A qualitative study on the barriers to accessing health services: Perspectives and experiences of men in rural areas of South Africa.

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COLLEGE OF HUMANITIES

DECLARATION - PLAGIARISM

I, Nkanyiso Gift Ngwazi declare that:

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Abstract

The need to improve men's usage and access to essential health care services remains an important global concern. In South Africa, as elsewhere, health is one of the most fundamental human rights, and a strong and available healthcare system is important to satisfy this right. There is also a growing body of literature to suggest that men are less likely than women to seek assistance from healthcare professional, with women and children in South Africa having been the main focus of health services. The time has come to include the health needs of men, as those in rural areas remain neglected from the health services framework of South Africa. The aim of the study **was** to explore the barriers to accessing health services among men in rural areas of South Africa. For the study in-depth face to face interviews were used to collect data. In total 20 in-depth interviews were conducted among men aged 18 and over in a rural area at Umgababa (Mnini area). The findings suggest that rural men experience multiple barriers accessing health services including cost, transport, fear, distance and so on. In addition there are underlying factors that contribute to barriers in accessing health care such as poverty, culture, notions of masculinity, gender and health care providers. The study suggests that more community engagement and consulting needs to be done in order to encourage more rural men to visit health services. Moreover, the idea of 'health literacy', which is characterized as the capacity to make sound health decisions on a regular day to day basis, at home, in a group, at work, in health care systems, the commercial centre and the political field. It is a basic strengthening technique to build individuals' control over their health, their capacity to look for information and to accept responsibility. Health education is important for promoting health and prosperity.

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Acronyms and abbreviations

- AIDS- Acquired Immune Deficiency Syndrome
- ART- Anti Retroviral Therapy
- BIG- Basic Income Grant
- BM- Behavioural Model
- GP- General Practitioner
- HIV -Human Immune-deficiency Virus
- KZN- KwaZulu-Natal
- LMIC- Low Middle Income Countries
- MAP- Man as Partners
- NGOs- Non-Governmental Organizations
- NHI- National Health Insurance
- PHC- Primary Health Care
- STDs- Sexual Transmitted Diseases
- STIs- Sexual Transmitted Infections
- Stats SA- Statistics South Africa
- TB- tuberculosis
- UNAIDS- United Nations Aids Programme
- UNICEF- United Nations Children's Emergency Fund
- WHO- World Health Organization

Contents Page

Cover page……i

Declaration……ii

Abstract…… iii

Acknowledgements……iv

Acronyms and abbreviations……v

Chapter One

Introduction

1.1 Background……...1
1.2 Justification of the study……...3
1.3 Problem Statement……....6
1.4 Significance of the study……...7
1.5 Research Questions……...7
1.6 Aims and Objectives……..…...7
1.7 Theoretical Framework…….……8
1.8 Organisation of the dissertation……9

Chapter Two

Literature review

2.1 Introduction……...10
2.2 Factors associated with health care utilization among men…….....10
2.2.1 Ill-health……10
2.2.2 Age……....11
2.2.3 Place of residence……...12
2.2.4 Employment ……..13
2.2.5 Education ……...13
2.2.6 Medical Insurance……..14
2.2.7 Need for Family Planning…… .14

2.3 Barriers to health among men……..15
2.3.1 Culture…….....15
2.3.2 Gender……..……17
2.3.3 Cost……...20
2.3.4 Transport ……..23
2.3.5 Distance…….24
2.3.6 Notions of Masculinity ……25
2.3.7 Health care providers……...….27
2.3.8 Poverty……..29
2.3.9 Stigma & Discrimination.……30
2.4. Summary…….31

Chapter Three

Methodology

3.1 Introduction…….……32
3.2 Study context …….……..32
3.3 Qualitative methodology…….……33
3.4 In-depth Interviews……..34
3.5 Sampling criteria and sampling strategy……..35
3.6 Data collection…….35
3.7 Data Analysis……...37
3.8 Ethical considerations……..37
3.9 Limitations of the study……...38

Chapter Four

Results

4.1 Introduction……..39
4.2 Sample Characteristics ……39
4.3 Perceptions and experiences of men at health services……...40
4.4.1. *Positive gains*……...44
4.4.2 Availability of services…… …...45

4.5 Barriers to accessing health services ……48
4.5.1 Distance……..48
4.5.2 Transport……..……..50
4.5.3 Cost……52
4.5.5 Long hours……..53
4.5.6 Health care providers……54
4.5.7 Confidentiality……....55
4.6 Overcoming the barriers……....56
4.7 Conclusion……..…..57

Chapter Five

Discussion

5.1 Introduction……...59
5.2 Summary of the main findings…….….59
5.3 Recommendations…….……65
5.4 Conclusion…….……66
References…….……..68
Appendix I: INTERVIEW GUIDE…….……85
Appendix II: ETHICAL CLEARANCE APPROVAL…….……..88
Appendix III: INFORMED CONSENT…….....89

List of Figures and Tables

Figures

Figure 1.1 Anderson Model of Health Care Utilization……..……...8
Figure 3.1 Location of Umgababa, Mnini Area…….32
Figure 3.2 Umnini Primary school…….36

Tables

Table 4.1 Demographical Profile of the Sample……..……...40
Table 4.5 Barriers to accessing health services……..**.....**48

Chapter One

Introduction

1.1 Background

The need to improve men's usage and access to essential health care services remains an important global concern. In South Africa, as elsewhere, health is one of the most fundamental human rights, and a strong and available healthcare service facility is important to satisfy this right (Jobson, 2015). South Africa has made significant strides to fulfilling this right, especially in rural areas, but it is clear, that rural health services delivery has not received the same limited attention or resources as urban facilities. In South African, particularly in the province of KwaZulu-Natal, rural areas are generally characterized by limited resources, lack of employment opportunities and scattered households (Buthelezi, 2001). These conditions might result to barriers to accessing health services for rural men, who are often out of touch with the health care system and do not always seek health care when they need it (Sandman et al., 2000), which can put their health in danger.

Globally, numerous studies suggest that men tend to experience mortality earlier than females (Smith et al., 2006). There is also a growing body of literature to suggest that men are less likely than women to seek assistance from healthcare professionals (Galdas et al., 2005), with women and children in South Africa having been the main focus of health services. There has been over 10 years of focus on women's health in South Africa, mainly because they may use the health care system more, not necessarily due to gender socialization, but because they may have a greater need to visit health services during their lifetimes. Typically, women experience more nonfatal chronic illness, such as arthritis, respiratory conditions, thyroid diseases, migraine headaches, which may draw them into the health care system at higher rates than men (Gast & Peak, 2011). The time has come to include the health needs of men, as those in rural areas remain side-lined from the health services framework of South Africa (Obrien et al., 2005). Hence, more attention regarding men's health is called for, given their greater risk of premature mortality (Sandman et al., 2000).

In South Africa, there have been significant improvements in the healthcare system since 1994, such as the introduction of free Primary Health Care (PHC) for all. The foundation of public health systems are the primary healthcare clinics that form the first line of access for many individuals requiring health support services (Jobson, 2015). South Africa’s healthcare

system also consists of a private sector, which is comprised of health care professionals who provide services on a private basis, being funded by the subscriptions of individuals who belong to medical aid schemes (Jobson, 2015). Lastly, numerous non-governmental organizations (NGOs) add to the health arena, with considerable attention on HIV/AIDS and tuberculosis (TB) that accounts for a large proportion of donor money of approximately R5.3 billion annually (Jobson, 2015). However, despite the growing health sector, South Africa remains confronted with numerous health problems, especially in rural areas. Rural communities experience significant barriers to accessing health care, including finances, inadequate transport, and distance to the nearest health facility, as well as limited services available in these areas (Gaede & Versteeg, 2011). Moreover, understaffing and the poor state of infrastructure in many rural areas adds to existing inequities between rural and urban areas, and this influences the poor health seeking behaviour of men (Gaede & Versteeg, 2011).

Most discussion on men's health-seeking positions and describes them as unwilling patients or 'behaving badly' with respect to their health. Their poor health seeking behaviour limits their access to information and restricts opportunities for health improvements, cooperation and essential care utilization (Smith et al., 2006). *Health-seeking behaviour* is considered to be the recognition of a health concern together with the range of resulting actions, one of which is *health service utilization* (Smith et al., 2006). In addition, Chrisman, (1977) asserted that *health-seeking behaviour* refers to the sequence of remedial actions that individuals undertake to rectify perceived ill health. Most definitions on health-seeking behaviour are largely centred on the idea that individuals have the ability to access health services when needing care. Not all men are the same, nor does it make sense to assume that individual men behave similarly in all help-seeking contexts. The study uses these terms, interchangeably because the study acknowledges that men access health services in different ways and the barriers they face are not the same so therefore using the definition interchangeable allows the study not only stick with one perspective but to explore many more perspectives and experiences that men face with regard to health services.

Peerson & Suanders (2009) addresses the idea of 'health literacy', which is characterized as the capacity to make sound health decisions on a regular day to day basis, at home, in a group, at work, in health care systems, the commercial centre and the political field. It is a

basic strengthening technique to build individuals' control over their health, their capacity to look for information and to accept responsibility. Health education is important for promoting health and prosperity (Kickbusch et al., 2005). Men's limited health literacy is additionally related to underuse of health services and unfortunate practices (Courtenay, 2000: p1388). This absence of health literacy among men brings about their wanting to depend on themselves and their support networks (families and partners) instead of looking for professional help (Howat & Cairns, 2006). Various barriers keep men from visiting health services. Men face multiple barriers in accessing healthcare services, including: culture, cost, gender, occupation, socio-economic status, age, sexuality, distance and masculinity. Moreover, men also face barriers such as a lack of time, poor access, inadequate opportunities, having to tell their employer the reason for their visit, and the lack of a male health care provider (Howat & Cairns, 2006).

Other underlying factors include place of residence and poverty, which indirectly affect men's utilization of health services in many rural areas in South Africa. Since the transition to democracy in 1994, the health system in South Africa continues to be confronted by numerous challenges. Some of the difficulties in the South Africa health system originate from its broader socio-economic inequalities that indirectly contributed to unequal access to health services (Galdas et al., 2005). Government and other resourceful social support structures need to recognize the barriers rural men face in order to respond to their health needs (Galdas et al., 2005).

1.2 Justification of the study

There are a number of reasons why more studies need to focus on men's health, especially in rural areas. According to the WHO (2015), globally, the health of men has deteriorated more than women in the last 25 years, mainly due to men being more likely to engage in high-risk reckless behaviour. They consume more alcohol than women, and four out of five men drive while under the influence of alcohol compared to one in five women (WHO 2015). There are growing notions of masculinity associated with manhood that prohibit them from accessing health services. For example, men are generally considered physically stronger than women, as they are bigger and more muscular than women, which enables them to run faster, lift heavier objects and throw things farther (Courtenay, 2000). However, while men rule on the

aforementioned, in medical and health terms it is an entirely different story. They are less likely to visit health services.

The majority of black South African men live in rural communities with limited resources (Jobson, 2015). Being a man in a democratic South Africa is different to the pre-democracy era, yet the present does not represent a complete rupture from the past. Some men are seeking to be part of a new social order, while others are becoming more resistant (Walker, 2005). Social constructions of manhood have strong effects on both men's and women's health in South Africa. Men's risk-taking behaviour and failure to seek health care increase their exposure to injury and illness (Walker, 2005). Men's health needs in South Africa are determined by the fact that they are employed in dangerous environments; are prone to the excessive use of alcohol, which is often seen as a sign of manhood; and may have no choice over cultural matters, and are forced to undergo certain practices (traditional initiation rites) (Walker, 2005).

The study acknowledges that addressing the health needs of men would not be easy, as there are a number of underlying factors that prevent them from seeking healthcare services. A study on Man as Partners (MAP) stated that, in certain South African provinces, individuals still accept or confide in their traditional leaders rather than seek care from health professionals (Peacock et al., 2009). The MAP study was conducted in three provinces (KwaZulu-Natal, Eastern Cape and Mpumalanga) typical of rural areas and characterized by few employment opportunities, high levels of out-migration for labour, and relative social isolation. The study participants were entirely male because the aim of the MAP study was to look at Men as partners, their attitudes, values and beliefs in relationships. Values and attitudes that embrace traditional beliefs are inevitable, and can produce men who are disengaged with their health issues, being detached, and frequently on a mission to demonstrate their masculinity (Peacock et al., 2009). These attitudes and beliefs can trade-off men's health by encouraging them to engage in a range of unsafe practices: brutality, substance abuse, multiple sexual partners, abusing women, while at the same time urging men to view health-seeking as a sign of weakness and an indication of their own shortcomings (Peacock et al., 2009).

Men are very private when it comes to issues concerning their health. Addis & Mahalik (2003) noted that some patients prefer their health status to be kept confidential between the service provider and the patient. This can be driven by a few factors, with men generally being portrayed as socially challenged because of their independence and difficulties forming commonalities and emotional attachments in relationships (Addis & Mahalik 2003). Men likewise feel that they cannot trust health care providers with their health conditions and for this reason they may decide to delay or refuse to look for help altogether (Gupta, 2000). Some men do not feel comfortable being examined by females, and notwithstanding counselling with females about their sexuality, feel uncomfortable because these are perceived as sensitive issues that they prefer to share with other males or keep to themselves (Gupta, 2000).

The fact is, men are not merely to be blamed for their reckless and sloppy behaviour. There are a combination of cultural and biological factors at play (Smith et al., 2006). Men have not been taught to be watchful about their health, but this is slowly changing. However, more needs to be done if South Africa wants to increase their productivity and develop as a nation, because a healthy population is productive and efficient. Hence, it is critical that health administrations acknowledge that the reluctance and hesitance of men to seek health is a major concern affecting many rural areas of South Africa, and that an urgent and reliable health system is needed to address this issue (Smith et al., 2006).

In South Africa, there is no standardised definition of the term ‘rural’, stakeholders use a range of criteria to define rural, or do not use ‘rural’ as a variable at all. According to Gaede & Versteeg, (2011), several authors used the 1996 and 2001 Census data to define ‘rural’ on the basis of a number of indicators, including whether an area fell under a traditional authority, was located outside metropolitan areas and lacked ‘urban characteristics, such as availability of facilities and infrastructure. South Africa has poor health outcomes in both rural and urban areas, despite spending significantly more on health than other middle-income or developing countries (Smith et al., 2006). The high levels of deprivation in rural areas contribute significantly to poor health outcomes. Issues of education, sanitation, availability of potable water, household income, and food security all have an impact on the health status of individuals and households in rural areas (Smith et al., 2006). The levels of

deprivation in rural areas suggest that insufficient attention has been given to the role of social determinants of health in uplifting the health of rural communities (Smith et al., 2006).

1.3 Problem Statement

South Africa has made significant strides in increasing access to health care, yet progress has been insufficient and even reversed for a large number of the health objectives. Since 1994, life expectancy has reduced by nearly 20 years, mainly due to the rise in HIV-related mortality, and average life expectancy at birth is currently 50 years for men and 54 years for women (Chopra et al., 2009).

During the transition to democracy, there was considerable restructuring of various important systems, particularly the healthcare system, which underwent major changes that continue to impact the health of many South Africans, especially in rural areas. The new health system was intended to improve access to PHC facilities and to benefit the rural populations, as the public healthcare provides coverage through a network of community-level care services, PHC facilities and hospitals (Jobson, 2015). However, studies suggest that men in rural areas feel that their health needs have been neglected (Peacock et al., 2014). Men have indicated that they find the pre-democracy health system to be better than what they are currently experiencing in terms of access to facilities and proper health care (Chopra et al., 2009).

Men's reluctance to consult a general practitioner (GP) has been recognized as an important problem to enhancing men's health seeking behaviour in South Africa (Banks, 2001). Underlying this is a concern that fewer visits to the GP and delays in getting timely advice may diminish men's chances for early identification, treatment, and counteractive action of a disease. Men's 'under-use' of the health service systems has been labelled as a social issue. It is possible that men's circumstantial claims of ‘self-observing’ reflects a desire for self-dependence and to avoid going to the GP and hearing ‘terrible news’ about their health status (e.g. elevated cholesterol, corpulence, disease conclusion), receiving unwelcomed counselling about the ‘way of life’ changes, and taking part in formal health frameworks, which make them awkward (Buckley & Tuama 2010). Additionally, before the age of 50 years, for every 10 premature female deaths, 16 men die prematurely, mainly from cardiovascular diseases, accidents, suicide and neoplasms (Smith et al., 2006).

The availability of community-based primary health care clinics that are more male friendly is one contextual factor that has received limited attention (Bersamin et al., 2011). Tending to such an issue would not be simple, as health help-seeking is a complex phenomenon in which there are probably going to be multiple influencing factors notably: gender, occupation, financial status and age (Galdas et al., 2005). Other influencing factors include: culture, cost, sexuality, class and manliness, all of which will be further discussed in the study. Engaging men in the work for health equity in healthcare access must also necessarily be work that is guided by a broader agenda for social justice in health (Sonke Gender Justice, 2009).

1.4 Significance of the study

Little research has been carried out on health-care utilization behaviour and access to health-care in South Africa by men (Dunkle et al., 2006). The study was shaped by two important aspects, the first being that men and women share many of the same health concerns, but there are certain health conditions that mainly affect men, such as heart disease, high blood pressure and reckless behaviour (Addis and Mahalik, 2003). Therefore, it is important to produce health services that are unique and friendly to men in order to provide awareness to rural men on the diseases that may affect them. The second aspect was that rural areas have often been neglected in terms of health service delivery. Therefore, the study aims to observe whether there has been change over time in terms of health service delivery in rural areas.

1.5 Research Questions

The study attempted to answer the following key questions.

What are barriers that prevent rural men from visiting health service centres?
How do men perceive health facilities?
Is there a strong or poor utilization of health services among rural men?

1.6 Aim of the Study

The aim of the study is to explore the barriers to accessing health services among men in rural areas of South Africa.

The specific objectives of the study are:

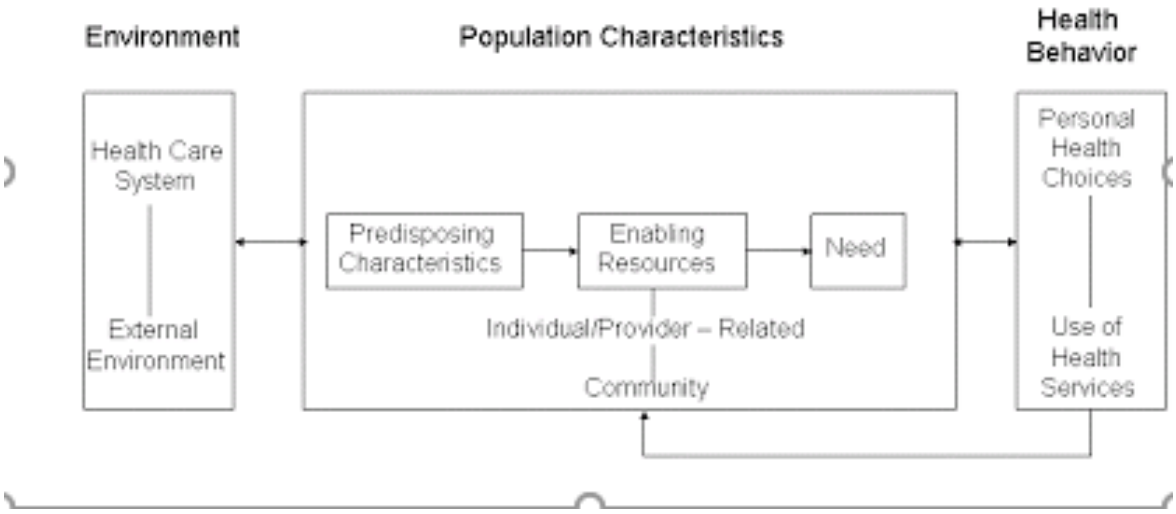
- to ascertain the health seeking behaviour of rural men.

- to examine the attitudes of rural men toward health services.
- to explore the opportunities and constraints for changing the health seeking behaviour of men.

1.7 Theoretical Framework

The study adopted the framework of Ronald M. Andersen, the Behavioural Model of Health Services Use (BM) that was developed in 1968. The BM is a multilevel model that incorporates both individual and contextual determinants of health services use (Babitsch et al., 2012), and has been applied in numerous systematic reviews on various aspects of health care utilization. There are three components to this model: the environment, population characteristics and health seeking behaviour. Figure 1.1 shows a diagram of the three components that incorporates both individual and contextual determinants of health services use.

Figure 1.1: Anderson Model of Health Care Utilization



Source: Babitsch et al. (2012)

The predisposing characteristics are factors that predispose individuals to the use of health services, including the demographic and social structure of their communities (age, sex, education, occupation, etc.), their collective and organizational values, cultural norms and political perspectives. The enabling resources include financing and organizational factors that serve as conditions enabling services utilization. Financing includes the price individual pay in accessing health services, and the organisational factors includes whether an individual

has a regular source of care and the nature of that source. They also include means of transportation, travel time to and waiting time for health care. Need factors are differentiated between perceived need for health services (i.e. how people view and experience their own general health, functional state and illness symptoms) and evaluated need (i.e., professional assessments and objective measurements of patients' health status and need for medical care). The framework adopted by the study has been used in a number of developed countries including Germany, United States of America, United Kingdom, France, Spain and many others to assess and analyse health services utilization within the country.

The theory has been found to be valid and useful, especially within the contexts in which they were designed (that is, within developed societies), but cannot be applied blindly in all circumstances and to all problems. This is particularly apparent in developing countries, where factors beyond the individual have an impact that warrants special consideration (Eaton et al., 2003).

1.8 Organisation of the dissertation

This chapter serves as an introduction to the study. It outlines the context, the purpose of the study, and the theoretical framework. Chapter two reviews relevant literature, global and local perspectives on the barrier's men face in accessing health services. Chapter three describes the research methods used in the study as well as techniques for data analysis. Chapter four presents the study's finding and results. Chapter five summarizes the study findings and compares it with findings from other studies and also presents recommendations for action.

Chapter Two

Literature Review

2.1 Introduction

Men's health has emerged as a major public issue in recent years. The weight of statistical evidence shows men's health outcomes in South Africa, whether by mortality or morbidity, are distinctly different from, and in some cases significantly worse than, those of women (SSCMH, 2009). Increasing evidence suggests that men are more prone to poor health outcomes and this phenomenon is continuing and involves many factors (Jobson 2015). With the increase of sexual transmitted diseases, HIV, and other severe illnesses, men are constantly at risk and in need of health services, placing pressure on the health care services across South Africa. This chapter reviews previous studies on the utilization of health services by men and the barriers they face in accessing health services.

Various studies have as of late investigated the barriers to accessing health services among men. However, there are comparatively fewer studies that have taken the initiative to investigate and explore the factors that are associated with health care utilization among men. Consequently, this study aims to address this gap by focusing on the health experiences of rural men in a South African context.

2.2 Factors associated with health seeking behaviour

Certain factors are known to influence access to, and utilization of, health care services (Bentley et al., 2002). Men visit health services to seek treatment for illness, medical diagnosis and injuries (Barsky, 1981), with several factor being associated with good health seeking behaviour and these include age, place of residence, employment, education, medical insurance and family planning.

2.2.1 Ill-health

Despite men's personal unwillingness to visit health services, treatment, medical diagnosis, injuries and visits provoke then to seek care. The desire for treatment from severe illnesses,

such sexually transmitted infections (STIs), HIV, Tuberculosis (TB) and cancer may result in men visiting health services due to the fear of dying (Smith et al., 2006). Obtaining medical diagnoses are also important for men as they may fear infecting their loved ones and the people closest to them. Injuries, often from reckless behaviour, such as car accidents, substance abuse (alcohol, drugs) and fighting, are the main drivers that force men to visit health services (WYR, 2003). It is often not out of men's willingness to visit but something they need and feel they have to do.

2.2.2 Age

Age can have a direct or indirect impact on the health status of an individual, with children aged 1-5 years having little direct control over their health, which is monitored by their parents, but as people grow older, they start to take care of their own health. Attention must be paid to the health of men, specifically the youth (18- to 30-year-olds), who remain largely invisible to health services, and middle-aged men (30- to 40-year-olds), who also have a limited presence (Courtenay, 2000). Many young men bear the burden of poor health due to the effects of accidents and injuries, including those caused by political insecurity, war and occupation (Courtenay, 2000). However, men aged 30 and over are likely to monitor their health because they are at a stage where they are looking to marry or are already married (Houx & Jolles, 1993). Elderly men are in an advantaged position, since most of them are married, and by being married they enjoy better health and a higher socio-economic position than the men who are not (Maharaj et al, 2013). However, there are relatively few studies on this.

The percentage of the world's population aged 65 years or older is projected to increase in the coming years, from 21% in 2011 to 34% in 2050 while morbidity and mortality due to chronic diseases associated with ageing are increasing worldwide (Xavier et al., 2010). South Africa is not exempt from this challenge, with the proportion of the population aged 60 years and over being predicted to increase from 3.5% in 2006 to 4.8% in 2030, with the associated increasing burden of chronic diseases being already evident (Xavier et al., 2010). The higher number of elderly will have an impact on health care utilization. As people grow older, they become more vulnerable to diseases, which make them more likely to utilize health services (Maharaj, 2013).

2.2.3 Place of residence

Several studies have shown that individuals that live near a healthcare facility are more likely to utilize it and have more awareness of health services (McLaren et al., 2014). Proximity to health care has also been shown to be an important factor affecting a large array of health outcomes. Proximity to facility has been associated with increasing maternal and infant mortality, decreased vaccination coverage, increased adverse pregnancy outcomes and decreased contraceptive use (Tanser et al., 2006). In contrast, proximity to care is also associated with increasing frequency of use of health care facilities. Improving geographical access to PHC can therefore have a direct bearing on improving adverse health outcomes.

In South Africa, 24 years into democracy, residential location remains largely racially defined, which can exacerbate barriers if health facilities are located far from neighbourhoods that rely on public sector services. There has been significant progress made by government to bring primary health clinics closer to communities, but they remain difficult to access for people who are not within walking distance or do not have access to transport (Tanser et al., 2006). Although bringing primary health clinics closer to the people has improved access and utilization for many rural people, it has also given rise to new challenges (Nemet & Bailey, 2000). Tanser et al., (2006) also found evidence of distance decay in primary health care utilization in rural South Africa. Regarding the use of anti-retroviral therapy for AIDS, the study found that there is a strong negative association with distance to the nearest facility, with individuals living five kilometres from the nearest clinic being only half as likely to access the medication as those living next-door to the facility (Cooke et al., 2010). These results indicate the importance of proximity in mediating care-seeking behaviour. If distance reduces utilization of a life-saving treatment regime, it is likely to reduce uptake of less essential care. This poor health seeking behaviour is driven by the fact that HIV infected individual want to keep their status confidential, and visiting the nearest health facility can expose their HIV status to the public. Despite the adverse stigma associated with HIV, several studies find place of residence to have a positive effect on access and utilization of health services (Bersamin et al., 2011). The study by Nteta et al., (2010) conducted in the Tshwane Region of Gauteng Province South Africa, found that, proximity and distance to a PHC facility were the biggest hindrances to the utilization of health services, particularly in rural areas.

2.2.4 Employment

A large body of research has established that employed individuals are healthier than those who are not employed (Yelin et al., 2003). Employment can improve health by increasing social capital, enhancing psychological well-being, providing income, and reducing the negative health impacts of economic hardship. Employment has social, psychological, and financial benefits that improve health. While healthy people were more likely to work, health also has an impact on an individual's desire to work and their likelihood of being hired or retained (Yelin et al., 2003). Employment provides individuals as the financial means to access health services, nutritious food and safe housing, all of which impact health directly (Jin et al., 1995). Clark & Oswald (1994) found that employed South African individuals reported higher levels of well-being compared to those who are unemployed. Not all jobs have the same impact on health with some contribute to poor health due to unhygienic conditions and exposure to infections (Clark & Oswald, 1994). Underemployment may not provide the same health benefits of full employment (Goodman, 2015). Despite poor working conditions, several studies support the notion that employment motivates good health seeking behaviour. If job satisfaction is important to health, people should seek rewarding employment (Crawford, 1977).

2.2.5 Education

Education can enlighten and empower an individual with higher levels of education being associated with better health. In developing countries, health education directed towards these goals remains a fundamental tool in promoting health and preventing disease (Nutbeam, 2000). Many health education programs that emerged during the 1970s **were** found to be effective only among the most educated and economically advantaged in the community. It was deduced that these groups had higher levels of education and literacy, personal skills and economic means to receive and respond to their health needs (Nutbeam, 2000). Individuals who are less educated are less likely to visit health facilities, and face more barriers accessing health services than those with less education. Lower levels of schooling might lead to poor health, due to lower awareness (Cutler & Lleras-Muney, 2007). Cutler & Lleras-Muney (2007) also found that better educated people have lower morbidity rates from the most common acute and chronic diseases, independent of basic demographic and labour market factors. In addition, life expectancy has diverged over time between those with and without a college education. The mechanisms by which education influences health are complex and

likely to include (but are not limited to) interrelationships between demographic and family background indicators; effects of poor health in childhood; greater resources associated with higher levels of education; a learned appreciation for the importance of good health behaviours, and social networks (Cutler & Lleras-Muney, 2007). The relationship between health and education is a complicated one, with a range of potential mechanisms shaping their connection (Klasen, 2000).

2.2.6 Medical Insurance

People with higher incomes are more likely to have a regular provider of medical care and health insurance coverage. One of the most significant financial benefits of working (besides income) is health insurance. Individuals with health insurance are more likely to see their primary care doctor and receive routine screenings for blood pressure and cholesterol, and receive preventive care (Goodman, 2015). South Africa is trying to fill this gap by introducing the National Health Insurance (NHI), which aims at providing universal health coverage where everyone receives quality healthcare regardless of their economic status. However, the biggest challenge to the NHI has been the unequal distribution of health professionals between the private and public sector, and between urban and rural areas. The majority of rural individuals do not have access to medical insurance, while the people in urban areas who have better employment opportunities and receive higher incomes are more likely to have medical insurance and to utilize health care services more frequently. Individuals that have medical aid access private health facilities that are more efficient and convenient than public health services. Consequently, not having insurance does not give rural individuals the luxury to utilize health services as often as they would like too (Brown et al., 2000).

2.2.7 Need for Family Planning

Another reason why men visit health service centres is for contraceptives, especially condoms. Kapphahn and colleagues (1999) found that in a focus group study of 13 to 21 year old British males (ethnic mix was not described), young males were most likely to access reproductive health services to get free condoms, but felt that most health services were not welcoming. The group members stated that a visit to the clinic was regarded as a visit to get condoms. Participants indicated that going to the family-planning clinic for condoms was a common behaviour among their peers and thus would not result in gossip. Men often claim

that they go to health centres to fetch condoms, mainly in bulk, so that they do not have to return often and are therefore not seen regularly by providers or the public, as they might feel embarrassed being seen with condoms. However, men who regularly collect condoms, gel, and contraceptive pills have better health as the visits encourage health seeking behaviour, which has the potential to improve the lives of both men and women, thereby reducing health care costs (Nemet et al, 2005).

Family planning programs are key to influencing men to visit health services and increase their knowledge of reproductive health. According to Maharaj & Cleland (2005), who conducted a study on male attitudes towards family planning in KwaZulu-Natal Province of South Africa found that, contrary to the belief that men disapprove of family planning, the majority expressed very favourable attitudes to using safe methods of delaying and preventing pregnancy. This strong support for fertility regulation was found among both rural and urban men. Virtually all the male respondents indicated that family planning could be used not only for birth spacing, but also for delaying and/or preventing unwanted pregnancies. Their attitudes were therefore attuned to the idea of contraception being used for family limitation, their interest in family planning being largely motivated by the desire to limit family size. A study by Mbizvo & Adamchak, (1991) in Zimbabwe established that attitudes towards family planning were indicated by men's approval and on-going use of family planning; involvement in family planning decision-making; experience in obtaining information about methods; communication with their wives about family planning, and opinions about when family planning should commence. Therefore, the development of family planning clinics has played an important role in advancing men's heath seeking behaviour.

2.3 Barriers to men's health seeking behaviour

Studies have indicated a number of barriers to men seeking health care, such as culture, gender, cost, transport, distance, notions of masculinity.

2.3.1 Culture

Culture is one of the factors that work outside the individual to facilitate or hinder health seeking behaviours. Culture contains several aspects, for example, tradition, norms and values of the larger society, social discourse in the general public, shared beliefs and

qualities, and variations in such factors across subgroups and segments of the population (Eaton et al., 2003). As indicated by Kilmann et al., (1986), culture can also be defined or is characterized as the mutual understanding of insights, philosophies, values, suppositions, convictions, desires, mentalities, and standards that bring a group together. However, a few components make culture a barrier to accessing health services and often leads to poor health seeking behaviour among rural men.

In South Africa, and in KwaZulu-Natal in particular, culture plays a pivotal role in human behaviour. For example, traditional medicine has always been a key component of the pulbic health care in the country, but the actual contribution of traditional healers to health care is not known. While traditional healers have been predominant in providing medicine for the physically ill and injured, they have also formed a barrier for men to seek or access modern health services. Puranwasi (2005) characterized traditional healers as individuals who are available and socially acknowledged human services suppliers. "A traditional healer is a person who has no formal therapeutic training, yet is perceived by the population in which he/she lives as being equipped to give human services by utilizing vegetable, creature and mineral substances and certain different strategies based on social, cultural and religious foundation and additionally the learning, states of mind and convictions that are predominant in the group with respect to physical, mental and social well-being and the causation of the illness and disability" (WHO/UNICEF, 1978: p56).

In 2000, there were approximately 200,000 traditional healers practicing in South Africa, compared to 25 000 doctors of modern western medicine (Abdool-Karim, 2005). It has been claimed that 80% of the black population utilizes the services of traditional healers (Ziqubu & Arendse, 1994). Furthermore, 70% of male patients consulted a traditional healer as a first choice in KwaZulu-Natal with the Isangoma being the most popular type of healer (Abdool-Karim, 2005). Such figures raise important questions in the study, such as whether rural men seek health care but visit traditional healers and not health service facilities. What is also significant to note is that by having men constantly visit traditional healers they form a barrier to men accessing health facilities.

Culturally, some rural men associate western medicine with weakness. A study by Williams et al., (2008) reviewed patterns of health seeking prior to death among 1282 men and women

who lived in the Umkhanyakude District of northern KwaZulu-Natal. Information on the health care choices of those who died between January 2003 and July 2004 was collected after their deaths from their essential primary care-givers. The study analysed the choices made concerning health seeking behaviour prior to their deaths. It found that nearly all the men who were ill before death looked for treatment from a western medical supplier, going to either a public facility or a private specialist. In this district, which is predominantly poor, 90% of adults who sought treatment from a public clinic also visited a private doctor, while 50% also sought treatment from a traditional healer, suggesting that traditional medicine is seen as a complement to, rather than a substitute for, western care.

Culture does not only place a barrier on men seeking help from health services across South Africa, but with men across the world. For example, a study in Southeast Asia by Uba (1992) found that men had a negative attitude towards illnesses and western health systems. For example, beliefs that suffering is inevitable, or that a life span is predetermined, can cause Southeast Asian men not to seek health care. Cultural beliefs about the sources of illness and the correspondingly suitable types of treatment can be a barrier to men who are unfamiliar with western medicinal methods. Many rural men lack familiarity with western indicative methods and medications, and thus are uneasy with them. Health care providers' ignorance of non-western cultures can affect communication with patients, bringing about culturally irrelevant health services or confusion of symptoms of illness. Moreover, Uba (1992) further mentioned that Southeast Asians' lack of familiarity with western culture can make health care services geographically and economically inaccessible, and can cause Southeast Asian men to be ignorant of the available services or how to access them. In South Africa for instance, many rural men who are employed often have low-level jobs that do not provide health insurance benefits. Others do not know of the existence of health insurance, do not think that they are eligible, or cannot afford insurance premiums. Low-paying jobs, coupled with a lack of health insurance can make health care inaccessible (Bentley, 2003). As a result, culture was acting as a barrier that was obstructing access to essential health services for men.

2.3.2 Gender

As earlier mentioned, greater attention to men’s health is called for, given their greater risk of premature mortality. Life expectancy at birth for men is six years less than that for women

(Sandman et al., 2000). Men are more likely than women to die from heart disease and chronic liver disease. Suicide and violence related deaths are four times more likely among men than women (Harris et al., 2011). Studies indicate that male attitudes and behaviours concerning health are major contributors to this mortality gap (Sandman et al., 2000). There is a need for more research in the area of men's health for a number of reasons: that men die six years younger than women (U.S. Department of Health and Human Services, 2000), and mortality rates for men (and boys) from the top 15 causes of death (except Alzheimer's disease) in the United States are higher amongst males than females (U.S. Department of Health and Human Services, 2000). In addition, Lindberg (2006) expressed that essential conceptive medicinal services for male youth and youthful male grown-ups has received little consideration in the United States, despite their risk of STDs (including HIV), and unplanned parenthood. Compared to their female counterparts, men are less likely to receive routine primary care, disease screenings and pregnancy prevention services. As 'men' are not a homogenous group, just as all women are not the same, empirical data must be seen as inadequate from which to inform policy and draw firm conclusions concerning men's help seeking behaviour and use of health services (Galdas et al, 2005).

Men often deny and ignore illness and treatment, and some reach a point where they often blame women for their poor health status. A study by Mindry et al. (2015) found that when men were asked about ways in which they might reduce their risk of HIV infection, men frequently spoke about monitoring their partner's behaviour to determine whether or not they engaged in sexual relationships with other men. When men-initiated discussions about HIV with their partners, they more often focused on their partner's behaviour, encouraging their female partner to 'behave well'. Men predicated their use of condoms and their need to test for HIV on gender stereotypical assumptions regarding their female partner's behaviour. They focused their attention on monitoring women's behaviour as a means of managing their own risk of infection, including assessing whether a woman was respectable, had a 'grand appearance' or whether they were seeking material support from men. The protection of women's rights in the South African constitution, along with new laws that ensure women's legal autonomy, challenge existing gender norms and demand that men begin to change their behaviours (Mindry et al., 2015). However, these changes in gender norms are still very much under contestation, which results in sexual relationships in KwaZulu- Natal remaining complex. In South Africa, numerous interventions have appeared to address issue relating to

sexual orientation related dangers and vulnerabilities, including programs intended to reach and draw men to health services (Greig et al., 2008).

According to Hanass-Hancock (2009), sexuality is highly determined by gender norms. The study found that in the local Zulu culture, a man is expected to be sexually active, and many young men aspire to be 'isoka', the local word for Casanova. Others in contrast explained that a woman should be submissive and not challenge her husband's authority. In this context, two cases showed that deafness is a sought-after trait for some men seeking partners. The inability to communicate through spoken words may be seen as an advantage in a society where gender inequality is high. However, this 'advantage of deafness' is exploited by able-bodied men particularly if, as in these two cases, the woman is from a low socio-economic background, powerless and dependent on her partner. These women have little ability to negotiate their sexual pleasure and safer sexual practices. Therefore, male domination in this context does not only become a barrier to men health seeking behaviour but has a negative impact on the sexual and reproductive health of women.

Galdas et al., (2005) also draws on an example of men in the United States of America (USA) on how they have been out of touch with the health system compared to females, and face barriers to care. One of four (24%) men did not see a physician in the year prior to the survey, three times the rate found for women (8%). Furthermore, 33% of men did not have a regular doctor to go to when they were sick or needed medical advice, compared with only 19% of women. Men's irregular contact with doctors means they often do not receive any preventive care for potentially life-threatening conditions, their behaviours and reluctance to seek care placing their health at risk. When asked what they would do if they were in pain or feeling sick, one in four men said they would wait as long as possible before seeing a doctor, and another 17% stated that they would wait at least a week. Among men who recently visited a physician, few reported that they received counselling on ways to improve their health or to prevent illness or injuries.

Counselling rates were low, even among men known to have poor health risks (Sandman et al., 2000). Galdas et al., (2005) stated that investigating men's health-related help seeking behaviour has great potential for improving both men and women's lives, and reducing

national health costs through developing responsive and effective interventions. In all age groups, men are less likely to consult a general practitioner.

Men consistently do not report psychosocial problems and distress as an additional reason for consulting. An Australian study analysing help-seeking in response to emotional problems with a sample of 715 adolescents supplied further evidence for low help health-seeking of men: 27% of the sample were moderately or severely distressed (Rickwood & Braithwaite, 1994). Of these adolescents, 23% did not seek help at all for their distress, while only 17% did. High unemployment and levels of social deprivation (Crawford & Prince 1999), as well as the increasing rate of depression in young men, reveal the considerable extent of unmet needs in men. However, despite the above, women are more likely to visit health services than men. These differences do not only serve as a barrier for men to access health care but they also put the lives of women at risk.

2.3.3 Cost

Cost has been a major barrier in seeking appropriate health care services for both men and women in rural South Africa. Adding to this is the unemployment rate of 27.7% in the second from last quarter of 2017, being the over the last 13 years (Statistics South Africa, 2017). The economic polarization within society makes poor men more vulnerable in terms of affordability and choice of health provider (Hatcher & Heetebry, 2004). Not only is there a consultation fee or the expenditure incurred on medicine, there is also the fare spent to reach the facility, with the total amount spent for treatment being burdensome.

Cost remains a barrier to accessing primary health care for many rural poor people in South Africa, despite the country's health policies having sought to reduce inequity within the health system, with user fees for primary health care services for low-income individuals being removed in 1994 (Wilkinson et al., 2001). Data collected during 2003 – 2004 from a rural household survey indicates that low-income persons continue to face greater barriers in accessing health care than higher income households, despite the service being free (Nkosi et al., 2007). In general, poverty increases people's vulnerability to ill health. Data from a rural household survey also found that people from higher-income households were more likely to seek health care than ill people from the poorest households. This suggests that people with

the lowest household income prefer to wait as long as they can before incurring the costs associated with getting health care (Nkosi et al., 2007).

Adding to their financial burden are transport costs of getting to the health facility, either using public transport (busses) or local taxis and private cars, with costs increasing as the price of fuel rises. For example, in 2011, there was a 15.3% increase in cost of transport due to the increase in petrol price, with an incremental increase in the out-of-pocket cost to get to health facilities for those people who rely on public transport (Nkosi et al., 2007).

The South African private health system was changed into a coordinated, nationally administered system, driven by the need to review imbalances and to provide essential health care to the disadvantaged, especially the rural population (James et al., 2006). Common too many of these systems is that financing techniques do not provide adequate resources to give the desired levels of health services for the whole population. The available resources are not appropriately allocated to provide protection against household expenditure variance, or channelled through some form of pre-payment mechanisms, and the scarce resources that are mobilized often do not lead to value for money in terms of the health care on which it is spent to reach men in rural areas (Case & Ardington, 2004). Poor men and other vulnerable groups who need health care are the most affected by these inadequacies, especially the out-of-pocket expenditures on health, which are both impoverishing and providing a financial barrier to needed care for rural men (Betancourt et al., 2005). Cost is a major barrier to accessing health, not only due to finances, but because it causes people to ignore symptoms, or make their own diagnosis of what they are feeling or going through, without visiting the nearest health facility (Betancourt et al., 2005). The patient can be faced with not being able to seek health care, and faces the risk of the condition becoming serious due to the disease being ignored. Finance is a very important deterrent regarding seeking health care for men, as the level of unemployment rises for this population.

Health services expenses can also be due to conducting procedures and providing treatment related injuries or illness (Nicholl et al., 1994). Although, South Africa is considered a middle-income country, it has health outcomes that are comparable to numerous lower income nations (Coovadia et al., 2009). As with many other low- and middle-income countries, South Africa continue to search for better ways of financing their health systems.

While health care access for all is cherished in the country, significant disparities remain, mainly due to distortions in resource allocations between urban and rural facilities. In low-middle income countries (LMIC), health care and its related expenditures (such as transport) are contributing causes of impoverishment (Noponen & Pradan 2004). Krishna (2006) identified the cost of treatment for illnesses to be the reason for 85% of all instances of impoverishment for poor males in India, where health services are free, but patients need to pay towards other expenses. In addition, Van Doorslaer et al. (2006) found that an additional 43 million men in 11 Asian nations would fall beneath the poverty line if they had to spend more of their income on health expenditures and other out-of-pocket consumption for health care services. In South Africa, however, many men live below the poverty line, which hinders their utilization of health services.

Heltberg and Lund (2009) found that the costs related to illness among poor rural men in Pakistan led to reduced food consumption, withdrawal of children from school, sale of major assets, putting children to paid work and bonded labour, with only 12% being able to recover from the associated economic shocks (Jacobs et al., 2011). The Black male population in South Africa is the largest population sub-group (representing 67.4% of the male population), and is the most impoverished of all groups (Bourne et al., 2002). There are very few cross-sectional studies that have attempted to explore male food consumption patterns in representative samples of South Africans who are undergoing transition, making comparisons difficult (Walker, 1975; WHO, 1997). However, these cross-sectional studies are outdated, and this study acknowledges that times have changed therefore people have new consumption patterns in these modern days, the introduction of cash crops has change many consumption patterns in the world (Aw et al., 2005).

Another factor is absence of protection from health insurance which has repercussions for men's access to health care. According to the Australian Institute of Health and Welfare (2005), compared with men who have health insurance, uninsured men are more than three times at risk of not getting the needed health services and basic primary care. In addition, men with inadequate access to health insurance generally report worse health status, and have less understanding of their medical conditions and treatment. Low-income and less-educated men, as well as men who live alone, are also more likely to face barriers to medical care or to lack a regular physician (Nutbeam, 2000).

Married men may benefit from having a concerned spouse and from women's greater propensity to seek health care for themselves, to take primary responsibility for their children's health care, and generally to make health care decisions for their family. Access to health services are often compromised by long waiting times, out-of-pocket expenses, services restricted to ill patients (Clinical Oncological Society of Australia, 2006), lack of clarity regarding the different roles of the various professions, and a shortage of specialized health care providers. These factors are particularly relevant for rural men, specifically those in South Africa, who have limited access to appropriate services, due to geographic isolation, poor transport links and shortages of healthcare providers. Disabling factors for men to access health care, such as service cost and accessibility, can impede health care use amongst rural men (Corboy et al., 2008). Transport costs are a major barrier influencing access to health for men, with Ensor and Cooper (2004) noting that location and distance are often seen to adversely affect service utilization. Access barriers include long distances and high travel costs, especially in rural areas (Harris et al., 2011). Travel costs are an important consideration in the decision about which health facility to attend and can affect health care seeking.

2.3.4 Transport

Most rural men in South African are likely to use the nearest health facility, the farther away the facility, the lower the likelihood it will be used (McLaren et al, 2013). Men are 41% less likely to use the closest clinic if it is more than 2 kilometres away while women are 33% less likely to use their nearest clinic if it is more than 2 kilometres away (Nkosi et al, 2007). These estimates do not change after controlling for the local density of clinics by including a variable for the number of clinics within a five kilometres radius of the household (McLaren, 2013). For men, none of the health status variables are associated with the probability of using the closest clinic. This suggests that travel costs (both monetary and time) are an important determinant of the choice of health service point. The cost of travelling to clinics is an obstacle to most poor rural men, with flat-fee public transportation options reducing the travel cost differential to reach a slightly further, but potentially better quality facility. Men attempt to manage their health care as best they can if they do not face any socio-economic constraints. Transport costs are a major barrier to accessing health services amongst many rural men in South Africa and reforms to address this need to be addressed.

The outcomes are severe when transport is unavailable, as distance becomes a major factor for those needing care. People need transport when hospitalization is required by someone who cannot walk or access public transport, with means of communication not always been available to call emergency services. This may take some time as some of the participants observed when they were interviewed in a study in Port Elizabeth (Ardington, 1984). In this study, 39% of respondents stated that when someone was ill they made a stretcher and carried the person to the local shop to call an ambulance. In addition, 17% noted that they carried them to the nearest car which would take them to hospital; 6% stated that they carried them to the nearest bus; 26% noted that they sent someone to call for an ambulance to come as close to the home as possible and 3% stated that they called a car which would come to the home and then take the ill patient to the hospital (Ardington, 1984). All these procedures are extremely time consuming and expensive. However, with the growth of technology in the modern world, it is rare to find individuals who do not own a cell phone and as a result such hardships are slowly fading in rural areas.

2.3.5 Distance

According to Bersamin (2011), distance is a barrier to accessing health care, with the male study participants indicating that they would not walk more than five kilometers to get condoms. They would rather have unprotected sex or no sex at all than to walk such a distance (Bersamin, 2011). Consequently, distance is not only a major barrier for accessing health services, but also influences and encourages risky sexual behaviour among men (Ardington & Case, 2010). Using data from the first nationally representative panel survey in South Africa (NDHO, 2014), together with administrative geographic data from the Department of Health, enabled an investigation into the role of distance to the nearest health facility on patterns of health care utilization. The survey reported that 90% of South Africans live within seven kilometres to the nearest public clinic, and two-thirds live less than two kilometers away. However, 15% of Black African adults live more than five kilometres from the nearest facility, in contrast to only 7% of Colored's and 4% of Whites (NRPSSA, 2014). In addition, distance affects the uptake of important health services, such as access to skilled birth attendant, immunization programmes and regular mandatory visits for children. The poorest men tend to reside furthest from clinics and therefore do not have the funds to bear the travel costs, which constrains them from accessing health care facilities (Arcury et al.,

2005). Within this general picture, men and women have different patterns of health care utilization, with the reduced use associated with distance being greater for men than it is for women. Much has been done to redress disparities in South Africa since the end of apartheid, but progress is still needed to achieve equity in health care access and improve the number of health care clinics in rural areas (McLaren et al., 2013).

Several studies confirm that increased distance from health facility does reduce utilization (Bersamin et al., 2011). This barrier effect of distance is assumed to be greater for those with reduced access to transportation (for example, elderly men), and for those living in sparsely populated areas where distances between residences and facilities are large (for example, rural residents) (Bailey et al., 2007). In a study of travel for primary care in western Maine, USA, Shannon et al. (1979) found that relying on distance as the only spatial determinant of utilization resulted in inaccurate designations of access and underserved areas. This suggests that distance may play a complex role in mediating help seeking behaviour.

2.3.6 Notions of Masculinity

Gast & Peak (2011) defines masculinity as ways of acting, feeling and thinking based on socially prescribed norms of masculinity, and may be adaptive and flexible in the way it influences male behaviour. All men will not necessarily adhere to the masculine scripts in the same way in similar situations. In addition, Kimmel (1994) describes masculinity as a constantly changing collection of meanings that people constructed through interactions. Manhood is neither static nor timeless; it is historical, it is not the manifestation of an inner essence, being socially constructed. Manhood does not bubble up to consciousness from biological makeup; it is created in culture, meaning different things at different times to different people. People come to know what it means to be a man in their culture by setting our definitions in opposition to a set of ‘others’, such as racial and sexual minorities, and above all, women (Kimmel, 1994). Masculinity may be an important factor in the differential response to health issues by men.

Men and boys are often socialized to hide vulnerable and to be self-reliant and physically tough (Addis & Mahalik, 2003). This is in contrast to the health care environment, where patients are expected to ask for help, reveal physical and emotional vulnerable, and forfeit control to others (Courtenay, 2000). Waldron (2001) noted that men are more likely to

engage in more than risky behaviours, making them vulnerable to disease, injury and/or death. Men have not been encouraged to consider the potentially negative consequences of their actions (e.g., non-use of seat belts, helmets, condoms). According to Gupta (2000), prevailing norms of masculinity that expect men to be more knowledgeable and experienced about sex, put men, particularly young men, at risk of infection. Such norms prevent them from seeking information or admitting their lack of knowledge about sex or protection, and pressures them into experimenting with sex in unsafe ways, and at a young age, to prove their manhood. Health and illness can be socially defined, as are gender roles. For example, research has found that the social construct of manliness affects the help-seeking behaviour of Latino men (Peak, Gast, & Ahlstrom, 2010). Research suggests that men who hold more traditional views of masculinity have an increased risk of poor health and have fewer health promotion practices (Mahalik, Burns, & Syzdek, 2007).

These health risks include excessive alcohol use, avoiding health screenings, physical fighting, difficulty managing anger and other mental health issues, as well as risk taking with both automobile use and sexual practices (Mahalik, Lagan, & Morrison, 2006), and being less willing to seek health care when needed (Addis & Mahalik, 2003). It has been suggested that the only time when it is considered acceptable for a man to adopt health help-seeking behaviour is if it validates a valued aspect of masculinity, such as in connection with sexual performance or being with a good health provider (Addis & Mahalik, 2003).

Varga (2003) illustrated that with regard to male adolescents in KwaZulu-Natal Preston-Whyte's work suggested that, for young Zulu men, early fatherhood is a welcome affirmation of masculine maturity and strength. These finding have been echoed in studies undertaken in Kenya (Nzioka 2001) and Ghana (Ampofo 2001), indicating that by early adolescence, boys have begun to view fatherhood as a marker of manhood and sexual prowess. The importance of sexuality in defining Zulu masculinity is embodied in the concept of ‘isoka’, a term that denotes a man who is socially successful and popular with women, although its colloquial usage has strong sexual connotations (Vilakazi, 1962). Among the most highly regarded features of being an isoka was dominance and decision-making power in a relationship:

"*The belief [in male dominance] is created in society. You know that you do not question [a man's] word*" (Vilakazi, 1962: p136).

This sentiment is echoed in the study by a 20-year-old rural Zulu boy in KwaZulu-Natal:

"*A man knows everything, and he can make better decisions [than a woman]*" (Vilakazi, 1962: p138).

In many cases, men use their decision-making power to justify sexual coercion of their partners. Men are believed to have a natural or biological need for sex that makes it acceptable for them to expect sexual consent in a relationship and to have multiple partners. Man, and most boys, agreed that sexual conquests with repeated sexually transmitted infections (STIs) were vital elements of a strong masculine image, this being considered laudable proof of a boy's multi-partnering success. In boys' perceptions, it is fun to be sleeping around, as far as the social setup is concerned, uyisoka [you are being an isoka]. However, women or girls who have many sexual partners will be criticized, referred to as ungcolile [you are dirty, disreputable] (Vilakazi, 1962).

Notions of masculinity are a considerable barrier to men seeking health care in rural areas, as these notions are deeply rooted in culture and can make or break the health of men. Most boys are socialized to embody these notions of masculinity and to 'take it like a man' at an early age, being discouraged from showing feelings of vulnerability or weakness (Evans et al., 2011). The implications of this remain problematic for men, because the social expectation of toughness and independence lead to the suppression of emotion, social isolation, and resistance to accessing health services.

2.3.7 Health care providers' attitude

Client satisfaction is an important indicator of success in any form of service delivery, as it encourages use by the consumer. Addis (2003) notes that some male patients prefer their health status to be kept confidential between the service provider and the patient. This can be driven by several factors, as Addis (2003) further noted that men are increasingly characterized as relationally challenged, because of excessive self-reliance and difficulty establishing mutuality and emotional intimacy in relationships with health-care providers.

Kapphahn and colleagues (1999) found that 23% of 1551 American male adolescents preferred a male provider, while 65% expressed no gender preference. However, there were a considerable number of young men who preferred female providers for genital exams, and clinics with caring, helpful staff and clean, safe environments. Marcell, Raine and Eyre (2003), who conducted group interviews with African American, Hispanic, and White male

adolescents in the United States, also found that males who delayed seeking care feared healthcare providers' reactions to their problems, and were concerned about confidentiality. A lack of trust by male users in health care providers, or the intermediates who link them with these providers, make men reluctant to use these services (Ozawa and Walker, 2009).

Myburgh et al., (2005) found that years after the election of a new democratic government in 1994, race and socio-economic status continues to significantly influence levels of satisfaction with health care providers in South Africa. The study revealed high levels of satisfaction with health care providers, with 40% of respondents rating healthcare providers as excellent, and a further 49% as good. However, this high overall level of satisfaction with the care provider may mask some of the underlying differences in levels of satisfaction across the different strata of South African society. Comparing the 1994 patient satisfaction survey results with the 1998 results, it appears that the percent of white male respondents who rate their health care experience as 'excellent' increased by 13% (48–61%). The 1994 survey, however, assessed male patient satisfaction in general, and levels of satisfaction with the patient–health care provider interaction**.** One possible explanation for these variations in client satisfaction with health care providers by race and socio-economic status may be due differences in client values, including how they expect to be attended to by the health care provider. An alternate explanation could be that the treatment provided might have been different as a result of race or class influences on the patient–provider dynamic. This would amount to inequitable or discriminatory health care practices, something the post-apartheid government made a firm commitment to address by implementing a range of policies to eradicate past inequities.

In addition, a study that explored the perspectives of men about the health system and providers, found that regarding the latter, they were cautious and not always positive. One man stated that:

"*When I go to the doctor … I always ask to let me see them take the needles out of the box… cause I don't like them going to the back, like they pulling something out of the garbage, poking me with something that they have already poked somebody else*" (Kimmel, 1994).

In addition "*It takes too much time, I can't be there all day. Other people's kids running around and jumping on you, and then, you get upset*" (Betancourt, 2004).

An important aspect of service coverage is not just availability of facilities or the range of services available, but also the quality of the care received from the health care providers. Men also feel that they cannot trust health services providers with their health conditions, with some not feeling comfortable being examined by females and consulting with females about their sexuality feels discomforting (Gupta, 2000). The lack of male health care providers highlights a significant barrier to men accessing health services. Consideration should be given to how health practitioners behave when interacting with men. Therefore, having more male healthcare providers might bring change in how men perceive health facilities, and how health services make them feel comfortable and welcomed.

2.3.8 Poverty

Poverty is a major barrier to men accessing health services, with an important distinction between two types of poverty: absolute and relative. Absolute poverty refers to the inability to provide the minimum requirements of life (Mbokazi & Bhengu, 2012), while relative poverty is the inability to maintain a decent standard of living as set by society (Mbokazi & Bhengu, 2012). Absolute poverty is mostly found in rural areas of South Africa, whilst relative poverty is generally observable in urban areas. Several rural men in South Africa are faced with absolute poverty, and therefore find it very difficult to visit or access health services. Poverty in all parts of South Africa, and globally, is associated with poor health seeking behaviour (Coovadia et al., 2009).

A lack of financial resources or information can create barriers to accessing services. When health care is needed but is delayed or not obtained, men's health worsens, which in turn leads to lost income and higher health care costs, both of which contribute to poverty (Peters et al., 2008). The relationship between poverty and access to health care can be seen as part of a larger cycle, where poverty leads to ill health and ill health maintains poverty. The introduction of user fees, or price increases, can lead to decreased utilization of health services among men. Fortunately, in SA, the introduction of free PHC led to the abolition of user fees, and while this included poor rural men, there were also situations where user fees have been associated with improvements in quality of care (James et al., 2006). Public health and clinical health services, along with food, water, sanitation and other assets, such as

knowledge and education, can be considered necessary conditions for good health among men (Ensor & Cooper, 2004).

Despite improvements in providing access to health care for poor rural men, a substantial proportion of their populations have limited access to health services. Poor men suffer from a disproportionate burden of disease, yet usually have less access to health care. The challenge remains to find ways to ensure that vulnerable men have a say in how strategies are developed, implemented and accounted for, and to ensure that information and incentives are aligned in ways that can demonstrate improvements in access by the poor rural men.

2.3.9 Stigma and discrimination

HIV-AIDS-related stigma is pervasive in some segments of South African society, and can impede efforts to promote voluntary counselling and testing, as well as other HIV-AIDS prevention efforts, which in turn impede access to health (Smith, 2011). Sub- Saharan Africa is home to more than 60% of all people living with HIV, equating to approximately 25.8 million people in 2008 (UNAIDS, 2008). Several studies that have examined the relationship between false beliefs (stigma and discrimination) on HIV/AIDS and have found them to negatively impact the health of men. For example, a study by Kalichman and Simbayi (2004) of 487 men and women living in a Black township in Cape Town, showed that 11% (n=54) believed that AIDS was caused by spirits and supernatural forces, 21% (n=105) were unsure if that was the cause, and 68% (n=355) did not believe that to be true. People who believed HIV/AIDS is caused by spirits and the supernatural demonstrated significantly more misinformation about AIDS, and were significantly more likely to endorse repulsion and socially sanction stigmatizing beliefs against people living with the disease (Muller, 2014). Moreover, such traditional beliefs about its possible cause are likely to be even more prevalent in rural areas of SA. This misinformation about the causes of HIV has a major negative effect on men living with the disease, as they will perceive this to be a barrier to prevention efforts, accessing adequate health, psychological and social support, and appropriate medical treatments. It is well documented that people living with HIV/AIDS experience stigma and discrimination on an ongoing basis (Skinner, & Mfecane, 2004). This impact goes beyond the individuals infected with HIV to reach broadly into society, both disrupting the functioning of communities and complicating prevention and treatment efforts among men.

2.4. Summary

In this chapter the researcher presented at first the literature review on the factors that influence or encourage men to visit health care services. However, greater attention and priority was focused on the barriers that affect men from accessing health services. It is clear from the literature that men face a number of barriers in accessing health care services, some of which include culture, cost (health & transport cost), distance, gender, masculinity, poor interpersonal relations with health care providers, poverty, and HIV.

Chapter Three

Methodology

3.1 Introduction

Over the past several decades there has been relatively little research on rural health especially those focus on men, in developing countries. The overall aim of the study was to provide insights into the perceptions and experiences of rural men in accessing health services. This study draws on qualitative in-depth interviews to understand the attitudes of men to accessing services as well as the barriers they face. This chapter first provides a description of the study context. It then examines the methods that were used throughout the study. Thereafter, it describes the process of data collection. Lastly the chapter reviews a few limitations of the study.

3.2 Study context

The study was conducted in Umgababa. Umgababa is situated on the south coast of the N2 freeway and unlike several highly developed settlements on the coast, refer to Figure 3.1. It is typical of rural areas in KwaZulu-Natal with very slow development and service delivery.

Figure 3.1: Map of KwaZulu-Natal

Source: Mbhele (1998)

The area remains poorly resourced and lacks essential health services. Umgababa, like many other rural areas in South Africa has problems with scarce health facilities. This area is served by three primary health care clinics that are at least 30 kilometres away from each other. For serious health problems people usually travel to Scottburgh, Umlazi, Kingsburgh, Isipingo and Durban that has both public and private health services. Accessing health services in these areas is expensive due to high transport costs to the hospitals at these places.

3.3 Qualitative methodology

The study employs qualitative research. Over the years, the qualitative research approach has been identified as very useful in data collection as it is marked as a true reflection of the population (Patton, 1990). It gives the researcher access to the "real world setting" whereby the researcher is unable to "manipulate the phenomenon of interest" (Patton, 1990). In addition, Hancock et al. (1998) observes that qualitative methods are useful when studying health and social care settings particularly when exploring concepts, sensitive topics and real-life contexts. Detailed data is gathered through open ended questions that provide direct quotations and in this process the interviewer is an integral part of the investigation (Weseen & Wong, 2003).

Qualitative research is criticized for not being 'scientific' in nature. Sometimes qualitative research is condemned for lacking the ability to generalize and that it tends to produce large amounts of detailed information from a small sample (Carr & Kemmis 2003). Moreover,

qualitative research may be criticized for being unreliable in predicting the population and that they can expand possibilities but cannot identify the best possibilities (Woodlife, 2004). Nonetheless, qualitative research was found to be suitable for this study because the aim of the study was to obtain detailed information about perceptions and experiences of men in rural areas.

This study uses qualitative data drawn from in-depth interviews. In order to understand the health perceptions and experiences of men, qualitative research was conducted using 20 in-depth interviews of rural men from Umgababa. The sample consists of males, young adults aged 18 and over residing in the rural area of Umgababa (Mnini area) in KwaZulu-Natal.

3.4 In-depth Interviews

In-depth interviewing is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, issue, or situation (Boyce & Neale, 2006). Moreover, according to Kvale (1996) in-depth interviews are appropriate for eliciting individual experiences, opinions, feelings, and addressing sensitive topics. This method also has the strength of eliciting information on a range of norms and opinions in a short period of time. In-depth interviews can get at interpretive perspective, i.e., the connections and relationships a person sees between particular events, phenomena, and beliefs (Kvale, 1996). In-depth interviews are essential in the use of a qualitative study in order to acquire an in-depth understanding of the health perceptions and experiences of men in a rural area. More studies reveal that interviews are a good way of accessing perceptions and meaning of participants (Punch, 2005). However, like many other types of data collection methods, in-depth interviews have a disadvantage because they are time consuming. It may take time to conduct in-depth interviews and to transcribe, and analyse the data, this may also not be cost effective (Punch, 2005).

The study draws on in-depth interviews to provide an overview into the experiences and perceptions of men in accessing health services. It would have been interesting to have had a focus group to stimulate conversations between the two subgroups of the study, but the researcher felt that this might reinforce notions of masculinity or cause conflict and would not

stimulate conversation as older men feel they should be respected by younger men. Therefore, in-depth interviews were a useful method to investigate the factors that impact on the delivery of healthcare of men.

Umgababa is largely (entirely) occupied by the isiZulu speaking population, and the in-depth interviews were conducted by the researcher in isiZulu. Many rural areas in South Africa are predominantly occupied by the African population. Therefore, the study only focused on black South African males as they are the dominant ethnicity in Umgababa.

3.5 Sampling criteria and sampling strategy

In qualitative research sample selection has a profound effect on the ultimate quality of the research (Coyne 1997). For this study, a typical rural area in KwaZulu-Natal was selected. And this sampling method is often appropriate in sampling villages for community development studies in Third World Countries (Patton, 1990). The study looked at the development and outreach of health development aimed at men in South Africa. Participants were selected using convenient sampling. In this case, the aim was to be able to conduct the In-depth Interviews at a scheduled time and date to make it convenient for participants to share their experiences as well as perceptions that these men have towards health services. The primary author selected the study participants through purposive stratified sampling, mainly, men who were older than 18 and who may or may not face barriers to seeking health. These men were randomly selected according to their availability and willingness to participate in the study. However, only 20 were selected, ten aged 18-30 and ten aged 30 and over. Both cohorts are critical for the study, since it is often noted by several scholars that young men, face ill-health because they engage in reckless behaviours such as drinking, smoking, and fighting (Jobson, 2015), whereas, older men are looking to settle down. It is argued that older men have already experienced being young and thus are more likely to manage their health.

3.6 Data collection

The interviews were arranged by appointment and held in a classroom. Participants had to walk to get to the school but none of them complained as it was a short walking distance. An

audio recorder was used to record the interviews and data was then be translated and transcribed as well as analysed thematically. There were several challenges encountered during data collection. For instance, several men did not want their meeting to be held at the school because some felt nervous that they would be participating in a health study and people might assume that they are ill. This was carefully dealt with through carefully explaining to the participants the purpose of the study in the introduction, when signing the informed consent form and before turning on the audio. Another challenge encountered is that some participants were not available at the scheduled time, therefore the interviews had to be rescheduled. If the participant was not available for 3 consecutive appointments then a new participant was identified and interviewed.

Figure 3.2 Umnini Primary school

An average of five participants was interviewed per day in the classroom and the interviews took a maximum of 30-45 minutes. Confidentiality was maintained through interviewing one participant at a time in the classroom and the primary researcher indicated before the interview that no names would be mentioned in the final report. A semi-structured interview guide was used during the interviews and an audio recorder was be used to record the interviews. Each interview took a minimum of 30- minutes. After the in-depth interviews were conducted and recorded, the data was then transcribed verbatim and also translated by the researcher. After translation the researcher reviewed the data from the in-depth interviews to highlight important content that would answer the study's research objectives.

3.7 Data Analysis

The data was then transcribed, translated and analysed. Transcripts were read repeatedly to get familiar with the data. Data was then manually and inductively coded to first familiarise as well as identify and explore emerging themes using thematic analysis. Thematic analysis is a search for themes that emerge as being important to the description of the phenomenon (Daly, Kellehear, & Gliksman, 1997). The process involves the identification of themes through "careful reading and re-reading of the data" (Rice & Ezzy, 1999, p. 258). During the coding process, key words or phrases, notes on linguistic and non-verbal aspects of data and conceptual comments were be made on the left column of the transcription document. Following this, emerging themes were coded on the far left-hand column of the transcription document. The aim of this process was to organise the comments into themes that decreased the volume of information, whilst at the same time retaining complexity (Taylor & Bogdan 1984). Once the themes are identified, connections across themes were sought through ordering and re-ordering themes on Microsoft word to develop variations that fit together.

3.7 Ethical considerations

Prior to the commencement of the interviews ethical approval for the research was required. The University granted the researcher ethical clearance to proceed with the study. The proposal was sent to the School of Built Environment and Development Studies Higher Degrees Committee for approval. Before each interview was conducted, the aims of the study were briefly outlined. A consent form was given to the respondent to sign before the interview. All twenty participants signed the informed consent and agreed to be audio recoded. The researcher guaranteed that the respondent understood the purpose of the study before beginning with the interviews. All the men who participated in the study were informed that their participation in the study was voluntary and there were neither rewards nor reimbursements that were involved in participating in the study. The researcher also explained to the participants that some or part of extracts from the interviews may be used in the final report. Confidentiality during the interviews was maintained and no names of participants were used in the final report. All participants completed, singed and handed in the informed consent form to the researcher. All the transcripts from the interviews will be destroyed after a period of five years.

3.8 Limitations of the study

The aim of qualitative research is to gain insights into the experiences of participants. The participants selected from Umgababa (Mnini area) were only a sub-section of the entire population. Only twenty males aged 18 and over were sampled and this does not reflect the entire population of men in rural areas. The sample is too small to yield information that would provide a true reflection of the perceptions and experiences of all rural men at health care services. It would have been ideal to interview more men for the study but it is important to consider that qualitative technique methods require time and resources to gather data; therefore, the study was done only in one site. Translation is also time consuming and requires resources. Other limitations include the weather, for example, on a rainy-day participants could not get to the set location because the roads are muddy and as a result these interviews were rescheduled.

Chapter 4
Results

4.1 Introduction

This chapter presents some of the perspectives of rural men with regard to health services utilization. These perspectives are established using qualitative methods drawn from in-depth interviews. In order to understand the health seeking behaviour that have characterized the lives of rural men in South Africa, the study allowed men to share their personal experiences at health services. Men were also encouraged to suggest ways in which they could overcome barriers that prevent them from accessing health services. This chapter starts by outlining the characteristics of sample and then presents the themes that were generated from the thematic analysis of the in-depth interviews.

4.2 Sample Characteristics

All 20 participants spoke IsiZulu, as it is the one common language in the community. In total 20 rural men were interviewed at the local primary school, with some indicating that there were born and grew up in the area. The area is still developing therefore it is not surprising to find that most families have less than 20 years of living in this community. The area is situated near the coast so there is a steady movement of the rural population from the inland areas migrating to the areas nearest the coast in order to be closer to services and industries. Table 4.1 shows that six of the 20 men interviewed were married and the remaining 14 were not married. Studies suggest that married men exhibited greater monitoring and awareness of health services than unmarried men (Moreira et al., 2005).

Twelve out of the 20 men interviewed had finished secondary school but only four of the 12 reported that they had furthered their education after completing secondary school. Only eight of the men interviewed reported that they had not finished secondary school. As noted earlier, the community is developing and more and more people are still moving into this area therefore four out of the 20 men have less than 10 years of living in this community.

Table 4.1 shows that only five out of the 20 men regularly visit health services for routine check-ups and tests, with the majority (9 out of 20) reporting visits only when they feel sick.

Four reported that they sometimes visit, but not regularly, mainly for emergencies, such as the fear that they slept with someone without using a condom, visiting their loved ones, and when there are programs associated with HIV, condoms, testing etc. Only two men interviewed reported that they do not visit health services but regularly visit traditional healers whenever they feel sick.

Table 4.1 Demographical Profile of the Sample (n=20)

	Characteristics	No.
Age	18 - <30	10
	>30	10
Marital Status	Married	6
	Unmarried	14
	N ? no data?	20
Level of education	Less than secondary school	8
	Completed secondary school	8
	National senior certificate	3
	Diploma	1
	Degree	0
Length of Residence	Less than 10 years	4
	10 years and more	16
Use of health care services	Visits regularly	5
	Visits when sick	9
	Visits sometimes	4
	Never visits	2

4.3 *Perceptions and experiences of men at health services*

Several men interviewed expressed being out of touch with health services, which resulted in them being unable to perform certain tasks because they are not in control of their health. Some respondents reported that they do not dwell on the causes of their poor health seeking behaviour because these are due to circumstances that are not under their control, such as poverty, economic instability, domestic stress and culture.

The majority of men expressed feeling comfortable at health centres, with only a few feeling any discomfort on their visit. They felt that the staff were welcoming, and as a result it was not an unpleasant experience, which is important as it is likely to encourage men to return to the health facility.

"I feel very comfortable when I am at the health facility because everything they do, they do it with love and care, and they always ensure that people are not disappointed" (P1).

"In my personal experience I think they are quite comfortable, and whenever the nurses start treating me in an improper way or if there is something that makes me feel uncomfortable I would alert them but for now and over the years they have been really good" (P4).

"I do feel welcomed and comfortable when I am at the centre. The doctors and the nurses do actually welcome me" (P6).
"I think the level of service at our clinic is very high. I feel comfortable and welcomed when am there because they treat me very well, like when I was there the last time they really took good care of me and I have had no reason to complain" (P14).

However, some reported feeling a degree of discomfort when planning to visit a health facility or when they were at the health facility. Several rural men held negative attitudes towards health services in the area, with some describing feeling traumatized and stressed, as one man who held very traditional values reported that:

"I hate clinics, they make me sick, going to a place where there are plenty of sick people makes me sick. You sit in a queue with ill people and they tell you their sad stories about their health conditions and how many times they have been coming in and out of the clinic, that is why I prefer not to waste my time and follow what my great-great fathers have been using throughout the years, which is traditional medicine" (P13).

Some did not find health services to be welcoming and were very critical of staff, who were seen as rude, aggressive and unhelpful. They were particularly concerned that the staff did not give them proper directions, which resulted in a great deal of loss of time. There appeared to be a hierarchy between the clients and the staff. Some of the men felt that the staff did not use words that could be easily understood by patients and this resulted in them feeling very

alienated. The men complained about the poor interpersonal relations with the staff who were often rude and difficult. They also did not like the long waiting period, which added to their feeling of distress. Many of the men had travelled a long distance to get to the health facility. They therefore did not appreciate the long waiting period in addition to the significant amount of time spent getting to the health facility.

> *"I think the service at our health facility is very poor, usually we are not assisted, and it's difficult to get assistance. At the same time, we walk to get there and when we eventually do get there you find the nurses are aggressive to you and tell you to wait because they are still on lunch. The services are free, probably that is why the nurses are so aggressive. You find a person is sick and they will be busy shouting at you, giving you imprecise directions that are wrong telling you to go this way or that way, we end up looking like a fool, not knowing what to do"* (P3).

> *"I do not usually feel comfortable and welcomed when I am at the health centre because the nurses there cannot properly talk to a person. When they talk they use big words that are not usually even spoken at our households"* (P4).

> *"The nurses at the clinic do not make time or have time to assist us when we feel sick, and secondly, we have to wait long hours when you go there at the health centre. I just feel as if am not welcomed because the time the nurses have is to sit and gossip about other people non-stop and they forget that there sick people who are there to received help and assistant"* (P5).

> *"I think the service is sometimes really poor, you know there are unnecessary delays and you have to wait long hours, the waiting is just too exhausting*"(P19).

Long queues and health provider's attitudes towards rural male patients were mentioned by many participants as making them feel uncomfortable and unwelcomed at health services. Men expressed the importance of having more friendly health providers who are calm and composed. They felt that the attitudes of some of the staff were very demeaning, and that they made no attempt to make their experience at the health facility pleasant in any way. However, they did acknowledge that there were some staff who were more accommodating and helpful.

> *"Not all nurses are aggressive. There are some that make you feel welcomed and comfortable. There are other humble ones who are able to ask you properly and direct you to where or what you should do next"* (P2).

With regard to the issue of long queues, one respondent reflected on the shortage of staff and the size of the clinic asserting that:

> *"They need to add the amount of nurses available at the health centre, as I have noted that there are long queues at the clinic. Maybe they need to extend the size of the clinic because it gets too congested. There is one clinic that services quite a number of people"* (P3).

One man pointed to the shortage of staff at the health facility, with the few staff being required to provide services to a large number of clients. In addition, the infrastructure at the health facility was not able to accommodate the large crowds, which added to the unpleasant experience. As the health facilities were overcrowded, this resulted in long waiting queues.

In addition, participants indicated feeling embarrassment, hunger, and fear of illnesses as factors that also enhanced poor seeking behaviour. They reported generally feeling embarrassed when they present for STI related illnesses, it would feel like their sexual partner was sick. They were worried that they may become the subject of gossip; as a result they did not feel comfortable discussing sensitive matters with the staff.

> *"I feel embarrassed especially when I have an STI to go there because they will spread rumours of me and my partner saying that "we are sick" and they will start to stay away from us because they are afraid"* (P7)

Some men also reported that they did not want to visit health facilities because they did not want to sit in long queues with other sick people. They were worried that they may catch infections and get seriously ill, with long queues adding more distress to some men when they visited health services.

4.4.1. Positive gains

Despite the negativity reported by participants, the study also explores the positive outcomes that men experienced when they visited a health centre. A majority noted that they often come back from the health centre feeling much better than they before they went:

> *"What I gained in my experience when I was sick and had TB, is that they were able to give me medication and I recovered very well after taking the medication. I felt very healthy again"* (P1)

> *"Visiting the health centre allows me to know my health status and in this way I am able to live a longer and better life and that really makes me happy"* (P4).

> *"Well, when I was hurt they helped me a lot by giving me bandages and cleaning the wound and I felt better than I was before" (P6)*

The men indicated that a lot of good comes out of visiting health services, yet most do not want to visit them regularly. However, a few men reported that they did not gain anything by visiting their local health service centre. They expressed concern about the long period it took for them to recover even after visiting a health facility.

> *"It is only for a little while that I feel better, because I usually go there for those minor illnesses such as flu, tests and a sharp pain. A week does not even end, I feel well and recover quite well, but as I have said it was a long process and it took time for me to heal"* (P3)

Two men do not visit health centres because they prefer traditional medicine, although they did not report any negative experiences with the health services. They expressed greater trust in traditional medical and were sceptical of modern medicine. They contended that traditional medicine made them feel better, and did so faster than modern medicine.

> *"The reason why I do not visit health services is because they give pills there. I hate the smell and taste of pills and western medicine, I have to swallows pills for months to get better, just imagine, and yet they are distasteful. In addition these*

things do not treat, you eat them for an entire duration and then the next batch comes along, now you are starting to think that maybe it is these pills that are making me much weaker and weaker and these doctors are prescribing them to you because they want you to rely on them for the rest of life. Whereas with traditional medicine, I apply today and the next day, not even the next afternoon you will be feeling much better" (P13).

The second respondent expressed personal and sensitive information with regard to why there was nothing positive about health facilities. He related his own personal experience and argued that modern medicine contributed to early death, and for this reason he would prefer to rely on traditional medicine. He expressed great trust in traditional medicine and had little experience of modern medicine.

"There is nothing positive to gain at health services, in my personal experience I have never set a foot at a health facility. My parents tell me stories that they took me there once but I cannot remember or recall anything. If it were for me I would not have gone there, many of my relatives have relied on clinics, but where are they today? Six feet under, I always tell them that there are certain illnesses such as a severe sharp pains, that need traditional methods of treating them but they never listen and look where they are today" (P15).

These excerpts from the men suggest that they stay away from health services, but they also encourage many men to not visit them by painting a negative image of health services.

4.4.2 Availability of services

The number of services available at a health centre is key to improving men's use, with most reporting that health facilities provide comprehensive services. They reported that all the services were available at the clinics that they had gone to receive care for.

"All kinds of services are available there, so far in my experience, I have received all the medication I need when I visit the health facility here in the area. In terms of those services that are not available I would have to say I have not noticed any of the services that are not available" (P1).

> *"In my opinion I have received all the services that I need and require at health care centre so I would not know which services are not available"* (P9).

A few men were very appreciative of the services that they had received at the health facility. They noted that the clinic was able to treat minor illnesses and referred clients to the hospital for more serious illnesses.

> *"Our health care centre does have those minor services such as when you suffering from flu they are able to help you but when you are hurt or wounded, they would transfer to the hospital at Umlazi Mshiyeni hospital"* (P11).

Some men complained that some services were not available, which can discourage rural men from visiting health services. They were also particularly concerned that the health facility lacked what they perceived as basic equipment, which impacted the delivery of the services. This sometimes resulted in them having to go to other facilities for services, which resulted in extra costs.

> *"The other day I went there to clean my teeth and the doctor said I cannot clean my teeth. That made me very angry and sad because I had arrived at a health centre but was not able to receive the service I had hoped for or required/ Even today I have not returned to our local clinic but am still upset about not receiving what I came for"* (P4).

> *"I went there hurt and I needed to be stitched but they were not able to patch me up because I think they lacked the equipment or tools but they gave me pills instead. It was very frustrating because I could still feel the pain, our local clinic is very bad. These are the things they should always have because they know we are men and we get into fights a couple of times so therefore the clinic needs to have the equipment for such situations, because they know we will fight"*(P6).

Men reported that they hate travelling back and forth for administrative reasons. When they get to the clinic they are referred to the hospital because the local clinic does not have the

tools and equipment to help them with their health condition. When they reach the hospital they are usually sent back to their local clinic because the health care providers tell them that these types of services are available at their local clinic, and that they are congesting the hospital for a service.

> *"The pills are sometimes available and sometimes they are not so we have to travel further to other health facilities such as Mshiyeni and Scottsburgh and when we get there you will find that they too would tell you to go back to your local clinic, now that's a problem because I am sick and at the same I need transport money to be able to travel to the clinic. This is really a problem"* (P2)

In cases like these, men reported that they usually save their money to go to a private doctor or a hospital in the city, but not the local clinic, because the services are not available.

> "*When you arrive at the clinic, there are those diseases that are very dangerous like kidney failure, they won't be able to treat you when you have those types of diseases, and they do not have the dialysis machine which you only get at the hospital at Mshiyeni Hospital. And even when you want samples you have to go to the hospital, they usually refer you to the hospital"* (P8)

One older male who mentioned that there are some lifesaving services are not available at the clinic. In addition, there is only one doctor that comes to the local clinic and he often only comes once a week. The lack of staff adds to the burden on the health facility.

> *"If I can recall, it would unfortunate not to receive the desired service you require. If I can also remember the doctor is unavailable, the doctor comes there once a week, and the doctor has to assist a lot of people, at that time you are really sick when he is not there during the other days. Because you know sickness does not choose the day it will strike, it can happen on Monday or Tuesday, or whenever. You just never know. What happens when a severe illness strikes and the doctor is not there"* (P15)

The participants further noted that it is usually far to get to the hospital, which is located in the city and often far from their place of residence. They noted that this is worrying,

particularly if they are sick at night. In addition, the distance to the hospital means that they have to hire a car or wait till the next morning for public transport. Hiring a car is expensive and getting a sick person to catch a taxi in the morning is exhausting. Moreover, people in the taxi do not want to sit next to a sick person because not only does it make them nervous but they also fear infections.

4.5 Barriers to accessing health services

It is important to understand barriers to health care services in order to improve the quality of health care. The health status of older people in rural areas are impacted by the way in which health services are managed, and how these services are made accessible to the people they are intended for. Umgababa is a typical example of rural areas that are neglected in terms of service delivery. In the interviews, many participants expressed concern about the mobile clinics, which used to visit the community, but this has stopped. This has been identified as a major barrier to accessing health in rural areas, particularly for the elderly.

Men reported a number of different barriers they face mainly accessing local health services. Table 4.5 indicates the main barriers facing rural men.

Table 4.5 Barriers to accessing health services

Barriers	**N**
Distance	13
Transport	10
Cost	8
Confidentiality	2
Health care Providers	2
Long Hours	4
Shortage of Staff	2

4.5.1 Distance

The distance to the health facility is a major barrier in rural areas, with the men having to walk a long distance before they can get to a health facility. One participant explained that access to health services is essential for all men living in the rural areas of South Africa. Geographical accessibility of the health services has a direct bearing on utilization of these services (Tanser et al., 2006). Men sometimes neglect their illness because they cannot afford

to reach a primary health care service facility, leading to poorer health seeking behaviour among rural men.

> *"It is the distance I travel, the clinic is really far away, I get there feeling really tired and still have to wait long hours so it is really exhausting"* (P9)

> *"The first barrier I come across with is that the public health facility is very far way, if I had to walk to clinic I have to walk for three hours. It is better if there is a car or if I take a taxi to get there but then when I am able to get transport that means I will have to pay money which is what I do not have because I am unemployed" (P5)*

The men indicated the long distance to the clinic as a barrier, with many in the area being unemployed, and they therefore cannot afford to pay for transport. If they are sick they have to walk to the health facility, which is situated far from their place of residence, which can take one hour and is exhausting, especially for the elderly. In addition, there is a long waiting time at the health facility. Accessing health services in rural areas is time consuming and complicated.

> *"I am usually forced to get transport money because there is no health care centre close to us, these health care centres are far away"* (P10)

> *"The major barrier is how to get there and you find you do not have the energy to get there because you are feeling sick. It is far away and they delay a lot when you finally get there, so now that is really frustrating"* (P11)

> "*The barriers I come across with is that the clinic is far away and that transport to get there is not easily available which means you have to walk to the clinic to get there, you walk about 1 hour and 30 minutes"* (P17)

> *"The thing is the long distance we have to travel whenever we feel like visiting our health care centre. The long distance makes me feel lazy to even go and you find that I wish to visit the clinic but I cannot because it is far away"* (P14)

Distance was reported to be a major barrier hindering rural men from accessing health services, as indicated by 13 of the 20 men. They felt that mobile health units should reduce some of the burden, which used to visit once or twice a week and made services more accessible. The mobile clinic played an important role in reducing the distance that the men usually travel to access health services, because they came into the community and went to prime spots to treat the people.

> "*If they could bring back mobile clinics that would really be good, because we have old men constantly falling sick and are told to often visit health services and they cannot walk such long distances to the health facility"* (P2).

4.5.2 Transport

Transport was the second most frequent barrier that leads them to poor health seeking behaviour. Several men reported that it is not only transport they worry about, but also they have to wait a long time before they are able to get transport. This adds to the time it takes to access health care and can make them reluctant to visit the clinic.

> "*When I fall sick I first have to worry about how far the clinic is. Because I am feeling sick I realize that I might not survive if I walk to the clinic so my next worry is money. I have to borrow money from the neighbours to get to the clinic. I also have to eat while I am at the clinic so now its transport money plus food money. It takes a bit of time to catch a taxi because taxis want people who are going to the city and local places because they know you will pay half price… When I get to the clinic, the queues are long, the babies are crying and the nurses are up and down, it just makes me even sicker. You ask the health providers where should you go and they show a long queue that just makes you even more exhausted. You finally get to the nurse or a doctor if he is available, and whilst he is attending to you nurses and other patients are coming in and out and listening to our conversations…another thing is that I have to worry about the same things when I have to get back home. Taxis are generally full coming back from the city. I have to either walk back home or wait hours to catch a taxi"* (P12)

There was a great deal of concern about transportation to and from the health facility. The cost of transportation influences the health seeking behaviour of men, and public transport does not go directly to the health facility. As it is a shorter distance from the public transport to the health facility, it is not financially profitable for the taxis to transport them. In addition, some indicated that, given the long waiting period at the health facilities, it was also necessary to buy food, which meant additional costs, and this also influenced their use of health services.

"*Transport to get to the health facility is a major barrier. The taxis that pass here are always full and they do not want people who will be dropped off at the clinic because their final destination is to Isipingo, so they do not want to take you because you are going to pay less money and fill up the taxi wasting space for other people that are going to Isipingo which is their final destination*" (P16)

"Transport to the health care centre is really a barrier because it is really quite a long distance for me to get there maybe it is around 8 kilometres to get there and the transport is really poor. There is no transport that goes straight to the health care centre" (P11)

"The major barrier is that the place I live is quite far away from the clinic and transport to get to the health care centre is not easily available. You get that I will wake early in the morning around 8 a.m. and I would wait for transport until 11 a.m. and you find that I am very sick and when I get to the hospital I have lost a lot of energy, you see" (P18)

"What needs to happen is that here in our community we need transport like a specific car that will transport people to and from the clinic because the elderly cannot walk such long distances, and you find that sometimes the elderly end up being pushed in wheelbarrows, imagine pushing an old person for one and a half hour. When you get to the clinic you have to wait in a line, it's so exhausting, and at that same I am busy worrying about the fact that I still need to push the old lady back home with the wheelbarrow for yet another one and a hour, just imagine" (P13)

"*I think transport is one major barrier that you come across with and you end having to walk all the way to the clinic*" (P7)

4.5.3 Cost

The out of pocket costs of accessing health services for most rural men are often transport cost, food and drinks, with the service at the local clinic being free. The cost to access health services is often affected by socio-economic variables, such as poverty and unemployment. The men complained about the lack of money to travel to health centres, as they are poor and unemployed. They would often have to borrow money from neighbours and this puts them in unnecessary debt, which they try to avoid.

"Yes, there are barriers but I usually do not mind them. I usually feel that the health centre is a bit far away from us here, and sometimes I do not have transport money to travel there so I have to walk, but as a rural man walking long distances does not trouble me. But it is quite far when I walk if I had to estimate, I walk for about an hour, and usually whenever I have had to walk I arrive home late when it is about to get dark and that really makes me angry. But sometimes when I feel really sick I usually borrow money from the neighbours as it is not such a big amount I think it is around R12 and the return is R24" (P3)

"I usually do not have transport money to go there because it is a bit far away from us. I end up borrowing the money from people and that makes me fall into unnecessary debt" (P4)

"When I am able to get transport that means I will have to pay money which is what I do not have because I am unemployed" (P5)

"These old people before they could even get attended by a doctor they still have to hustle here first for transport money, and this is very troubling for us because we too are unemployed" (P8)

Medical insurance was also associated with cost and the utilization of health services. Employed or well-off individuals generally have medical insurance in South Africa. One participant in the study reported that he had medical insurance and was a regular visitor at

health services because he did not want his monthly instalment that he pays for medical services to go to waste without making use of it.

> *"I had luck of having medical aid, whenever I feel sick I go and see a doctor, and feeling ill is not necessarily the reason I sometimes visit there, I also went there to clean my teeth's and put a gold tooth. I am a regular there my friend, because these medical aides are expensive, the amount of money we pay…it shocking, so you have to take advantage and regularly see the doctor"* (P8)

4.5.5 Long hours

Men reported that the minimum waiting time at the local health facility is 1-3 hours, and that this is very annoying, being one of the main reasons why they decide to not regularly visit local health services. The amount of time men spend waiting at the health facility forms a barrier, because it could be well used for productive economic activities. Rural men are also highly dependent on small time informal jobs, such as construction work, building houses and security. They therefore cannot afford to lose out on these minor job opportunities due to having to spend long hours at the health facility. Moreover, the long waiting time at the health facility is also going to make them more ill.

> "*When you get to the clinic you have to wait in a line, it is so exhausting, one and a half hour, just imagine by the time you reach the doctor you are already dead"* (P13).

> *"I get there feeling really tired and still have to wait long hours so it is really exhausting and they delay a lot when you are finally there, so that really frustrating"* (P19)

The participants stressed the importance of urgency at a health facility. Several men report that they do not want to spend long hours for an illness that is not life threatening. They would rather not visit a health facility than to wait long hours. In order to overcome this the study recommends that better health service delivery, through hiring more healthcare providers expanding infrastructure to accommodate the number of patients and making health facilities to more user friendly.

4.5.6 Health care providers

Many men reported major problems with health providers in terms of health care and service delivery. Interactions between men and health providers have proved to be one of the primary concerns in terms of utilization of health facilities by men. The men complained about the treatment that they receive from the health care providers. They feel that providers do not have adequate training to deal with men and their health needs.

Many men complained about the quality of service that they receive from the health workers, and that they were not treated in a respectful manner. The health providers were often unfriendly and unhelpful, and some felt that they did not treat them in a professional manner. They did not show them empathy and it appeared as if they did not enjoy their jobs, as they did not seem to care for their patients. Men further stated that the health workers in the public health facilities were not welcoming, which did not make it easy for them to visit the health facilities more often.

> "*My relationship with health service providers I take that as something that is really not there because whenever those people talk to you, they do not treat or take us as a sane person. I do not even know the name of even one of the nurse there because they do not introduce themselves and tell us who they are and they do not try to befriend the people who are there, that need their help and assistance, so our relationship and interaction is minimum. What connects or makes us interact is the service that I require"* (P4)

> "*Our interaction is not there at all, it is very miserable because they do not have care at all. The do not care about the people, you find that if a very sick person comes there they say they are busy and still on their lunch break and eating non-stop. This is unacceptable that they would say they are still at lunch and not help the ill person, I do not know if they want to see him dead, then maybe they will assist him*" (P6)

However, a few men reported that they share a very good and welcoming relationship with health care providers. They do not feel afraid to ask questions, especially about the instructions of the medication prescribed to them. Most of these men noted that they felt very

enthusiastic about visiting the health service centre the next time, because the treatment and quality of care they had received at the health service facility.

> *"Our interaction and relationship is so amazing with the nurses I have met because when I am there I have this thing of people knowing me. I am well known in this community, so when I arrive there at the clinic they welcome me with honour and say "hey Mapholoba you are back again" so they love having me there. So I would not know about the others who are not well known they might be treated as good and not being taken seriously so I would not know about the interaction between them"* (P15)

> *"I would say that they are really okay. They are friendly and you just do not fear to ask questions because they make you feel welcomed. We interact with them and they treat you very well, you. There are just no issues with them. I really like their service"* (P18)

> *"Our interaction with them is quite good I just wish if they could find a secret room where they could prescribe and give us our medication that would be very nice. Because sometimes we end up being afraid to even take the medicine because people are watching"* (P1)

4.5.7 Confidentiality

A few men reported being concerned that their confidential information was shared not only at the clinic but also in the community. They also felt that the infrastructure did not allow for privacy, as the local clinics are small as are the rooms. One participant indicated that nurses are coming in and out of the room while they are trying to explain their health condition. They feel that by the time the patient leaves the hospital all the nurses, and some other patients, know all about the patient's health condition.

> *"I am scared of visiting our local clinic because there are people that talk behind your back and say 'we know this gentlemen he is suffering from this particular disease'. People talk in shebeens and the nurses too they are also drink and spread rumours about you and your health condition…I am telling you these*

people they have no respect. All they want to do is embarrass us here in the community" (P8)

"The barriers that I face are that the people that assist me such as the nurses usually prescribe or give us medication in front of the other patients and therefore other people are able to observe our health conditions and see what is troubling us" (P1)

The men were very worried about the lack of privacy at health facilities, and were particularly concerned about the health care providers discussing their problems with other members of the community. They did not want to become the subject of gossip and would prefer greater confidentiality at health facilities.

4.6 Overcoming the barriers

Many rural men reported they go through different barriers when they often visit local health services in the area. A large number of men reported cost, distance and transport as major factors that prohibited them accessing local health services. This is generally because respondents reported that they have to use taxis or walk to get to clinics and hospitals. Rural areas are often characterized by lack of health facilities, with Umgababa being no different. There are limited health services that are available to the men and most vulnerable sectors of the population. Men suffer from severe illnesses as a result of not having easy access to health services, which are situated far from their place of residence. There are two clinics near the area and men have to either pay for transportation or walk long distances to them. Access to health services for men at Umgababa appears to be a serious concern. One participant reported that mobile clinics used to come to the community but that they did not provide comprehensive services for men and they are currently unavailable. They therefore have no alternative but to travel to the nearest facility for health care, which is often situated a significant distance from their place of residence.

The majority of the rural men felt there was a solution to solving the barriers they faced in accessing health services, this being to build a community clinic closer to the people in the area. They also felt that the government needs to consider providing the community with mobile health units, which will not only reduce the distance they travel to the nearest health

facility but it will also cut out-of-pockets costs and the long hours spent waiting at a health facility. Some saw this as an opportunity for the local people to be employed, and in doing so, would keep the community members healthy. Both older and young men felt that it was important to bring health services to the community. At the moment there are not enough nurses, which increases the waiting period, with the suggestion that more nurses should to be recruited to health facilities to better meet the needs of the population.

> *"It would be great if they could build clinics that are closer to us here in the community, or if they could bring in mobile clinics, because we have old men people who constantly fall sick and are told to often visit health services and they cannot walk such long distances to the health facility. In this area we are required to always have money at the same time we are unemployed. We depend on the old age pensions that our granny gets from government which is also not enough*" (P2)

> "*I think what could be done, in particular pertaining to nurses is to add the amount of nurses available at the health centre as I have noted that there long queues there at the clinic which extends outside the building. The building gets too congested. There is one clinic that services quite a number of people. Another thing they could do is to build a clinic closer in our community. There should be a clinic here, it does not have to be so many people there at that one clinic {says this repeatedly}"* (P3)

> *"What they need to do is to build a clinic closer to the people, because really old people are suffering, there were talks a long time ago that a clinic was going to be built in our area but even today we still do not have one. I sometimes see men pushing old people in wheelbarrows and that makes me upset because if we had our own clinic this would not be happening*" (P8)

4.7 Conclusion

The aim of this chapter was to shed insights into the health experiences and perceptions of rural men at Umgababa. It is evident that the rural men are affected by a range of barriers in accessing health services. Distance was the main barrier, with the government health support

services being difficult to reach. Transport is also not available and the out-of-pocket costs make it difficult for men to access health services as most are unemployed. The primary health care services are very far, which makes it difficult to access their medication regularly. The men remain optimistic of the future, reporting that their health seeking behaviour will improve over the years because health services have generally focused on women and children, with an anticipated change towards greater attention to men. This will encourage men to visit health services more regularly, and they believe that they will receive better access to health facilities with good quality care. The aims of the study were clearly presented in the first chapter and from the above results it is clear that rural men do face barriers in accessing health services. However, the study cannot prove that poor health seeking behaviour leads to barriers in accessing healthcare or whether it is the barriers that lead to poor health seeking among rural men. However, the attitudes of men might suggest that men in general are poor at seeking healthcare and they would rather delay or ignore the healthcare services altogether.

Chapter 5
Discussion and Conclusion

5.1 Introduction

Rural men in South Africa are faced with many challenges, one of which is health problems, which has received little attention, their many health-related matters therefore having been neglected. Without access to health services, adequate medication, and proper service delivery, poor health seeking behaviour will continue to pose a threat to the health of men in rural areas. The research attempts to shed insights into the perceptions and experiences of rural men towards health services. The study suggests that many rural men in South Africa face barriers to accessing health services, which lead to poor health seeking behaviour.

Twenty rural men aged 18 and over were included, ten being 18-30 years and 10 being 30+ years. While it included only a small sample of men, and therefore it is not possible to generalize to the whole of the South African population, it does shed some insights into the perspectives and experiences of rural men. There are a number of predisposing, enabling and need factors (theoretical framework) reported in the study that are associated with access to health services.

5.2 Summary of the main findings

The study found that men in rural areas face a number of barriers in accessing health services, with a negative association between distance and health service utilization. In the study, distance was the most frequently reported barrier to accessing health services, with 13 of the 20 men reporting it to be a problem. As rural areas in South Africa are often sparsely populated, with many men being reliant on social support services, distance to health services is likely to affect those living in these areas more than in urban areas. The study area has a limited number of primary health care facilities that are far apart from each other, and there are no hospitals nearby. The health facilities are located a considerable distance from the rural areas, with community members having to rely on public transport to get to a health facility. Public transport can be difficult to access, which results in some men having to walk to get to the health facility.

The men in this area have to wake up early and travelled long distances to access health services, and have to spend money on transport costs to get to other health facilities. Similar results were found in a study by Tanser et al. (2006) that distance affects primary health care utilization in South Africa. Proximity to care has also been shown to be an important factor affecting a large array of health outcomes. The study predicted that the mean travel time to nearest clinic is 77 minutes, and that 64.8% of homesteads interviewed travel more than one hour to attend a clinic.

Another study by Tanser et al. (2001) found that physical accessibility of services is a major factor influencing patient choice of health care facility, and that attendance rates at health facilities declines markedly with distance. In some developing countries, where health facilities are relatively sparse and access is often on foot, it has been assumed that patients will preferentially use the health facilities nearest to them, and that there is a limit to the distance that patients will travel for health care. However, it is not clear whether these results are transferable to other settings. For example, in a study of 859 patients in Nigeria, it was found that although distance was the leading factor in determining health utilization, it accounted for only 31.8% of the total responses, with social factors accounting for the remaining 68.2% (Egunjobi, 1983). Despite the above, several studies contend that proximity to primary health care has long been considered a major factor contributing to the health of populations (Perry & Gesler 2000).

Cost adds to the barriers of utilizing health services among rural men, this being the second major barrier that prevented them from accessing health care. Although all the participants confirmed that they do not pay for health services, they did, however, mention how they are affected by additional costs incurred in accessing health care. This is unfortunate, because most of them reported that they are not in full-time employment and do not have the money for such emergencies, making it necessary to borrow money from the neighbours, which put them in debt. The out of pocket costs have an impact on the health utilization of rural men. Despite the South African government making significant progress towards providing free primary health care for all inhabitants, the out- of-pocket cost incurred in accessing health services remain a central concern. Transports cost, food and beverages are some of the additional costs reported by the participants that they incurred when accessing health services.

Rural men's low socio-economic status is mainly attributed to their difficulty in securing employment, and the income that they receive from the part-time work is often shared and stretched in the household, this being common in many rural areas in South Africa. Health status, along with income and consumption, is a key determinant of welfare (Deaton and Paxon, 1998). Men with low socio-economic status complained that managing their health becomes difficult as they do not have the means to do so. Participants also affirmed that they cannot afford extra care and medication if they needed it. The men also contended that, because of their low socio-economic status, they do not receive proper respect when they visit facilities as they are seen as poor and old, and hence deserving of ill treatment and neglect.

Studies found that being insured significantly increased the likelihood of health service use (Insaf, 2010; Mills et al., 2012). Only one respondent reported that they had medical insurance because his parents have the financial means and they can afford medical insurance. The respondent showed great knowledge and utilization of health services, mainly because he was insured and remarked that he will continue to utilize health services because he does not want his parent's money to go to waste. A study in the United States found that uninsured men from Latin America were significantly more likely to delay care than their insured counterparts (Insaf, 2010). Individuals' ability to access health insurance depends on their employment status and income. A study by Mills et al. (2012) on the equity of health-system financing and service use in Ghana, South Africa, and Tanzania found that the overall distribution of service benefits in all three countries favoured richer people, although the burden of illness was greater for lower-income groups. Access to needed, appropriate services was the biggest challenge to universal coverage in all three countries. Those who did not have insurance raised many concerns regarding the high amount of money individuals pay for medical aid, and therefore rely on free primary health clinics when needing care.

There is an interconnectedness between culture, notions of masculinity and confidentiality, and these three factors being characteristics that are important to rural men. Cultural factors and notions of masculinity are identified in Anderson's model as predisposing factors influencing utilization of health care services. It was evident in the study that the above factors impede utilization of health care services for rural men. In the study, two men

reported that they prefer to consult a traditional healer than a healthcare professional when feeling ill. Both men showed a great deal of trust and reliance on traditional healing, regarding it as being more effective and efficient than western medicine. One respondent reported that he sometimes needs to supplement modern medicine with traditional medicine, because he feels that the former cannot help them on its own. Despite the efficiency and effectiveness of traditional healing this also forms a barrier for men to seek or access public health services, as they often constitute the first line of access to health care for many rural men.

Traditional notions of masculinity also have a negative impact on men's routine health examination (Hammond et al., 2010). While traditional healers have been predominant in providing medicine for the physically ill and injured, their contribution to health care in the province of Kwa Zulu Natal or South Africa is not known. A study by Abdool Karim, (2005) found that 70% of male patients consulted a traditional healer as a first choice in KwaZulu-Natal, with the Isangoma being the most popular type of healer. A number of studies argue that these practices encourage men to subscribe to masculine values. The tendency for many men to engage in high risk practices (e.g., excessive use of alcohol; high speed driving etc.), avoid preventative care, delay treatment, and ignore health information and physician recommendations can be interpreted as practices of masculinity and, in turn, contribute to poor health outcomes for men (Evans et al., 2011).

Health care providers are at the centre of the success of health service delivery in South Africa, and they have an important role to play in the utilization of health care services. Several studies have confirmed that some men do not feel comfortable being examined by female's health care providers, or consulting with females about their sexuality (Gupta, 2000). In many PHC centres in South Africa healthcare, providers are mainly female. Several rural men reported that the attitude of health workers at the health care facilities is not appropriate, and they are not accommodative of their needs. Many men complained that they did not feel comfortable asking for information, and accused the providers of acting in a judgmental and condescending manner towards their patients.

South Africa needs to make significant strides in attempting to encourage more male health care providers at health facilities. A study by Kappham and colleagues (1999) found that a

large percentage of young American men preferred to receive services from male providers. In addition, Marcell and Eyre (2003) found that men delayed seeking health care because they feared the reaction of providers to their problems and expressed concerns about lack of privacy at health facilities. A lack of trust by male users in health care providers contributes to the reluctance of men to use health services (Ozawa and Walker 2009). The lack of male health care providers highlights a significant barrier facing men in accessing health services. In the study, it was evident that the attitudes of health care providers towards men is an important factor that acts as a barrier to men accessing health services. Negative staff attitudes, such as unapproachability, rudeness and patient-blaming were described by men. These attitudes were often attributed to pressures of working in overburdened services (Yeap et al., 2010), but need to be addressed.

Other studies in Africa report that people spend more time waiting to receive treatment than travelling to clinic, with an average waiting time of 150–160 min (Buor, 2003). The long waiting period at large rural areas clinics obstruct primary care delivery, imposing time costs on patients, deterring appropriate utilization and causing patient dissatisfaction (Bachmann & Barron, 1997). In the study, the men reported that they spent nearly 1-3 hours at the health facility and felt that this was very exhausting, because they have other important commitments, such family and work. However, despite the geographical location of any health facility, long waiting hours form a barrier or impede utilization of health services. A study in an urban setting in Gauteng by Yeap et al. (2010) found that long waiting hours and overcrowding were commonly reported obstacles impeding health care.

The study found that clients were anxious about breach of confidentiality, which is consistent with other studies that found firstly, that they feared the reactions of their sex partners (violence, break-up of marriages etc.) should health care professionals disclose their status without their permission (Campbell et al., 1997: p93). Secondly, they fear the reactions of health care professionals themselves. In a study on the attitudes towards voluntary counselling and testing among men in rural south west Uganda, Pool, Nyanzi & Whitworth (2001: p605) found that although the men were prepared to be tested, there was a widespread fear that staff might refuse to assist them to access treatment. There were also rumours that medical staff intentionally kill HIV positive patients to stem the spread of infection. In this

study, several men reported that they want their health profile to be kept confidential because they do not want people gossiping about their health in public.

Perceptions of ill-health among rural men have different dimensions, though all can agree that illnesses pressure men to visit health services. In the study, nearly all the men reported that they only visit health facilities when they fall ill. However, perceptions of ill-health differed between the young and older men. Many older men are prone to more chronic diseases, such as high blood pressure, high cholesterol and diabetes. A study by Maharaj (2013) found that older people in rural areas held negative attitudes towards their health, describing it to be an experience of pain brought about mainly by chronic diseases. Many older people reported that they experienced ill-health, which led to them being unable to perform certain tasks on their own.

However, many young men bear the burden of ill health owing to the effects of accidents and injuries, including those caused by insecurity, war and occupation (WYR, 2003). Some men do not dwell on the causes of their illnesses because they are due to circumstance that are not under their control, such as poverty, economic instability, domestic stress and the burden of orphaned grandchildren (Maharaj, 2013). In the study, several young men were more concerned about a loss of work opportunities and role of being a provider than monitoring their health. As noted earlier, men in rural areas are often unemployed, and depend on part-time jobs to provide food for their families. These men are in a difficult situation, because if they do not work, their families go hungry, but if they do not monitor their health, they are likely to experience greater illnesses that can lead to death, with their families facing the burden of losing a breadwinner. Therefore, it is important for men throughout the world to monitor their health, because the healthier they are the more productive they can be.

With the increasing burden of HIV and STIs related diseases, more monitoring by young men of ill health is needed. Young men are less likely than women to test for HIV and engage in HIV care and treatment (Fleming et al., 2016). Consequently, despite women having a higher HIV prevalence than men, more men in sub-Saharan Africa die from AIDS than women (Dovel et al., 2015). Moreover, Hancock et al. (2015) found that men in KwaZulu-Natal who were living with HIV were concerned about a loss of work opportunities and inability to fulfil the masculine role of being a provider. Dageid et al. (2012) found that South African men

living with HIV had to renegotiate their masculinity in order to disclose their HIV status and receive care.

Poverty is one underlying factor that forms a barrier in utilizing health services and is likely to affect access health care, as financial resources may need to be directed elsewhere, which may result in funds for travel to a medical clinic that provides treatment not being available (Kagee et al., 2011). In the study, the men did not report that they felt that they were living in poverty, but did indicate that there was unemployed and that they lacked the funds to utilize health services regularly, therefore the root cause for this lack of utilization was mainly driven by poverty. In South Africa, a Basic Income Grant (BIG) is being considered as a means to provide citizens with an income, to enable the poorest households to meet their basic needs, stimulate equitable economic development, and promote family and community stability (Kagee et al., 2011).

5.3 Recommendations

Rural men have poor health seeking behaviour, mainly due to the barriers they face in accessing health services. The lack of care and consideration for rural men in terms of access to health care facilities, utilization of health services and attitudes of health workers has an impact on the quality of health care received by men. Support structures that are aimed at men and meeting their health needs should be considered and made available and accessible to rural men. Rural areas should become the main focus in terms of the distribution of health facilities, particularly due to the vulnerability of all rural men.

Health literacy interventions should be a priority in rural communities, with community and traditional leaders placing more emphasis on men's health and the barriers they face in accessing health services, in the absence of which men will retain their poor health seeking behaviours throughout their life. The majority of men did indicate that traditional and political leaders need to organize communal meetings and address men on the importance of monitoring their health. Traditional leaders are well respected and have the power to effect change at Umgababa, and therefore need to play an important role in inspiring rural men to visit health services, as most are males and can associate with men who hold masculine values. This could lead to more rural men being motivated to visit health services. Health literacy programmes have the potential to address not only notions of masculinity and poor

health seeking behaviour, but also create awareness and increase knowledge on illness such HIV and STIs, which often affect men.

It is important that all factors that affect the health of rural men be addressed, this includes in particular, access to health facilities and the factors that affect utilization of health facilities. Many other factors affect the utilization of health of rural men, such as the socio-economic factors of poverty and unemployment. There is a need to consider outreach and apprentice programs to create employment and lift rural men out of poverty in order to lessen their reluctance to utilize health services. Policies and structures that are aimed at improving the lives of rural men should extend to assist them in their communities and at their homes. Unmet needs regarding rural men's healthcare can be addressed by improving healthcare resources. Adequate training of health care personnel is important to appropriately care for the men who feel uncomfortable at health services due to health providers make them nervous and fearful.

5.4 Conclusion

The study found that rural men continue to be out of touch with the health care system and face barriers to accessing health, their behaviours and reluctance to seek care **place** their health at risk. Young men often put their own health at risk by engaging in reckless behaviour, such as smoking, substance abuse and fighting, which makes them more prone to illnesses, accidents and injuries. Rural men face multiple barriers in accessing health services, such as distance to health centres, transport, cost, long waiting hours and queues, negative health care providers, lack of medical insurance and confidentiality.

The findings in the study suggest that evaluating effective ways to reduce these barriers is an under-researched area, but one where the policy implications are potentially substantial. It suggests that in designing interventions, the communities should be fully involved in order to ensure that the resulting solution is socially acceptable. However, interventions must not only focus on the barrier's men face but also pay attention to the indirect variables that affect men, such as poverty, unemployment, education and low socio-economic status, these sometimes being the underlying factors that contribute to the barriers in accessing health services among rural men in South Africa.

The subject was worth exploring in the era of myriad of barriers to accessing healthcare in South Africa. This was easily documented by reporting on the perspectives and experiences of people who seek healthcare services at public health facilities. The study adds to important debates about the shortages of healthcare professionals in the country, the limited number of studies documenting health seeking behaviours of men and the socio-economic challenges facing rural areas, which all affect the health of the population. It was evident in the study that barriers such as illiteracy, unemployment, geographical location and men's health seeking behaviours are key to their limited access to health services. Other barriers that were found include the perceived lack of confidentiality of healthcare providers as reported by the participants, a gendered perspective of the health service and the exaggerated level of poverty which altogether are major barriers to healthcare access.

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Appendix 1: INTERVIEW GUIDE

Interview Guide (IsiZulu)

1.) Iminyaka? Ushadile? Izinga lokufunda?
2.) Unesikhathi esingakanani uhlala kulomphakhathi?
3.) Ucabangani ngezinga lomtholampilo kulomphathakathi? Kungabe liyakhokhelwa noma elamahala? Uyazizwa wamulekile futhi unethezekile emtholampilo?
4.) Uvamisile yini uvakashela umtholampilo wasemphakathini?
5.) Wagcina nini ukuvashela umtholampilo wasemphakathini?
6.) Oluphi usizo olukhona? Oluphi usizo olungekho noma elingatholakali?
7.) Okuphi okuhle ozizwa ukuzuzayo uma uvakashela umtholampilo?
8.) Eziphi izingqinamba ohlangabezana nazo uma ufisa ukuvakashela umtholampilo?
9.) Yini engenziwa ukubhekana nokuqeda lezingqinamba?
10.) Ungabucaza ngokudlelwane obukhona phakathi kwakho nabasizi basemtholampilo?
11.) Eziphi izindlela, noma okungenziwa ukuthuthukisa izinga lwabantu besilisa bavakashele imitholampilo?
12.) Okuphi ukungenziwa abaholi bendabuko noso politiki ukwandisa nokuthuthukisa izinga lwabantu besilisa bavakashela imitholampilo?

Interview Guide English

1.) Age? Marital status? Religion? Level of education?

2.) How long have you lived in this community?

3.) What do you think about Health care services in the area? Are they free? Are they and friendly service centres? Do you feel comfortable at these services? Why? Why not?

4.) How often do you visit a health care service centre?

5.) Which services are available and which are unavailable?

6.) When was the last time you visited a health care service centre?

7.) Are there barriers to accessing Health care services? What are these?

8.) What are the barriers to accessing health care services? Elaborate?

9.) What do you think could be done to overcome these barriers facing men?

10.) How would you describe your interaction with the health providers? Do you feel comfortable asking questions?

11.) What are some of the ways, programs/projects do you think can be developed improve men's ability often visit health care centres?

12.) Is there any intervention by the traditional leaders or political leaders to further enhance men's likelihood of visiting health care centres?

Appendix 11: ETHICAL CLEARANCE APPROVAL

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATAL

12 December 2017

Mr Nkanyiso Gift Ngwazi 212539403
School of Built Environment and Development Studies
Howard College Campus

Dear Mr Ngwazi

Protocol reference number: HSS/0681/017D
Project Title: The study examines the barriers to accessing health services: Perspectives to experiences of men in a rural area in South Africa

Full Approval – Full Committee Reviewed Protocol

In response to your application received 02 June 2017, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Professor Pranitha Maharaj
Cc Academic Leader Research: Prof Oliver Mtapuri
Cc School Administrator: Ms Nolundi Mzolo

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: singhsh@ukzn.ac.za / snymanc@ukzn.ac.za / mohunp@ukzn.ac.za
Website: www.ukzn.ac.za

Appendix 111: INFORMED CONSENT

Informed Consent (IsiZulu)

Incwadi yesivulelwano socwaningo

Mnumzane/Nkosikazi/Nkosazana

Igama lami ngingu Nkanyiso Gift Ngwazi, ngingumfundi waseNyuvesi yakwaZulu-Natali. Inombolo yokuba umfundi kanye nekheli ithi: 212539403. Inombolo yami yocingo ithi: 071 731 2071. Uyamenywa ukuba uhlanganyele nami ocwaningeni olumaqondana nesihloko esithi: Kungani kunzima ukuya emtholampilo: kumadoda ahlala ezindaweni zasemakhaya esifundazweni saKwa Zulu-Natal.

Lolucwaningo luzoba nenani labantu abangu 20 endaweni yaseMgababa. Indlela oluzoqhutshwa ngayo: umphathi ohlelo uyobe ebuza imibuzo ejulile mayelana nocwaningo bese indoda iyaphendulo (In-depth Interviews). Lemibuzo iyishumi siyonke, abantu abazohlanganisa uncwaningo bangama shumi amabili (20). Isikhathi semibuzo sizoba ihora elilondwa. Imibuzo, ezobe ibuzwa umcwaningi imaqondana nesihloko. Lolucwaningo aluxhasangwa ngezimali futhi awukho umkomela ozotholwa ngokuba ilunga lwalolucwaningo. Ngiyabonga ukuthi uvume ukuba yingxenye yalolu cwaningo. Inhloso yemibuzo ukuthi kube nengxoxo phakathi kwethu, ngizocela ukhululeke ukuzwakalisa imibono yakho ngokuphelele. Ngicela imvume yokuba ngiqophe inkulumo yethu. Engikutholayo kulolu daba esikhuluma ngalo ngizokusebenzisa ukubhala umbiko. Kubalulekile ukuthi wazi ukuth uma ufuna ukuyeka ekubeni ilunga lalolucwaningo ungayeka noma inini.

Kulideleke ukuba lolucwaningo:

• Luthuthukise ulwazi maqondana nendlela abantu besilisa bayibuka kanjani imitholampilo.

• Labo abayingxenye yocwaningo bazoqonda ukuthi imtholampilo ibaluleke kakhulu empilweni.

• Amadoda azofunda ukugcina izimpilo zabo zihlanzekile futhi zithobekile ngaso sonke isikhathi.

Lolu cwaningo lusingethwe nguDokotela Pranitha Maharaj ngaphansi kwesikole seBuilt Environment and Development Studies eNyuvesi yakwaZulu-Natali lapho ngifunda khona. Yimi ozobe enza ucwaningo, uma unemibuzo ungabuza:

Isikole seBuilt Environment and Development Studies, eNyuvesi yakwaZulu Natali, Howard College, eThekwini. Imininigwane yami ukuze ngithinteke ungathumela umyalezo wombani kuleli kheli: 212539403@stu.ukzn.ac.za.

Uma udinga ulwazi oludlulele ungathinta: HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609 Email: HSSREC@ukzn.ac.za.

Ngaphambi kokuba siqale ngithanda ukugcizelela ukuthi ukuvuma kwakho ube ingxenye yocwaningo kuya ngothanda olusuka kwihliziyo. Esikukhulumayo kuphakathi kwethu, igama neminingwane yakho ngeke idalulwe.

Ayikho inkokhelo noma ingozi ekubeni ingxenye yalolu phenyo. Ungahoxa noma inini futhi uvumelekile ukungaphenduli enye yemibuzo uma ungakhululekile. Ungabuza noma imiphi imibuzo noma inini.

Ngicela usayine isivumelwano ngenzansi.

Mina …….. (Igama) ngiyakuqinikisekisa ukuthi ngiyifundile futhi ngayiqondisisa imibandela ethulwa ngu: Nkanyiso Ngwazi mayelana nocwaningo lwakhe. Nginalo ithuba lokubuza imibuzo futhi ngiyagculiseka ngezimpendulo ezibekiwe. Nginalo ulwazi lokukhetha ukuba inkulumo iqoshwe.

Nginalo ulwazi ukuthi ngingahoxa noma inini.

Ngiyaqonda ukuthi awukho umnikelo engizowuthola kulolu cwaningo

	YEBO:	CHA
Ngineminyaka engaphezulu kuka-18 futhi ngivumelekile	☐	☐
Ngiyavuma ukuzibandakanya kulolu cwaningo		
Ngiyavuma ukuba inkulumo iqoshwe		

Igama _____

Isiginesha _____

Usuku _____

Informed Consent (English)

INFORMED CONSENT RESOURCE TEMPLATE

Information Sheet and Consent to Participate in Research

Date: 15-05-2017

Greeting: Members of the community of Umgababa. My name is (Ngwazi Nkanyiso) from the school of environmental and developmental studies which is part of the college of humanities at Howard College. To contact me you use my mobile number which is: 0717312071 or email: which 212539403@stu.ukzn.ac.za. You are being invited to consider participating in a study that involves research on the barriers to accessing health services among men. The aim and purpose of this research is to:

1. To examine attitudes of rural men toward health services.
2. To explore the barriers that prevent rural men in accessing health services.
3. To examine experiences of rural men at health facilities.
4. To explore opportunities and constraints for changing health seeking behavior of men.

The study is expected to enroll 20 participants; 10 aged between 18-30 and 10 aged 30+ at Umgababa a rural area in KwaZulu-Natal located South of Durban. It will involve in-depth Interviews. The duration of your participation if you choose to enroll and remain in the study is expected to be a maximum of 45 minutes. The study is not funded by any donors therefore ther will be no reimbursements or payments made to you. It is voluntary to participate.

The study will enhance the community's knowledge on the relevance of accessing health services. It will also improve men's health seeking behavior. And essentially it will form a relationship between traditional leaders, health services and men.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number (HSS/0681/0171D).

In the event of any problems or concerns/questions you may contact the researcher at 0717312071 or email 212539403 or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

The research study is voluntary and participants may withdraw from the study at any given time and they may declare their information not to be recorded and analyzed, and that in the event of refusal/withdrawal of participation the participants will not incur penalty or loss of treatment or other benefit to which they are normally entitled. They are no cost that might be incurred by participants since the study is voluntary and seeks people's perspectives.

The study takes pride in keeping and protecting confidentiality of personal/clinical information because we realize how sensitive such information can be. Therefore consultation has been made with the traditional leader that any violations of personal/clinical information should be protected and kept confidential as it may adverse effects for participants. Data will be stored for five years and then later destroyed.

CONSENT (Edit as required)

I (Name) have been informed about the study entitled (provide details) Barriers to accessing health services among men. by (provide name of researcher/fieldworker).

I understand the purpose and procedures of the study (add these again if appropriate).

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at (provide details).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Additional consent, where applicable

I hereby provide consent to:

Audio-record my interview / focus group discussion YES / NO

Signature of Participant	**Date**
Signature of Witness (Where applicable)	**Date**
Signature of Translator (Where applicable)	**Date**