiritual factors influencing health-seeking behaviours of Xhosa people in Johannesburg.

4.2.2 OBJECTIVES

This sub-section details each objective and stipulates how they were met through the study. It further highlights how these objectives served as stepping stones to achieving the goal of the study:

- **Objective 1:**

To conceptualise and contextualise cultural and spiritual factors influencing health-seeking behaviour from a health belief perspective.

The first objective was met by conducting a comprehensive and detailed literature search and review to ensure a contextualisation of the cultural and spiritual factors influencing health-seeking behaviour from a health belief perspective within the Xhosa tribe.

This objective was therefore realised in chapters 1, 2 and 3 of the study, specifically, chapter 3 section 3.8. themes 1 to 13 detailing the cultural and spiritual factors

influencing the health-seeking behaviour from a health belief perspective within the Xhosa tribe as per theme discussion.

The exploration of literature started with gathering and reviewing international cultural and spiritual factors influencing health-seeking behaviour, leading to the national level, then to the tribal level. This exploration gave the researcher an idea of these factors on a global level and national level leading to the local level (tribal level).

- **Objective 2:**

To explore and describe cultural and spiritual factors influencing health-seeking behaviour of Xhosa people in Johannesburg.

This objective was achieved through chapter 3, section 3.8. sub-section 3.8.2 with detailed information from theme 1 to theme 13. An in-depth discussion of the achieved objective is clearly illustrated in chapter 3 of the study.

Objective 3:

To make suggestions to improve social work services in health care, taking into consideration the factors influencing health-seeking behaviour in diverse cultures. This is the last objective within the study, one which was met by ensuring that suggestions or recommendations to social work services were made with specific reference to section 3.8. theme 13 sub-theme 13.2 and chapter 4 section 4.3.

4.3 KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS OF THE EMPIRICAL STUDY

This section presents the key findings, conclusions and recommendations according to each theme that emerged from the study in chapter 3.

4.3.1 THEME 1: KNOWLEDGE AND DESCRIPTION OF HEALTH-SEEKING BEHAVIOUR

The theme focused on the participants' knowledge and understanding of health-seeking behaviour.

- **Key findings**

The findings in the present study depicted that the participants had a vast knowledge and understanding concerning the subject in question. They gave their descriptions of the term “health-seeking behaviour” using their own words as per their understanding.

The findings revealed that participants understood the term health-seeking behaviour as an action that entailed taking the necessary steps to seek help concerning your health position and maintaining good well-being.

The findings in this regard gave an indication of how individuals react when confronted with a health issue or a life-threatening disease

The study findings further revealed that the type of health avenues that people approached in seeking help concerning their health and that these health avenues were not only restricted to clinics and hospitals but also gymnasiums or physical fitness centres and psychologists or counsellors.

The study revealed the great understanding that participants had, and this surpassed the physical ailment, rather than taking into consideration the emotional and mental health. Their descriptions entailed a broader understanding of the term “health”.

- **Conclusions**

It can be concluded that the participants have an understanding and knowledge about the term “health-seeking behaviour”. The different health-care avenues as well as the way behaviour was attached to each were indicated.

It can be concluded that the people within the tribe have a vast knowledge about the health-care avenues within their communities.

It can be concluded that health care does not only comprise the physical ailment but also includes the emotional and psychological aspects of an individual’s well-being.

- **Recommendations**

It is recommended that:

  - The members within the Xhosa tribe be fully informed about the broader concept of health-care avenues and how it relates to the optimal well-being of an individual.
  - The Department of Health and Social Development establish and implement programs that focus on the broader aspect of health care and the well-being of an individual, taking into consideration the health avenues that exist within the community.

4.3.2 THEME 2: FINANCIAL AND SOCIO-ECONOMIC FACTORS AS INFLUENCING FACTORS TO HEALTH-CARE

The theme focused on the financial and economic factors as influencing factors of health care. The sub-theme that emerged from the theme was poverty and unemployment.

- **Key findings**

The participants indicated an inability to access health-care facilities within their communities due to the financial constraints experienced. These financial constraints contributed to the economic issue of unemployment. This was expressed by 3 out of 10 participants during the study.

The findings revealed the challenges experienced as a result of financial constraints, clearly showing how finances can hinder access to health care when the need arises; therefore, influencing the health- seeking behaviour of an individual.

The findings of the study revealed the fact that individuals lacked the funds to visit a doctor or pharmacy or to attend to a health ailment because they were unable to afford certain health benefits in society due to unemployment. It indicated that being unemployed restricts the financial resources necessary to attain the desired health care at the required time.

The participants in the conducted study reported that with regard to accessing health care services, there were certain impediments to fully accessing those health care services. In their attempt to share those impediments, three sub-themes emerged giving a detailed picture of what they were reporting. The findings of the study revealed poor service delivery within the health-care centre in their communities, services that did not really cater for the health needs, basically depicting a disservice by the health-care centre.

The study also revealed as reported by the participants that one of the health care challenges faced was poor planning and development of these health care facilities in their communities. This information received meant that the facilities were built or structured in a way that eliminated certain health needs and over the years no development has taken place to address that. In this regard the participants had reported that one has to travel to certain districts to get a certain type of service or in some instances, the clinics are only open for a few hours of the day and are not 24-hour services.

The study revealed that the health care facilities experienced a shortage of resources, ranging from human resources to physical resources such as medication. This was indicated by the participants as one of the most frustrating and overwhelming health care challenges within their communities.

The study revealed that within the Xhosa tribe a certain gender was required to access a different health-care avenue. The study revealed that this did not mean the general health issues of that particular gender, but specific health issues were deemed private and required a tribal appropriate health avenue. These findings specified that men, specifically the Xhosa men could not access clinics, doctors, or any form of western medicine to attend to their sexual health, this specific health area was the responsibility of a traditional healer.

- **Conclusions**

It can be concluded that the financial and economic factors influence health-seeking behaviour. It can be concluded that service delivery and the standard of public health facilities remains an issue, not only in other communities but also within the community of Xhosa people residing in Johannesburg. It can be concluded that the issue of men's

sexual health is still a difficult issue that needs to be addressed in ensuring optimal health for all and that men still refrain from accessing public health-care facilities for their sexual health. In conclusion the Xhosa community within Johannesburg experience health care challenges that largely influence health-seeking behaviour.

- **Recommendations**

It is recommended that:

  - To curb the issue of affordability, communities should provide members with means to ensure financial stability and financial freedom.
  - The health care system be developed and structured in a way that ensures the community has access to affordable health care resources within clinics and hospital in the community.
  - Health care professionals are trained and equipped to fill the gap that exists within communities and most importantly, their patient base, the majority of South Africans, are unemployed.
  - The Department of Health find ways to improve its service delivery to ensure that communities are serviced efficiently and effectively.
  - All stakeholders take part in fixing and upgrading the state of the health care systems within South Africa to a position that is beneficial to all members of the community.
  - The Department of Health should create more facilities that will cater for all communities within Johannesburg.
  - The Department of Health should find more ways and strategies to influence the youth to enrol in health courses like nurses and medical specialists to ensure a major pool of human resources.
  - Professionals are equipped with the value and importance the tribe holds in terms of the sexual health of men to effectively offer the appropriate treatment.
  - Education and awareness targeted at Xhosa men's sexual health are addressed within the tribe to ensure they are not disadvantaged in receiving treatment that could potentially save their lives in the long run.

4.3.3 THEME 3: HEALTH CARE APPROACHES EMPLOYED BY THE XHOSA PEOPLE

Theme 3 focused on the health-care approaches employed by the Xhosa people in Johannesburg. The sub-theme that emerged from the theme were traditional therapy, traditional medicine, spiritual/religious exercise and health and fitness.

- **Key findings**

The findings that emerged from the study provided a broader knowledge and understanding in terms of the health care approaches that exist within the Xhosa community. The study findings revealed by the participants clearly noted that there were many ways in which people within their tribe deal with health ailments, whether physical, emotional or psychologically.

The findings revealed that home concoctions, also known as home remedies or folk medicine, served as health care avenues. The findings of the study further revealed that traditional medicine or alternative medicine as referred to by other countries was a method still widely used by individuals to treat illnesses.

The findings also revealed spirituality or religious practice as one of the health care methods used in treating or solving health issues; the findings also displayed the faith that individuals had in this type of health approach in terms of fully implementing the method in their everyday lives in managing health issues.

Lastly, the study findings revealed that exercise or what we refer to also as health and fitness was noted within the study as one of the effective methods in treating health issues faced by an individual.

- **Conclusions**

It can be concluded that home-made concoctions are still greatly used within our communities and spirituality or religious practice remains an integral part of human life and therefore largely influences their health-seeking behaviour.

It can be concluded that despite the low number of exercise and/or health and fitness centres within the community, exercise remains an important part of the management of people’s health.

It can be concluded that traditional medicine is still an indigenous method or approach highly regarded by individuals and is most likely to be employed compared to western medicine.

It can be concluded that as much as the community offers western medicine to the people, adherence to these western health-care avenues is still limited and a number of individuals used combined methods of health care in treating and managing their health.

- **Recommendations**

It is recommended that:

  - Health professionals are equipped about the different health care approaches that exist to better serve their patients and avoid any discrimination or the failure of their employed or recommended treatment.
  - Social workers are encouraged about the effective functioning of their role within communities in ensuring that communities' function and plan and administer necessary programs as per needs assessment.
  - The Departments of Health and Sports and Recreation prioritise the development and maintenance of centres and areas that focus on health and fitness within communities.
  - The Department of Health find ways to integrate traditional medicine into mainstream health care to ensure the safe and healthy practice of traditional medicine.

4.3.4 THEME 4: SUPPORT SYSTEM AS INFLUENCERS TO HEALTH-SEEKING BEHAVIOUR OF XHOSA PEOPLE

This theme focused on the support system as influencers to health-seeking behaviour of Xhosa people. The sub-theme that emerged from the theme were family support and traditional support and spiritual/religious support.

- **Key findings**

The findings indicated family support and traditional support as factors that influenced health-seeking behaviour. This means that certain influencing factors were family-oriented and yet at the same time culturally embedded in each family. This included

advice offered by family members in terms of the management of their health issues. These are the factors that influenced how an individual reacts to a health issue, whether an action towards finding a solution to a health ailment is taken or what type of health avenue to choose.

The study findings show that spirituality or religious affiliation is one of the influencing factors, highlighting the factor that spirituality and culture has deep-rooted influences in people's daily lives or decision-making. This influencing factor revealed the fact that spirituality or religion does serve as a sounding board or guide to what type of health approach to access and whether to treat the health ailment using the mainstream methods (western medicine).

- **Conclusions**

It is imperative we understand that health-seeking behaviour is largely influenced, and the influence is beyond the spectrum we might have normal thought.

It can be concluded that family support and traditional support largely influence the health-seeking behaviour of Xhosa people residing in Johannesburg.

It can be concluded that despite the technologically advanced era we live in, the majority of people still value and respect their culture and religion or spirituality and therefore are guided and highly influenced by it in the treatment and management of their health.

- **Recommendations**

It is recommended:

  - Professionals need to structure their helping process in a way it involves the fundamental aspects of an individual, their family and clear understanding of their tradition and religion or spirituality.
  - Health professionals need to be constantly equipped and their knowledge about their client systems or patients upgraded, in this way they will be better equipped to effectively and efficiently assist or treat their patients.

- Education and awareness campaigns about the detrimental consequences of family, cultural and spiritual or religious support on the individual's health.

4.3.5 THEME 5: SOCIAL IMPLICATIONS TO THE CHOICE OF HEALTH-CARE PEOPLE RESIDING IN JOHANNESBURG

The theme focused on the social implications to the choice of health-care by Xhosa people residing in Johannesburg. The sub-theme that emerged from the theme was strained relationships.

- **Key findings**

The findings in the present study depicted that despite the fact that individuals have a right to the choice of treatment there were factors that hindered the individual's optimum and lasting health after that choice was made. This means there were certain or unspoken consequences that played out in each person's life.

The study findings revealed that the social implications that individuals experienced were due to their choice of health care approach. The findings further revealed that these disagreements were the cause of strained family relationships.

- **Conclusions**

It can be concluded that familial differences and disagreements do exist even in matters pertaining to treatment and management of an illness. It can be concluded that these disagreements about the management of disease have negative consequences for the family system in the long run. It can be concluded that the choice of treatment has the potential to erode the existing positive family ties and create awkward and unnecessary tensions amongst family members.

- **Recommendations**

It is recommended that

- clients are emotionally prepared for the social implication of their choice of treatment.

- Clients or patients' families should be guided toward supporting and respecting the client's or patient's choices for treatment and management of illnesses.
- In order to minimise the psychological impact of these disagreements, health care professionals need to be educated about the dilemmas that still exist within certain tribal families regarding treatment choices.

4.3.6 THEME 6: NON-ADHERENCE TO HEALTH-CARE INFLUENCING FACTORS

The theme focused on the non-adherence to health-care influencing factors. The sub-themes that emerged from the theme were the prolonged health-care attention and the lack of regular health-care check-ups.

- **Key findings**

The study findings revealed that individuals do not seek medical attention due to reasons associated with procrastination, meaning individuals delayed the process in seeking the medical attention at the onset of the health ailment and instead acquired that attention later than required.

The study findings further revealed that at times non-adherence was a result of not regularly accessing the health-care resources, but rather treating the matter of health-care attention as a part-time job and not a necessity in ensuring one's optimum health.

These findings depicted that there were factors at play that led to individuals not adhering to accessing health-care attention when the need arose.

- **Conclusions**

It can be concluded that individuals take the matter of health-care attention lightly and that it does not hold the highest regard as it should to every living individual. It is clear that non-adherence to health-care attention is a prevalent issue amongst the Xhosa people residing in Johannesburg.

- **Recommendations**

It is recommended that:

- Awareness programs on general health-care checks amongst communities should be increased.
- The communities should be educated on health disadvantages and shortcomings of delayed health-care attention.

4.3.7 THEME 7: DIVERSITY WITHIN THE XHOSA TRIBE AS A CONTRIBUTING FACTOR TO THE TYPE OF HEALTH-CARE

The theme focused on the diversity within the Xhosa tribe as a contributing factor to the type of health-care. The sub-themes that emerged from this theme were cultural diversity and spiritual diversity.

- **Key findings**

The study findings show that within the tribal community as AmaXhosa they differed in many ways and the two ways that set them apart in terms of the belief systems rest on spiritual and cultural diversity.

The findings of the study were that within the Xhosa tribe diversity in terms of belief systems exists. The findings revealed that the Xhosa tribe consisted of individuals and families that ascribed to a different cultural or spiritual fold other than the indigenous Xhosa beliefs.

The findings revealed that even within the same bloodline, family diversity largely existed, this were circumstances where a mother is a Christian and a son is Islamic, other instances are of individuals who believe in ancestors and consult with traditional healers and others believe it to be a sin.

The study revealed that within the Xhosa tribe, there is quite a bit of diversity, and it transcends more than imagined alluding to the fact that the tribe has grown and evolved over the centuries.

- **Conclusions**

It can be concluded that the study findings revealed a fully depicted picture of diversity within a tribe and the influences of such diversity for each individual or family. It can be included that the findings highlighted the important truth that no person is exactly

the same, and in this case, no member within a tribe can be the same even within their cultural or spiritual stance, it can be concluded that the nature of a belief system in any tribe is truly is broad and comprehensive.

- **Recommendations**

It is recommended that:

  - All health-care professionals and social workers be trained on and equipped about the diversity of the tribe, to ensure tailored treatment plans.

4.3.8 THEME 8: PHYSICAL AND PSYCHOLOGICAL IMPLICATIONS OF NON-ADHERENCE TO HEALTH-CARE

This theme focused on the psychological implications of non-adherence to health-care. The sub-themes that emerged were depression and suicidal attempts.

- **Key findings**

The findings of the study indicated that there are physical implications involved in not accessing the appropriate health-care avenues that exist within their communities. The findings of the study revealed that non-adherence to health care was influenced by the individual's tribal cultural/traditional obligations leading dire physical and psychological implications for the individual.

These study findings revealed that physical implications denoted a high risk as they led to the loss of life by tribal members participating in the traditional rite that condemned access to medical attention during the process. The findings further revealed psychological implications as a result of cultural obligations and not accessing the appropriate health-care avenues to manage the issues at hand.

The information revealed by the participants indicated that these psychological implications were severe and life-threatening as they could lead to the possible end of life of an individual. They further meant that there was indeed a conflict that existed between honouring one's culture/or and tradition and accessing western medicine. A conflict that caused more harm than good and denied one access to help or indicating they needed help.

- **Conclusions**

It can be concluded that the cultural obligations within the tribe indicated a provocation of psychological implication in the nature of the Xhosa tribe, implications that members of the tribe experienced.

It can be concluded that some men within the tribe lost their lives due to non-adherence to health-care avenues available in their communities in the bid to honour the tradition and customs of their tribe.

It can be concluded that cultural obligation exists amongst communities and in this particular case, the Xhosa tribe, and is not something of the past but rather very current even in this 21st century, an era of medicine and technological advancement.

- **Recommendations**

It is recommended that:

  - The Department of Health make more resources available to understand and curb the unnecessary results of traditional obligations influenced by individuals.
  - Health care professionals, including social workers, are equipped and trained on the cultural or traditional influencing factors of an individual's health-seeking behaviour.
  - South Africa is a diverse nation in both race, ethnicity, culture, tradition and religion, therefore treatment plans in place need to be tailored to cater for each or take into consideration factors that may hinder adherence.
  - Awareness should be raised about such issues that still exist on the ground and find ways to ensure the information is heard throughout the country.
  - The Departments of Health, Department of Social Development, Department of Justice and all the relevant departments should work jointly to find strategies to eradicate cultural practices that go against the rights of an individual.

4.3.9 THEME 9: HEALTH-CARE RESOURCES WITHIN THE XHOSA COMMUNITY IN JOHANNESBURG

The theme focused on the health-care resources within the Xhosa community in Johannesburg. The sub-themes that emerged were traditional healers, pastors or prophets and clinics or hospitals.

- **Key findings**

The findings of the study revealed that there were several health avenues at the individual's disposal, avenues that they relied on and trusted. These health-care avenues included hospitals and clinics; health avenues that form part of western medicine.

The study findings also revealed traditional healers as health-care avenues used in the management and treatment of disease amongst the tribe. The findings indicated that treatment by traditional healers were still held in high regard and with respect within the Xhosa community, revealing the trust the individuals still had in their indigenous tribal knowledge.

The study findings also revealed that spiritual leaders (pastors and prophets) as one of the health-care avenues used in the management and treatment of health ailment or any health issue experienced. These findings revealed that spirituality or religion was an aspect that held great value within people's lives and their communities.

The study revealed that pastors or prophets were regarded as experts on issues pertaining to individual health, and not limited to spirituality but also experts on the physical and psychological aspects of an individual's health.

- **Conclusions**

It can be concluded that there is variety within the health-care resources, not just within the frame of speciality but also in terms of their association and basis of treatment within the Xhosa tribe. It can be concluded that there are major factors at play in terms of which health-care resource is accessed by the individual within the tribe and that the choice is largely influenced by one's cultural or spiritual stance.

- **Recommendations**

It is recommended that:

- Health-care professionals are equipped on the different health-care resources that exist within communities.
- To create diversity in the management and treatment of disease, community members should be made aware of the benefits of other health avenue.

4.3.10 THEME 10: SUPPORT SERVICES TO ENSURE ADHERENCE TO HEALTH-CARE BY XHOSA PEOPLE

The theme focused on the support services to ensure adherence to health-care by Xhosa people. The sub-themes that emerged were education and awareness and social work services.

- **Key findings**

The findings revealed a need for support services existed within the lives of individuals and the communities at large. These ranged from education and awareness to the need for professional help through social work services.

The study findings revealed that individuals were aware of the needs in their communities and therefore required the necessary assistance from professionals. The findings also revealed that the people within the Xhosa community were aware of issues such as belief systems and cultural or religious associations that hindered the optimum health of individuals due to certain restrictions imposed or suggested by those particular formation or beliefs within their tribe.

The findings revealed a lack of resources within communities regarding this particular aspect, hence the need for professional assistance.

- **Conclusions**

It can be concluded that members of the tribe are in greater need of more education and awareness within their community in matters pertaining to health issues in general. It can be concluded that social work services tailored to assist individuals and communities at large is needed.

- **Recommendations**

It is recommended that:

- Social workers are equipped with the knowledge and trained in skills necessary to serve the needs of such communities as per the study.
- To curb hindrances to optimal health in communities, more health-tailored programs should be created.

4.4 FUTURE RESEARCH

It will be imperative and beneficial to the social work profession, health care professional, health care sector as a whole and the individuals affected if future researchers focus more on conducting this research on a wide scale to establish whether the findings received would match one of this particular study.

Moreover, future researchers can explore the emotional and psychological impact of the factors influencing the health-seeking behaviour of the Xhosa people in Johannesburg.

4.5 SUMMARY

A detailed discussion of the objectives of the study was conducted to demonstrate how they were met, ultimately leading to leading to their direct contribution to achieving the study's goal.

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APPENDICES

APPENDIX A: ETHICAL CLEARANCE LETTER

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Humanities 100
Since 1919

11 June 2020

Dear Ms S Somzana

Project Title:	The cultural and spiritual factors influencing the health-seeking behaviours of the Xhosa people in Johannesburg.
Researcher:	Ms S Somzana
Supervisor:	Dr NJ Bila
Department:	Social Work and Criminology
Reference number:	18245872 (HUM022/0320)
Degree:	Masters

I have pleasure in informing you that the above application was **approved** by the Research Ethics Committee on 11 June 2020. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

We wish you success with the project.

Sincerely,

Prof Innocent Pikirayi
Deputy Dean: Postgraduate Studies and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: PGHumanities@up.ac.za

APPENDIX B: INFORMED CONSENT

Date: 10/02/2020

Name: Sipokazi Somzana

Email: siphokazisomz@gmail.com

Cell phone No: 073 7800 536

LETTER OF INFORMED CONSENT

SECTION A: RESEARCH INFORMATION

Research Information

This letter serves to invite you to participate in a study the cultural and spiritual factors influencing health-seeking behaviour amongst Xhosa people in Johannesburg. The informed consent gives a brief explanation of the purpose and procedure of the research and the rights of participation. Please go through the form before you make an informed decision regarding your participation.

Title of the study

The cultural and spiritual factors influencing the health-seeking behaviour amongst Xhosa people in Johannesburg.

Purpose of the study

The purpose of the study is to explore and understand the cultural and spiritual factors that influence the health-seeking behaviours amongst Xhosa people in Johannesburg.

Procedures

You have been informed of the study and provided your contact details for researcher to contact you to partake in the study. The researcher will be responsible for conducting a face-to-face interview in order to collect data on cultural and spiritual factors influencing the health-seeking. Once you sign this letter, you agree to take part in the study. The researcher will arrange to conduct an individual interview with you when it suits you best. The length of the interviews can take plus minus 60 minutes with each participant interviewed. The location of the interviews will take place within Johannesburg however the exact place will differ from one participant to the other depending on the venue that will be most comfortable to each participant. The interview will be recorded, with your permission, to ensure that all the information you are sharing is captured for research purposes. A semi-structured interview schedule will be used during the interview to guide the interviewing process.

Please note that the recording will only be used for the purpose of data analysis of the research and will be kept confidential.

Risks and discomforts

Please note that the researcher does not intend to put you under any risk or discomfort with the information you will share. There is a possibility of emotional harm related to the sharing and exploration of and spiritual factors influencing the health-seeking behaviours. The researcher will debrief you after the interview is concluded and should you experience a need for counselling, you will be referred to a professional counsellor for intervention. The counselling service that you will receive will not require any monetary payment or fee on your part. You are free not to answer any question that will make you feel uncomfortable during the interview.

Benefits

You will not receive any form of remuneration/ compensation/ incentives for participating in the study. The study is however about gaining an in-depth understanding about the cultural and spiritual factors influencing their health-seeking behaviours of Xhosa people in Johannesburg, improving their health services by formulating intervention strategies aimed at aiding social workers offering efficient services. The findings of this study can also help other professionals to better understand the experiences of Xhosa people.

Participants' rights

Your participation in the study is entirely voluntary and you may withdraw from participation at any time and without negative consequences to you or your family members. Should you wish to withdraw from the study, all data gathered in respect of your interview will be destroyed.

Confidentiality

The information shared during the interview will be kept confidential and will be used for the purpose of the study only. The researcher will also not identify you by name during the report, using only pseudonyms to protect your identity. The only people who will have access to the data, will be the researcher and the supervisor.

Data usage and storage

Please note that the data collected might be used in the future for further research purposes, a journal publication or conference paper. The data collected will be stored in the Department of Social Work and Criminology, University of Pretoria for the period of 15 years as required.

Access to the researcher

You may contact the researcher using the contact details provided above for the duration of the study, should there be any questions or uncertainties regarding the study and your participation. It must be clearly stated, that the role of the researcher is to do research and not to provide counselling or therapeutic services.

Please sign Section B on the next page if you agree to participate voluntarily in the study.

Yours sincerely,

Sipokazi Somzana (Researcher)

SECTION B: INFORMED CONSENT OF PARTICIPANT

I ……., (*Full Name of participant*) hereby declare that I have read and understood the above information. I was given adequate time to consider my participation in the study. I was also given the opportunity to ask questions and all of them were answered to my satisfaction. I hereby give consent to participate voluntarily in this study.

Participant: ----------

Date: ----------

Signature: ----------

I…… (*Full Name of researcher*) hereby declare that I have explained the information in Section A: Research Information to the participant and he/she indicated understanding the contents and was satisfied with the answers to questions asked.

Researcher: ----------

Date: ----------

Signature: ----------

APPENDIX C: INTERVIEW SCHEDULE

Interview Schedule

1. **Biographic information**
   1.1 Biographic information
   Age :
   Gender :
   Marital status :
   Number of children :
   Religion :
   Home language :
   Highest qualification:

2. **Knowledge of health care seeking behaviour**
   - What does the word health-seeking behaviour mean to you?
   - What actions do you take to maintain a good health?
   - How long do you take before consulting a health care provider?
   - Who would you consult first?
   - How does your culture/religion influence your decision to seek / receive medical help when needed?

3. **Understanding of cultural and spiritual practices within your cultural/ ethnic/ spiritual group**
   - What does culture means to you?
   - What does spirituality means to you?
   - What are the cultural practices you are familiar with in your ethnic group?
   - What are the spiritual practices you are familiar with in your spiritual group?
   - What is the value of culture in your personal life
   - What is the value of culture in your community?
   - What is the value of spirituality in your personal life
   - What is the value of spirituality in your community?
   - What are your initial steps you take when you seek help regarding your health?
   - Were you or a family member ever faced with an illness and need to seek medical intervention which you could not allow due to your beliefs/culture. Please elaborate?

4. **Spiritual and cultural factors**
    - What spiritual factors contribute to your health-seeking behaviour?
    - What cultural factors contribute to your health-seeking behaviour?
    - What other factors do you think contribute to your health-seeking behaviour?
    - What is the influence of spiritual and or cultural factors on your health-seeking behaviour?
    - How did this affect you and your family?
    - What would be the consequences for family members?
    - Who guides you regarding spiritual or cultural health care related issues?

5. **Health-seeking behaviour and the family**
    - Can you tell me about your experiences within the family home, being influenced spiritually or culturally in seeking health care?
    - Who determines when too go for consultations when a family member is sick?
    - Do you depend on your cultural /spiritual guidance when you/family members are sick?
6. **Services**
    - What resources are there in your community for health care?
    - What challenges regarding healthcare resources are there in your community?
    - Are these services accessible? Please explain how you have to access these services?
    - Who guides you regarding health care related issues?

7. **Social work intervention**
    - Have you had any interaction with/referral to a social worker regarding health care issues?
    - Is there anything you think a social worker should know about your culture or religion that would help them do understand you better and do their job more effectively?
    - Do you think asking about patients' religions and cultures can help health practitioners devise treatment plans that are consistent with their patients' values?

8. **Recommendations**

- Do you have any recommendations for cultural or religious groups in your community that disregard accessing medical health services as a result of their beliefs? Please motivate
- Do you have any recommendations about integrating cultural and spiritual practices into medical health streams? Please motivate

APPENDIX D: Letter of the editor

Sury Bisetty Academic Editing Services –

CIPC No. 2021/360666/07

To whom it may concern,

I have edited the mini-dissertation entitled: The cultural and spiritual factors influencing the health- seeking behaviour of the Xhosa people in Johannesburg by Sipokazi Somzana, Student Number: 18245872, submitted in partial fulfilment of the requirements for the degree of Master's of Social Work in Health Care MSW (Health care) in the Department of Social Work and Criminology, Faculty of Humanities at the University of Pretoria

Sury Bisetty

Professional Language and Technical Editor 10 December 2021

CONTACT DETAILS

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MEMBER OF: CERTIFICATION:

Professional Editor's Guild (BIS002) PEGSA: Critical Reading

South African Council of Educators (222277) Editing Mastery: How to Edit to Perfection South African Monitoring and Evaluation Association (761237008553) Complete writing, editing master class.

ELSEVIER – Editor's guide to reviewing articles

Disclaimer: Please note, I provided language and technical editing as per discussion with the client. The content of the dissertation was not amended in any way. The edited work described here may not be identical to that submitted. The author, at his/her sole discretion, has the prerogative to accept, delete, or change amendments/suggestions made by the editor before submission.

APPENDIX E

Research Report Turnitin

Original Report

24% SIMILARITY INDEX 22% INTERNET SOURCES 14% PUBLICATIONS % STUDENT PAPERS 1 2% 2 2% 3 1% 4 1% 5 1% 6 1% 7 1% 8 1% 9 1% Research Report ORIGINALITY REPORT PRIMARY SOURCES uir.unisa.ac.za Internet Source www.ncbi.nlm.nih.gov Internet Source www.ajol.info Internet Source hdl.handle.net Internet Source repository.up.ac.za Internet Source link.springer.com Internet Source www.tandfonline.com Internet Source journals.sagepub.com Internet Source cssr.uct.ac.za Internet Source 10 1% 11 1% 12