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Late entry and chronic burdens: Black men's first contact with public primary health care in South Africa

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ABSTRACT: Mortality among men in South Africa continues to rise, with Black men disproportionately burdened by preventable and manageable conditions such as hypertension, diabetes, tuberculosis, Human Immunodeficiency Virus, and Acquired Immune Deficiency Syndrome. Despite the availability of free primary health care (PHC) services, evidence suggests that many delay seeking care until illnesses become advanced. This study examined factors influencing the late entry of Black men into public PHC facilities in Ga-Rankuwa. A qualitative, explorative, and descriptive design was employed, guided by the Theory of Planned Behaviour. Data were collected through 15 in-depth, semi-structured interviews with men aged 25–66 years, using purposive and criterion sampling. Thematic analysis identified five major themes: individual choices and the normalisation of ignoring symptoms, reliance on self-medication and delayed care-seeking, preference for traditional remedies and over-the-counter medication, stigma, shame, and masculinity burdens, and privacy concerns, gender of providers, and mistrust of PHC facilities. Findings revealed that delayed care was shaped by cultural expectations of endurance, economic pressures, reliance on self-care, and fear of stigma. Institutional factors, including perceived breaches of confidentiality and discomfort with younger or female providers, further discouraged early engagement. Many participants only accessed PHC at critical

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stages of illness, often prompted by significant others. This study demonstrates that late entry into PHC is not simply personal neglect but a product of cultural norms, systemic shortcomings, and structural barriers. Creating male-friendly, culturally sensitive, and confidential PHC services is crucial for promoting early engagement and reducing the chronic disease burden among South African men.

Keywords: *men's health, health-seeking behaviour, masculinity, primary health care, South Africa.*

Introduction

Over the past decades, mortality rates among men in South Africa have continued to rise, with Black men experiencing the highest burden compared to other racial and population groups. A significant proportion of these deaths occur prematurely and are attributed to preventable non-communicable diseases (NCDs) such as hypertension, diabetes, and high cholesterol, as well as infectious diseases like Tuberculosis (TB), Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). Many of these conditions are manageable when diagnosed early, as they present with recognisable warning signs and symptoms. However, evidence suggests that some Black men delay seeking formal medical attention, often relying initially on over-the-counter medicines or traditional remedies. For instance, a recent study conducted by Chavalala et al. (2025) in Limpopo Province, South Africa, found that men prefer to self-medicate using over-the-counter medication and traditional herbs, while others consult traditional healers to address health concerns. Similarly, research in rural KwaZulu-Natal (KZN) has shown that men frequently resort to herbal remedies and traditional healers for conditions such as hypertension, with masculinity ideals that endorse endurance, further discouraging early biomedical care-seeking (Chikafu et al., 2022). It is usually only when their medical conditions worsen that they present themselves at public primary health care (PHC) facilities (Chavalala et al., 2025; Makgopa et al., 2022). In fact, there is evidence that in most instances, their first contact with the public PHC facilities is due to symptoms related to chronic medical conditions. This trend endures even though post 1994, South Africa improved and expanded the number of its public PHC facilities and made the services accessible to all citizens at no cost (Coovadia et al., 2009).

South Africa’s health care system (HCS) consists of two parallel sectors: the public sector, funded by the state, and the private sector, which is privately funded through out-of-pocket payments, medical schemes, and insurance (Burger & Christian, 2018). The two sectors differ markedly in their modes of health care delivery. The private sector is primarily oriented towards curative care, while the public sector is designed around preventative health care services through PHC facilities. Public PHC services are provided predominantly through a nurse-led model supported by medical practitioners. However, these facilities have long been perceived as female-dominated spaces, both in terms of providers and patients. The services currently offered at public PHC facilities – such as family planning, maternal health care, child immunisation – are largely tailored to women and children, with limited attention to the specific health needs of men. This programmatic exclusion contributes to the perception among Black men, in particular, that public PHC facilities are not intended for them. Indeed, participants in a study by Chavalala et al. (2025) suggested that more public health care facilities with male-dedicated sections and male providers should be introduced to encourage utilisation of services.

For many Black men, the local public clinic becomes a place of last resort—visited only when all other options have failed, their conditions have deteriorated, and their lives are at risk. The severity of symptoms has also served as a strong motivator for Black men to seek medical help. It is, however, evident that in most cases, the decision to seek care is prompted not by personal choice but by the influence of significant others such as family members, friends, or co-workers. Makgopa et al. (2022) also agree that family members and co-workers play a significant role in supporting and encouraging the men to seek health care when they are sick. In some instances, their first formal diagnosis of chronic conditions such as hypertension, diabetes, or high cholesterol is made on their first visit to their local public clinics. This pattern is evident both among men who have consistently avoided health care altogether and those who initially relied on private health care providers, over-the-counter medication, traditional healing practices, or herbal remedies (Makgopa et al., 2022). What unites these groups is their delayed engagement with the public primary HCS. To understand these patterns more deeply, this study explored Black men’s lived experiences with public PHC facilities in Ga-Rankuwa.

Methods

Research design

This qualitative study explored the lived experiences of the participants with their local public clinics. To meet the requirements of the study design, which was explorative, descriptive, and contextual, the researcher prolonged engagements with the participants to familiarise herself with their experiences. Furthermore, the researcher took care to understand and accurately describe the participants' lived experiences and the study environment (settings). To understand men's HSBs in a specific social context (Ajzen, 1991), the study employed the theory of planned behaviour (TPB) as a theoretical framework. The study collected data through individual, in-depth, semi-structured interviews, some were conducted face-to-face and others remotely through WhatsApp calls (Polit & Beck, 2017). The original plan was to rely only on face-to-face interviews; however, due to the challenges posed by the coronavirus disease of 2019 (COVID-19) pandemic in March 2020, the researcher used remote or socially distant platforms to collect data from some of her participants.

Sampling and sample size

According to Barlett et al. (2001) and Creswell (2003), cited by Asiamah et al. (2017), participants in the general population must share at least one attribute of interest, which qualifies them as members of a research population. Therefore, this study defined the research population as all Black men residing in Ga-Rankuwa at the time of the study (Polit & Beck, 2017). The sample was drawn from Black men who attended the public PHC clinics in Ga-Rankuwa and those living near the selected public PHC clinics of the township, referred to as the accessible population (Polit & Beck, 2017). The study employed purposive and criterion sampling methods to identify and target participants who could contribute meaningfully to the research (Bradshaw et al., 2017; Polit & Beck, 2017). Eligible participants were Black men aged between 25 and 66 years who visited their local public clinics for medical treatment, accompanied others to the clinics, or lived near the facilities regardless of whether they had previously used them for medical treatment. All participants were required to meet this inclusion criterion, regardless of whether they preferred face-to-face or remote interviews. Sampling continued until no new information emerged, and recurring responses indicated data saturation. At this point, 15 participants had been interviewed (Bradshaw et al., 2017).

Data collection

The study collected data through in-depth, semi-structured interviews conducted both face-to-face and remotely (Polit & Beck, 2017). Six participants participated in face-to-face interviews, while nine were interviewed remotely via WhatsApp calls. All interviews were tape-recorded. An interview schedule was used to administer and guide the interview process, ensuring that the discussions remained focused on addressing the study objectives. The interviews varied in duration: face-to-face interviews lasted up to one hour and 45 minutes, whereas remote interviews lasted between 30 and 45 minutes (Bradshaw et al., 2017).

Data analysis

The study analysed data using thematic analysis (TA). A seven-step approach to TA, developed by merging Braun and Clarke's (2006) and Lonchmiller and Lester's (2017) methods, guided the process. Before commencing the actual analysis, the researcher translated parts of the transcripts from *Setswana* into English (Braun & Clarke, 2006; Lester et al., 2020; Polit & Beck, 2017). The researcher manually transcribed the collected data and read it several times to gain familiarity (Braun & Clarke, 2006; Maguire & Delahunt, 2017). The text was then broken down into smaller segments, which were coded so that segments carrying the same meaning received the same labels. After coding, matching labels were grouped to form categories. Finally, categories conveying the same or related ideas were placed under their matching preset themes. These preset themes were generated deductively, before data analysis, from the study's theoretical framework, the TPB (Nowell et al., 2017).

Measures for ensuring trustworthiness

To accomplish trustworthiness, the study ensured that the steps that were followed throughout the research enquiry were meticulous and guaranteed the believability of the final study outcomes (Bradshaw et al., 2017). The researcher adopted the four alternatives for showing and/or assessing the trustworthiness of a qualitative inquiry, described by Lincoln and Guba (1985), namely credibility, transferability, dependability, and confirmability, as well as the fifth criterion, namely, authenticity, which was later added to the framework (Elo et al., 2014; Polit & Beck, 2017), as the criteria to ensure that the findings of the study are valid and reliable.

Ethical considerations

The researcher obtained written informed consent from the study participants before she could start collecting data. To afford the participants an opportunity to make an informed and voluntary decision to participate in the study, the researcher thoroughly explained the nature and purpose of the study to them (Polit & Beck, 2017). She also made the participants aware of her own responsibilities and duties during the research process, and explained to them the possible risks and benefits that they (participants) could derive from the study. The researcher further removed from the transcripts any elements that could identify the participants and replaced them with numbers. This was done to ensure that the participants were not subjected to any harm in any way possible and that the information they provided was well protected (Babbie, 2007; Berg, 2004). Moreover, the privacy of the environment where the interviews were conducted was very carefully managed throughout all of the stages of the research inquiry (Arifin, 2018).

Ethical approval to conduct the study was granted by the College of Human Sciences' Research Ethics Committee (CHSREC). Furthermore, permission to conduct the research and access the research site was granted by the Gauteng Department of Health (DoH).

Results

Thematic analysis revealed five themes, namely, (1) individual choices and the normalisation of ignoring symptoms, (2) reliance on self-medication and delayed care-seeking, (3) p**reference for traditional remedies and over-the-counter medication, (4) stigma, shame, and masculinity burdens, and (5) privacy, gender of providers, and mistrust of public PHC facilities.**

Theme 1: Individual choices and the normalisation of ignoring symptoms

Many participants reported having often delayed seeking medical assistance, even when symptoms of illness were evident. They described how they would first response to bodily discomfort by monitoring symptoms at home or waiting for symptoms to disappear, instead of seeking immediate care. This “waiting it out” approach reflects a belief that minor illnesses would naturally regress, and that seeking help too soon is unnecessary. As one participant explained: *“No, when I’m sick, I don’t look for medical help immediately, I just wait and stay for a few days if it’s gonna get better ... is then when I go out then look for help.”* Others described this delay as an intentional test of endurance. Everyday explanations, such as alcohol use, overwork, or fatigue, were often used to downplay symptoms. For example, one participant dismissed persistent headaches as hangovers until the pain persisted for weeks. Work pressures also reinforced this habit, as missing a day’s wage discouraged early help-seeking: *“Even if a person is not feeling well, they have to go to work ... because if you don’t go to work you lose that one day salary.”*

Even when illness was recognised, participants often waited for external validation from significant others before seeking formal care. For example, one participant described ignoring severe symptoms during COVID-19 until his wife insisted he seek medical attention: *“I could go to see the doctor on my own, but I wanted to go home ... only to find that I am sick, and I was admitted to the hospital.”* These accounts revealed how **delayed health-seeking is not merely an individual decision but a socially and economically shaped practice**. Cultural expectations of endurance, workplace demands, and gender norms that valorise toughness and self-reliance combine to create a cycle of avoidance. Consequently, Black men’s first contact with HCSs, particularly their local public clinics is often delayed until their conditions become chronic or critical.

Theme 2: Reliance on self-medication and delayed-care seeking

Building on this pattern of waiting, many participants reported relying on home-based remedies or medication as a first response. Participants preferred to exhaust these options before seeking formal care. As one explained, *“Most of the time I* *prefer that I make my own remedy and stay home … then, when it has failed, that's when I decide to go to the clinic." For some, this attitude is rooted in the belief that the body can fight off minor illnesses without external help: "An attitude of like, you believe that you can fight this thing off, or is just like a minor issue. So, like, in two or three days, it should be okay."*

Illness is often regarded as a minor or temporary setback that their bodies can naturally overcome. As a result, they delay seeking external care until their symptoms persist, worsen, or begin to interfere with their daily functioning. For some, this was based on confidence in the body's ability to overcome illness without intervention: *"You believe you can fight this thing off. It's just a minor issue. In two or three days it should be okay."* Illness was thus redefined, by participants, as "serious" only when it was incapacitating. This threshold-based approach to health-seeking delayed contact with clinics until conditions advanced. As one participant explained, *"You do not start by running to the private doctor or to the clinic. You have to stay for a few days. If you feel the pain coming back, it is then that you can take a step."*

Theme 3: Preference for traditional remedies and over-the-counter medication

Closely linked to self-care was reliance on traditional remedies and over-the-counter medications. Many participants reported that they first turned to herbs, natural remedies, or common painkillers before visiting a clinic. For example, one participant said: *"I prefer finding herbs… before I go elsewhere."* Another explained: *"We start by using Paracetamols that we have in the house."* Traditional remedies such as Lengana, Moringa, and Sekanama were widely cited as trusted, natural options for flu and other common ailments. One participant recalled: *"I was sick that time. There was running nose, I was weak, so, I suspected corona. I still buy some medication, your Moringa, your Lengana, we did some concoction at home, and then I got better." Similarly, another* participant stressed the widespread acceptance of such practices among Black men: *"Men believe in traditional medicine such as Sekanama."*

Over-the-counter products like Panado, Paracetamol, or Flu packs were also popular. For some, these alternatives fully replaced professional care, while others used them as a first step before deciding to seek medical treatment if symptoms persisted. While some participants clearly stated that they did not use prescribed medicine or attend public clinics – *"I do not use the professional treatment from the clinic"* – others indicated that these alternatives were their first line of treatment, and only when they failed would they consider seeking medical assistance. As one participant explained, *"After taking those Paracetamols ... if I feel worse then I go out."*

Theme 4: Stigma, shame and masculinity burdens

Another strong theme was that clinic attendance conflicted with cultural norms of masculinity. Seeking medical help was seen as an admission of weakness, undermining men's expected role as resilient providers. One participant explained: *"We also think that we are strong, we do not want to be seen to be weak… if you go to a clinic… it's like you are weak."* The phrase *"Indoda ayikhali" (a man does not cry)* was often invoked to justify endurance rather than seeking care. Clinics were also associated with HIV treatment, fuelling fears of stigma and shame: *"...men are ashamed… waiting for ARV, ashamed of being seen that I'm sick."* For others, fear of being diagnosed with STIs further discouraged them from seeking care: *"Many Black men are afraid to go to the clinic… We are afraid to discover the venereal diseases… so we go when it is too late."* Clinic environments further reinforced this stigma, as participants felt exposed in crowded waiting rooms. Lack of confidentiality, especially around sexual health, intensified feelings of vulnerability: *"…all eyes are on you… everyone is listening… especially when you go to seek help for sexually related things."* These accounts highlight how gendered expectations of toughness intersect with stigma around HIV and sexual health, leading to delayed engagement with PHC facilities.

Theme 5: Privacy, gender of providers, and mistrust of public primary health care

Finally, concerns about privacy, confidentiality, professionalism, and provider demographics discourage participants from engaging with their local public clinics. Several participants reported instances where staff openly announced patients' conditions in public spaces: *"...they are going to just speak carelessly about your condition ... those who are suffering from such and such a condition, you may come. To avoid such things... men do not go to the clinic more frequently."* Participants described experiences and perceptions that clinics are not safe spaces for men to disclose sensitive health issues. The lack of discretion and the fear of public exposure created a strong sense of mistrust toward the system. As one participant explained, *"They will ask you some few questions there, so, everyone is listening. So, I think the issue of privacy is a concern."* This highlights their discomfort of being questioned about their health issues in front of others.

Beyond confidentiality concerns, the gender and age of health care providers emerged as an additional deterrent. Men reported discomfort when discussing intimate or sensitive health issues with younger female providers. As one participant explained: *"They have to be attended by a young nurse, or a young doctor, ... I can't be telling my daughter what my problem is."* These narratives suggest that Black men's reluctance to seek care is not only about individual attitudes but also rooted in **institutional practices and gendered dynamics within PHC settings**. Breaches of privacy, perceived lack of professionalism, and discomfort with female or younger providers reinforce the belief that clinics are not male-friendly spaces. Such experiences deepen mistrust and contribute to men's late entry into the public PHC system.

Discussion

This study explored the reasons behind Black men's late entry into public PHC facilities in South Africa, revealing five interrelated themes that shape their HSBs: (1) individual choices and the normalisation of ignoring symptoms, (2) reliance on self-medication and delayed care-seeking, (3) preference for traditional remedies and over-the-counter medication, (4) stigma, shame and masculinity burdens, and (5) privacy, gender of providers, and mistrust of public PHC facilities. Collectively, these findings illustrate how structural, cultural, and interpersonal factors intersect to discourage early engagement with health care services, often resulting in delayed treatment and chronic burdens.

Participants’ accounts revealed a widespread tendency to monitor symptoms at home, delay medical assistance, and “wait it out.” They often perceive illness as a temporary inconvenience rather than an urgent threat to their health. The belief that the body can “fight off” minor ailments reflects cultural norms of self-reliance and toughness, consistent with masculine ideals that discourage vulnerability (Mathewson, 2009; cited in Lubega et al., 2015:050). Another aspect cited by participants as being responsible for driving and reinforcing such cultural attitudes is the roles that Black men assume as heads and providers to their families. Hence, some chose to ignore their symptoms of ill-health to continue with their daily work activities (Eley et al., 2019). For them, taking time off from work may result in them losing their jobs. Similar findings were also reported in the study by Nyalela et al. (2018). This form of behaviour explains why most men often present with severe medical conditions, including chronic diseases, when they visit their public PHC facilities for the first time for treatment, and has significant implications for conditions such as HIV, TB, hypertension, and diabetes, where early detection is crucial.

Closely linked to delayed care was the widespread reliance on self-medication and home-based remedies. Over-the-counter drugs such as Paracetamol or Panado, as well as herbal remedies like Lengana, were frequently used before formal care was considered. The high levels of self-medication in this study are due to accessibility, affordability, and cultural familiarity. While some self-care practices may be harmless, the reliance on these remedies as substitutes for clinical care contributes to late diagnoses and complications. The results of this study are consistent with findings by Chikafu et al. (2022), who reported that men in rural KZN often rely on traditional healers and home-based herbal remedies for conditions such as hypertension. Chavalala et al. (2025) similarly found that men in Limpopo avoided public facilities by consulting peers, elders, and traditional healers, often due to mistrust of public health workers and the perception that Western medicine was less effective than traditional herbs.

The data also revealed how masculinity norms, particularly ideals of strength, resilience, and the avoidance of weakness, shape men’s reluctance to seek care. The phrase “*indoda ayikhali”* (a man does not cry) underscores how cultural narratives value endurance over seeking help. These findings imply that men delay HIV testing and treatment due to stigma and perceptions that clinics are feminised. In the present study, men described shame not only around HIV but also around sexual health consultations, reinforcing the idea that help-seeking compromises masculine identity. Chavalala et al. (2025) similarly reported that men in Limpopo avoided clinics due to fears of being judged, blamed, or perceived as weak.

Concerns around confidentiality, breaches of privacy, and discomfort with younger or female providers further discouraged men from attending PHC facilities. Men described being reluctant to disclose intimate conditions to health workers whom they perceived as unprofessional or too young. This echoes studies highlighting how perceptions of disrespect and lack of confidentiality undermine trust in PHC in South Africa (). Comparable findings were reported by Chavalala et al. (2025), who noted that many men avoided seeking sexual health care because they felt embarrassed to have their private parts examined by young female nurses, which in turn reinforced their avoidance of clinics until conditions became critical.

The findings illustrate that delayed health-seeking is not simply a matter of personal choice. Rather, it is shaped by intersecting pressures: economic demands that discourage taking time off from work, cultural norms that reward endurance, stigma surrounding illness, and systemic weaknesses in PHC delivery. This explains why men often only present to public PHC facilities when their conditions have reached a chronic or severe stage. By situating men’s decisions within these structural and cultural contexts, the study challenges the narrative that Black men’s poor HSB is solely an issue of “irresponsibility” or “negligence.”

For Black men in particular, these dynamics create a sense that clinics are not male-friendly spaces, reinforcing avoidance until illness becomes critical. For many Black men, the local public clinic becomes a place of last resort, visited only when all other options have failed, their conditions have deteriorated, and their lives are at risk. The severity of symptoms has also served as a strong motivator for Black men to seek medical help. It is, however, evident that in most cases, the decision to seek care is prompted not by personal choice but by the influence of significant others such as family members, friends, or co-workers. Makgopa et al. (2022) also agree that family members and co-workers play a significant role in supporting and encouraging men to seek health care when they are sick. In some instances, their first formal diagnosis of chronic conditions such as hypertension, diabetes, or high cholesterol is made on their first visit to their local public clinics. This pattern is evident among both men who have consistently avoided health care altogether and those who initially relied on private health care providers, over-the-counter medication, traditional healing practices, or herbal remedies (Makgopa et al., 2022; Chavalala et al., 2025). What unites these groups is their delayed engagement with the public primary HCS.

Implications

The results highlight the need for multifaceted interventions. At the cultural level, health promotion campaigns must reframe early health-seeking as a responsible and masculine act rather than a sign of weakness. At the systemic level, PHC facilities must strengthen privacy, confidentiality, and male-friendly services, while also building trust between providers and male patients. At the policy level, workplace protections and employer-supported health initiatives could reduce the economic disincentives that prevent men from taking time off for medical care. Together, such measures could shift patterns of late entry into PHC, improving early detection and reducing the chronic burden of disease.

Conclusion

This study has shown that Black men’s late entry into public PHC is shaped by a complex interplay of individual, cultural, and systemic factors. Thematic analysis revealed how the normalisation of ignoring symptoms, reliance on self-medication, preference for traditional remedies, and stigma associated with seeking formal care all delay engagement with health services. Structural barriers within the public PHC system, such as breaches of privacy, gender dynamics with younger or female providers, and a lack of male-friendly programmes, further reinforce avoidance until illnesses progress to chronic or severe stages. Consistent with Makgopa et al. (2022), who found that male TB patients delayed care due to denial, misattributing symptoms, and fear of stigma, this study demonstrates that men’s late engagement with PHC is not simply a matter of individual negligence but reflects the way illness threatens masculine identity and social standing.

These findings underscore that men's HSBs cannot be understood as merely personal choices. Instead, they reflect broader economic pressures, social expectations of masculinity, and institutional shortcomings within the health system. The result is a cycle where men only enter public PHC when conditions are advanced, increasing the burden of chronic disease and undermining opportunities for prevention and early treatment. Ultimately, reducing the chronic burden of disease among Black men in South Africa will require both systemic reform and cultural change. By creating a primary HCS that is accessible, respectful, and responsive to men's needs, it is possible to shift the current pattern of late entry toward one of earlier, preventative engagement, improving health outcomes for men and strengthening the health system as a whole.

Recommendations

This study highlights the urgent need for male-friendly PHC services that strengthen privacy, confidentiality, and respectful engagement while reframing early help-seeking as a responsible and empowering act. Health promotion should directly challenge harmful masculinity norms, and workplace policies must address economic barriers by supporting flexibility for medical consultations. Preventative health programmes, including routine screening for chronic conditions, should be integrated into PHC, alongside collaboration with traditional health practitioners to encourage timely referrals. Future research should explore men's perceptions of preventative care, the impact of workplace pressures on delayed health-seeking and innovative models for integrating traditional and biomedical care to improve early engagement.

REFERENCES

1. Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes, 50*(2), 179–211. https://doi.org/10.1016/0749-5978(91)90020-T

2. Arifin, S. R. M. (2018). Ethical considerations in qualitative study. *International Journal of Care Scholars, 1*(2), 30–33. https://doi.org/10.31436/ijcs.v1i2.82

3. Asiamah, N., Mensah, H., & Oteng-Abayie, E. F. (2017). General, target, and accessible population: Demystifying the concepts for effective sampling. *The Qualitative Report, 22*(6), 1607–1621. https://doi.org/10.46743/2160-3715/2017.2674

4. Babbie, E. R. (2007). *The practice of social research*. Wadsworth.

5. Berg, B. L. (2004). *Qualitative research methods for the social sciences*. Wadsworth.

6. Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research, 4*, 1–8. https://doi.org/10.1177/2333393617742282

7. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

8. Burger, R., & Christian, C. (2018). Access to health care in post-apartheid South Africa: Availability, affordability, acceptability. *Health Economics, Policy and Law*, 1–13. https://doi.org/10.1017/S1744133118000300

9. Chavalala, L., Lebese, T. R., & Makhado, L. (2025). Men’s views on factors contributing to their poor health-seeking behaviour in Limpopo Province, South Africa. *BMC Public Health, 25*, 83. https://doi.org/10.1186/s12889-025-21283-9

10. Chikafu, H., Mutero, I. T., & Chimbari, M. J. (2022). “If I were to suffer a stroke right now, the first place that I should be taken to is the traditional healer”: Community beliefs and health-seeking practices for noncommunicable diseases in rural KwaZulu-Natal, South Africa. *The Qualitative Report, 27*(1), 243–256. https://doi.org/10.46743/2160-3715/2022.5229

11. Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: Historical roots of current public

health challenges. *The Lancet, 374*(9692), 817–834. https://doi.org/10.1016/S0140-6736(09)60951-X

12. Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE Open, 4*(1), 1–10. https://doi.org/10.1177/2158244014522633

13. Eley, N. T., Namey, E., McKenna, K., Johnson, A. C., & Guest, G. (2019). Beyond the individual: Social and cultural influences on the health-seeking behaviors of African American men. *American Journal of Men's Health, 13*(1), 1–11. https://doi.org/10.1177/1557988319829953

14. Lester, J. N., Cho, Y., & Lochmiller, C. R. (2020). Learning to do qualitative data analysis: A starting point. *Human Resource Development Review, 19*(1), 94–106. https://doi.org/10.1177/1534484320903890

15. Lubega, G. N., Musinguzi, B., Omiel, P., & Tumuhe, J. L. (2015). Determinants of health-seeking behaviour among men in Luwero district. *Journal of Education Research and Behavioral Sciences, 4*(2), 37–54.

16. Maguire, M., & Delahunt, B. (2017). Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. *All Ireland Journal of Teaching and Learning in Higher Education, 8*(3), 3351–33514. http://ojs.aishe.org/index.php/aishe-j/article/view/335

17. Makgopa, S., Cele, L. P., & Mokgatle, M. M. (2022). Pre-diagnosis health seeking behaviour and experiences post-diagnosis, among men diagnosed with tuberculosis in a district of Gauteng Metropolitan City, South Africa: In-depth interviews. *International Journal of Environmental Research and Public Health, 19*, 13635. https://doi.org/10.3390/ijerph192013635

18. Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods, 16*(1), 1–13. https://doi.org/10.1177/1609406917733847

19. Nyalela, M., Dlungwane, T., Taylor, M., & Nkwanyana, N. (2018). Health seeking and sexual behaviour of men presenting with sexually transmitted infections in two primary health care clinics in Durban. *South African Journal of Infectious Diseases, 33*(5), 1–6. https://doi.org/10.1080/23120053.2018.1520480
20. Polit, D. F., & Beck, C. T. (2017). *Nursing research: Generating and assessing evidence for nursing practice* (10th ed.). Wolters Kluwer.