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"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

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Abstract

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The burden of chronic noncommunicable diseases in rural South Africa is exacerbated by delayed health-seeking. This study explored awareness, beliefs and health-seeking behaviour relating to diabetes, hypertension and cardiovascular diseases in Ingwavuma, a poor rural community in the uMkhanyakude district of KwaZulu-Natal, South Africa. Eight gender and age-stratified Focus Group Discussions (FGD) were conducted in isiZulu using a pre-tested FGD guide with seventy-six participants. Thematic analysis was done to discern views on access to care for noncommunicable diseases. Findings revealed limited awareness of hypertension, diabetes, and cardiovascular-related disease burden. The community practices medical plurality, and consultation with traditional healers precedes biomedical care for acute illness with symptoms like metabolic syndrome and cardiovascular diseases. Males prefer self-care and herbal remedies, probably due to cultural and masculinity expectations. Furthermore, distant health facilities and transport costs hinder biomedical care utilisation. Our study revealed the nuanced interaction of cultural and socioeconomic factors on chronic noncommunicable disease perception and health-seeking practices in Ingwavuma. The study indicates the need for improving access to primary healthcare facilities and community-based health promotion in partnership with community stakeholders to improve awareness and health-seeking behaviour.

Keywords

cardiovascular diseases, diabetes, disease burden, health beliefs, health perceptions, hypertension, rural KwaZulu-Natal, medical plurality, noncommunicable diseases uMkhanyakude, South Africa, traditional and herbal medicine

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"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

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The burden of chronic noncommunicable diseases in rural South Africa is exacerbated by delayed health-seeking. This study explored awareness, beliefs and health-seeking behaviour relating to diabetes, hypertension and cardiovascular diseases in Ingwavuma, a poor rural community in the uMkhanyakude district of KwaZulu-Natal, South Africa. Eight gender and age-stratified Focus Group Discussions (FGD) were conducted in isiZulu using a pre-tested FGD guide with seventy-six participants. Thematic analysis was done to discern views on access to care for noncommunicable diseases. Findings revealed limited awareness of hypertension, diabetes, and cardiovascular-related disease burden. The community practices medical plurality, and consultation with traditional healers precedes biomedical care for acute illness with symptoms like metabolic syndrome and cardiovascular diseases. Males prefer self-care and herbal remedies, probably due to cultural and masculinity expectations. Furthermore, distant health facilities and transport costs hinder biomedical care utilisation. Our study revealed the nuanced interaction of cultural and socioeconomic factors on chronic noncommunicable disease perception and health-seeking practices in Ingwavuma. The study indicates the need for improving access to primary healthcare facilities and community-based health promotion in partnership with community stakeholders to improve awareness and health-seeking behaviour.

Keywords: cardiovascular diseases, diabetes, disease burden, health beliefs, health perceptions, hypertension, rural KwaZulu-Natal, medical plurality, noncommunicable diseases, uMkhanyakude, South Africa, traditional and herbal medicine

Introduction

In South Africa, as in most developing countries, communicable diseases are prioritised over noncommunicable diseases resulting in a pro-communicable disease District Health System. However, the prevalence of noncommunicable diseases in rural South Africa has increased considerably over time, causing notable disability and premature mortality (Maredza et al., 2015; Pillay-van Wyk et al., 2016). Diabetes, hypertensive diseases and cardiovascular diseases are the leading contributors to the noncommunicable disease burden in South Africa (StatsSA, 2020). Yet, most deaths and disability from these diseases are preventable through lifestyle modification, early detection and management of risk factors, and timely medical attention to cardiovascular events (WHO & Canada, 2005).

Multiple and interrelated demand and supply-side factors influence the utilisation of healthcare services (Levesque et al., 2013; McIntyre et al., 2009). Availability and cost of care, demographic, economic and sociocultural factors, among others, have been conceptualised as influencing health-seeking behaviour in several frameworks, including the health belief model (Becker, 1974) the "five As" framework (Penchansky & Thomas, 1981) and Andersen's behavioural model of health care utilisation (Andersen, 1968, 1995; Anderson et al., 2014). Healthcare utilisation is also related to individuals' ability to recognise the need for care which may be influenced by the level of empowerment or health literacy (Levesque et al., 2013; McIntyre et al., 2009; Nutbeam, 2000). Despite being empowered, a patient's health-seeking behaviour may be confounded by cultural perceptions of illness and its management (Andersen et al., 2014; Penchansky & Thomas, 1981), resulting in variation between self-perceived and observed morbidity (Murray & Chen, 1992).

Poor service delivery, distant health facilities and transport costs have been cited as barriers to health-seeking in most rural South Africa (Chimbindi et al., 2015; Goudge et al., 2009; Tanser et al., 2006). Furthermore, cultural perspectives on morbidity also influence health-seeking behaviour and are crucial in health policy formulation (McIntyre et al., 2009). Although sociocultural influences are ubiquitous and affect the acceptability of care (Levesque et al., 2013), there is a paucity of studies probing health beliefs and perceptions and their influence on health-seeking behaviour relating to noncommunicable diseases in rural areas where cultural practices may favour herbal and traditional medicine remedies over biomedical health services. As such, evidence from narrative studies is imperative for public health policymakers to develop responsive healthcare strategies for regions where entrenched cultural practices influence health-seeking behaviour. This paper explores awareness, beliefs, and health-seeking behaviour relating to diabetes, hypertension, and cardiovascular diseases in Ingwavuma, a poor rural community in uMkhanyakude district, KwaZulu-Natal, South Africa.

Backgrounds and Roles of Researchers

The researchers have conducted multidisciplinary research in the Ingwavuma community. This study is part of the first authors' doctoral work investigating the burden of cardiovascular diseases in the study area. The second author (ITM) is currently a postdoctoral research fellow conducting community engagement research in the study area. The third author, the supervisor to the co-authors, has conducted research in the study area for almost ten years and is a Professor of Public Health. The researchers sought to understand perceptions and practices following results from the first authors' research indicating suboptimal screening, diagnosis, treatment and control of hypertension in the study area (Chikafu & Chimbari, 2021). Most evidence on disease burden is derived from quantitative studies. In this study, authors seek to provide policymakers with the community's lived experiences for consideration in developing culturally responsive public health interventions.

Methods

Setting

We conducted this study in three adjoining administrative wards (wards 13, 15, and 17) in the Ingwavuma area, a rural community under Jozini Local Municipality in uMkhanyakude district Municipality of KwaZulu-Natal, South Africa. The Ingwavuma community is located along South Africa's border with Eswatini and Mozambique, is semiarid and inhabited by IsiZulu speaking people under traditional leadership. There is low attainment of formal education among the adult population, widespread unemployment, high levels of deprivation,

and inadequate provision of essential services (Chikafu & Chimbari, 2020; Nell et al., 2015). Rural communities in the uMkhanyakude district practice disjointed medical plurality utilising allopathic, religious, and traditional health systems. Herbalists and traditional healers are highly regarded in the Ingwavuma community and are widely consulted. In Ingwavuma, biomedical healthcare is provided through a network of primary clinics within a sixty-kilometre radius of the regional referral district hospital supplemented by monthly mobile clinics and resident community health workers (CHW). Despite waiver of user fees in primary health centres, distant facilities and transport costs hinder healthcare utilisation in rural KwaZulu-Natal (Chimbindi et al., 2015; Tanser et al., 2006).

Study Design and Instrument

We conducted Focus Group Discussions (FGD) for this qualitative study. The focus group discussions were ideal for gaining deeper, more meaningful insights into our participants: how they behave, their views and what factors motivate their actions. We used a pre-tested discussion guide with three sections. The discussion guide was tested on gender and age-stratified groups in a village adjoining the study area. Section one of the FGD guide aimed to assess awareness of noncommunicable disease burden, particularly hypertension, diabetes, and cardiovascular diseases. For this, participants were asked to make a free list of common and dreaded noncommunicable diseases. Section two probed beliefs and perceptions of diabetes, hypertension, and cardiovascular diseases. Section three probed health-seeking behaviour and experiences relating to diabetes, hypertension, and cardiovascular disease.

Ethical Considerations

This study was approved by the University of KwaZulu-Natal Biomedical Research Ethics Committee (BREC/00000235/2019). Focus group participants provided informed consent and were encouraged to maintain the confidentiality of discussions. Participants were identified by numbers during discussions for anonymity.

Participants

Adult participants (at least eighteen years old) were randomly selected from a list of four hundred long-term resident villagers who had participated in a household survey we conducted before the FGDs. Only one person per household could participate in the discussion, and there were no incentives for participation. Seventy-six discussants comprising forty-one females and thirty-five males aged between eighteen and seventy-six years participated in eight FGDs (Table 1). Two thirds (65.8 %) were in a marital union, a third (35.5 %) had no formal education, and almost half (46.1 %) had attained primary level education.

Table 1
Characteristics of Focus Group Discussants

Characteristics		**Gender**		n (%)
		Female (n = 41)	Male (n = 35)	
Age group (years)	18 – 40	19	16	35 (46.1 %)
	40+	22	19	41 (53.9 %)
Marital status	Single	6	10	16 (21.1 %)
	In union	29	21	50 (65.8 %)
	Separated	2	1	3 (3.9 %)
	Widowed	4	3	7 (9.2 %)
Formal education level	None	16	11	27 (35.5 %)
	Primary	19	16	35 (46.1 %)
	Secondary	6	8	14 (18.4 %)

Data Collection

We conducted eight FGDs, two each in four villages, excluding the pilot-test village. All FGDs were conducted in settings familiar with participants in their communities (homesteads, classrooms, community halls, primary healthcare centres) at times agreed to by participants to avoid disrupting livelihood activities. Focus group discussions were stratified by age (18-40 and 40+ years) and sex to balance group dynamics and promote robust participation (Krueger, 2014) considering regional cultural norms. Among other aspects, kinship in rural communities limits public discussion of reproductive anatomy, sex and sexuality between gender and age groups. Furthermore, the conduct of women is restrained in the presence of males and views of the elderly are highly regarded, which limit engagement with younger participants on some matters. Age groups were determined in consultation with community leaders and health workers.

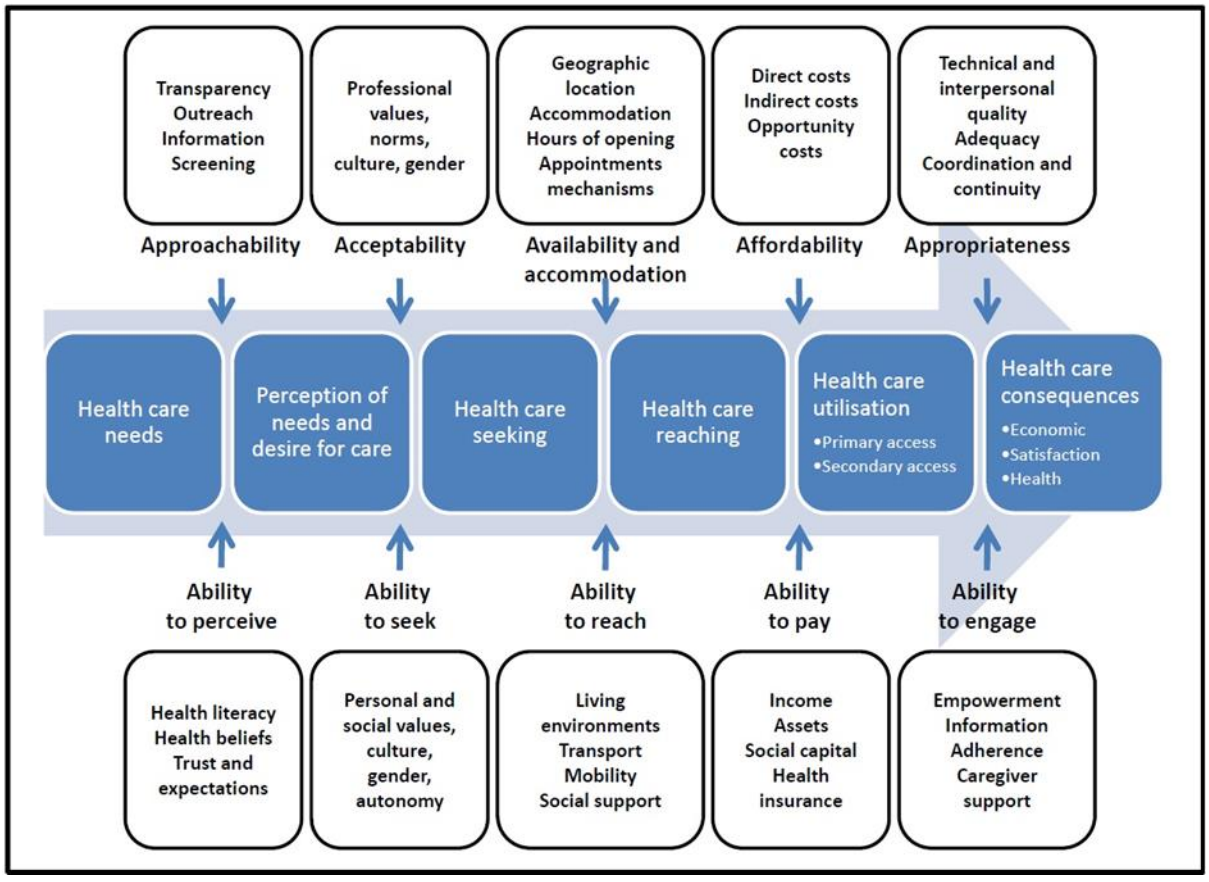
The size of the FGDs ranged between eight and twelve participants as recommended (Krueger, 2014). An experienced moderator who was part of the project research team and fluent in isiZulu, the local language, facilitated the discussions following the FGD guide. First, participants were asked to list common and dreaded diseases in their community without assistance from the research team. This was done to assess awareness of noncommunicable disease burden, particularly hypertension, diabetes, and cardiovascular diseases. Second, we probed beliefs and perceptions of diabetes, hypertension, and cardiovascular diseases. To ensure clarity and maintain focus in section two, a preamble to the discussion guide provided isiZulu terminology and general descriptions of medical conditions relevant for the discussion, including the following cardiovascular diseases: noncommunicable disease (*isifo esingathathelani*), stroke (*uhlangoti*), cardiovascular disease (*isifo senhliziyo nemithambo yegazi*), diabetes (*isifo sikashukela*), hypertension (*umfutho wegazi ophezulu or high high*), and heart attack (*isifo senhliziyo*). Third, we probed health-seeking behaviour and experiences relating to diabetes, hypertension and cardiovascular disease. The principal investigator observed the discussions and took notes on body language, gestures, and other non-verbal expressions. Proceedings were recorded using a handheld digital recorder, and meetings concluded with a brief question and answer session.

Data Analysis

The audio-recorded interviews were transcribed verbatim and translated from isiZulu to English by an isiZulu native speaker proficient in English. We used the demand side of the

Leveque access to care framework (Levesque et al., 2013) shown in Figure 1 to explore awareness, beliefs and access to care for diabetes, hypertension and cardiovascular diseases in Ingwavuma. The framework depicts the supply and demand sides of access to care, and it comprises five dimensions: approachability, acceptability, availability, affordability, and appropriateness of care. The demand side of access to care comprises of the following five abilities: (i) ability to perceive the need for care that is influenced by health awareness and cultural beliefs on illness, (ii) ability to seek care, (iii) ability to reach care, (iv) ability to pay for care, and (v) ability to engage with healthcare providers. Following Braun and Clark (2006), we applied thematic analysis to discern views relating to the five relevant abilities of access to care from coded data. The analysis entailed examining data following six key processes: immersion in the data, coding, identifying primary themes, reviewing the initial themes, defining themes, and transforming identified themes and sub-themes into a coherent narrative of findings.

Figure 1
Levesque et al. (2013), Access to Care Framework



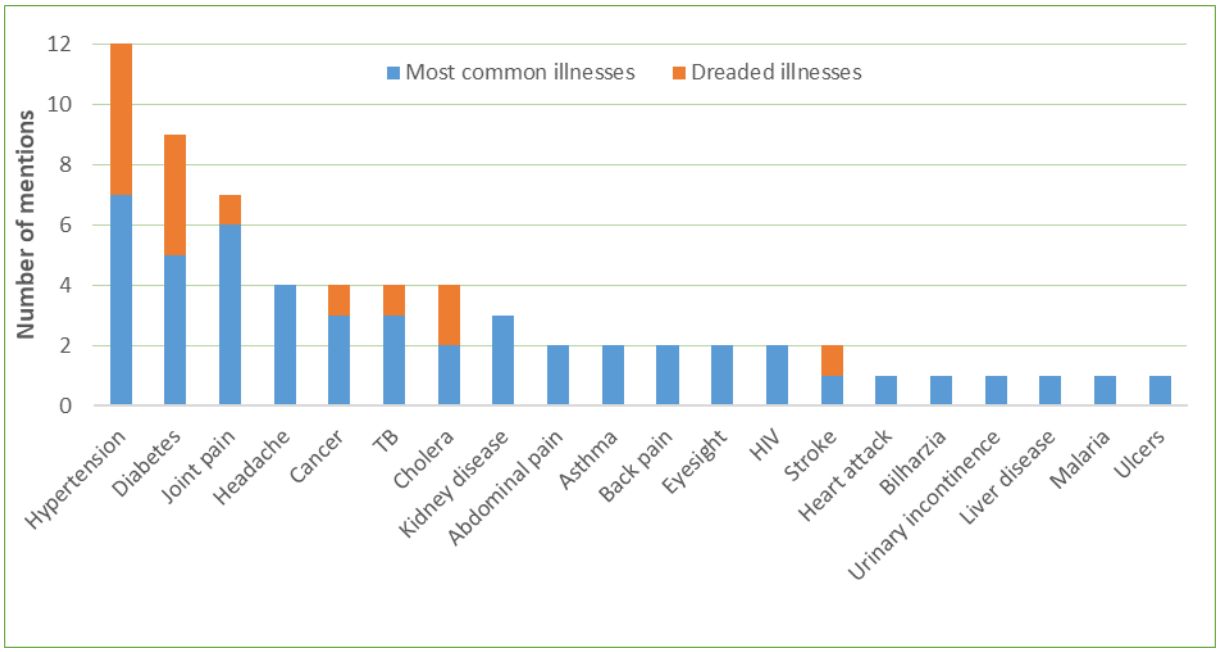
Findings

This paper explored perceptions, beliefs, and health-seeking practices related to diabetes, hypertension, and cardiovascular diseases in the Ingwavuma community. Although the participants were aware of the seriousness of chronic noncommunicable diseases, negative health beliefs and distant facilities impeded their access to health care.

Theme 1: Disease Burden and Ability to Perceive the Need for Care

Participants spontaneously listed twenty common illnesses (Figure 2) prevalent in their community, and almost the same illnesses were identified in female (18) and male (15) FGDs. Fifteen of the twenty morbidities were noncommunicable illnesses that included hypertension, diabetes, stroke, and heart attack. Hypertension and diabetes were identified among the most common illnesses in seven and five FGDs, respectively. Hypertension was listed in five groups, and diabetes in four groups as the most dreaded morbidities in the community.

Figure 2
Most Common and Dreaded Illnesses Mentioned by FGD Participants



There were contradictory views regarding treatment and cure for diabetes, hypertension, and cardiovascular diseases. Participants in seven of the eight FGDs noted that cardiovascular disease and associated risk factors could be treated in the biomedical system if patients follow treatment plans. The following are some of the quotes from the discussions: "Most diseases, including high blood pressure, can be treated at the clinic. They have medicines for most diseases there. But people have to go to the clinic while the medication can still work" (Female participant #5, FGD #2).

However, some participants expressed negative health beliefs. There was a strong belief that hypertension and diabetes were incurable in the biomedical and traditional medicine systems, potentially explaining their listing as dreaded illnesses:

> Other traditional healers and herbalists are gifted to help people; they are not using their gifts for money. They are taught while in initiation school. They then specialise in curing a particular illness, but they **cannot** heal HIV, high blood pressure and diabetes. (bold ours; Female participant #1, FGD #8)

Equally, there was an impression that diabetes is uncontrollable and fatal: "For me, the illness that I fear the most is diabetes because you **cannot** control it. With cancer, it is different. If detected early at the clinic, you can get help" (bold, ours; Female participant #9, FGD #4).

Theme 2: Ability to Seek Care

Findings show considerable demographic and gender variation in health practices in the Ingwavuma community. It emerged from both male and female FGDs that males had poor health-seeking practices. Participants reported that males often developed severe illness and that disability and mortality were higher among them because of their delay and, sometimes reluctance to seek care:

> The reason males have more illnesses than females is that males do not go to the clinic while females, on the other hand, always go to the clinic. Males find out that they have diabetes when it is too late and have to be amputated. (Female participant #1, FGD #6)

The male participants confirmed their reluctance to seek medical help:

> We are stubborn as men. As the saying goes, 'a man is the head of his household.' Nothing comes to us easy, and everything is hard. It is not easy for us to go to the clinic because you might appear very sick whilst you are not that bad. (Male Participant #3, FGD #1)

Sub-Theme 2.1: Gendered Health Perceptions

According to male participants, poor health-seeking practices emanate from their upbringing, and societal attributes of manhood and household leadership. The masculine perceptions of health implied a prolonged denial of illness as an expected quality of endurance for males: "It is because **men are strong, and women are weak**. You find that there would be mostly women at the clinic, and you can count the men there" (bold ours; Male participant #7, FGD #3).

Additionally, men's reluctance to seek medical care is partly influenced by the social constructions of male toughness: "Yes, it is true. We have this thing that if you are a man, you **must be tough**. I do not go to the clinic because that would make me seem **weak**" (bold ours; Male participant #1, FGD #7).

> Men will say that they will be OK. I can say that men are **brave.** They do not see a need to **rush** to the clinic. We grew up with that bravery in the olden days where women and children will go and hide, and men will fight the war. That is the spirit of bravery that men have. (bold ours; Male participant #11, FGD #3)

It was evident that delay in seeking care from gender influences caused financial strain on households. We noted that households incurred avoidable transport expenses when males were feeble and unable to reach care.

> Yes, we do have people who do not like going to the clinic, especially men. You find that someone is sick, but they refuse to go to the clinic. They go to the clinic when it is too late, and they can no longer walk on their own and hire a car for them. (Male participant #5, FGD #3)

Sub-Theme 2.2: Medical plurality

There is medical pluralism in the Ingwavuma community. It emerged from the discussions that the community seeks care for diabetes, hypertension and cardiovascular disease-like symptoms from faith healers, herbalists, traditional healers, and biomedical centres. Government clinics and traditional healers were listed as the major sources of care, while herbalists and Christian faith healers were seemingly second-tier sources.

> Yes, we do have prophets and traditional healers in this community. People go wherever they want to go. Going to the clinic is the person's choice. (Female participant #8, FGD #8)

> Going to the clinic is the first point. But **we don't stop** going to the traditional healers. (bold ours; Female participant #3, FGD #8)

The choice on which medical service to use is often informed by both the perceived efficacy of the service and the severity and source of illness: “It depends on the illness that you have at the time. There are illnesses that you can tell that you need to go to the clinic; some you consult a traditional healer” (Male participant #5, FGD #1).

Herbal therapy is practised in Ingwavuma through prescription from traditional medical practitioners and herbalists. There is a belief that herbal remedies offer effective relief against hypertension, as stated by a male participant (#2, FGD #5), "with high blood pressure, you get a traditional medicine called *vuka uhlale* (wake up and live), and you feel it working." Furthermore, findings suggest that self-care for hypertension management with herbal remedies is a common practice in Ingwavuma, mostly among males: “There is a traditional medicine that you can prepare yourself, and it helps bring down the high blood pressure” (Male participant #7, FGD #1).

Complementarity of allopathic and traditional medical systems was a widely discussed sub-theme in all four male FGDs. There were notable views for equivalence of the two systems: inclusion of traditional medicines in biomedical institutions and recognition of traditional healers as medical practitioners:

> We need to integrate western medicine and traditional medicine. We have been using traditional medicine from the beginning of time. If you see that there is a problem, the doctors should allow you to consult a traditional healer and not shut you down. (Male participant #2, FGD #5)

> I feel that western and traditional medicine should work together because most illnesses need traditional medicine, and some need western medicine. (Male participant #9, FGD #5)

Sub-Theme 2.3: Health-Seeking Trajectories

Health seeking permutation was the most debated subtheme in all FGDs. The dominant view was the precedence of consulting with traditional healers before seeking allopathic care for all acute and sudden illnesses. Participants argued that sudden and acute illnesses with symptoms like collapsing almost often had spiritual connotations or resulted from witchcraft. Such illnesses require cleansing by traditional healers and treatment with traditional remedies whose efficacy may be compromised by allopathic remedies: “There is an illness that could cause me to collapse on the floor. I would need to be taken to the traditional healer, who will

then diagnose me because I would think that I have been bewitched and sent evil spirits to kill me," remarked a male participant (#1, FGD #5). Although some participants did not publicly acknowledge traditional healing as the preferred source of care, consulting with traditional healers is seemingly common practice in the community: "**If we are to speak the truth**, many of us believe in going to the traditional healers. Once you have given up on the traditional healer, that is when you go to the clinic to receive help" (bold ours; Female participant #8, FGD #6).

During one FGD, the permutation contest had to be settled by a hand count, and the majority identified with the precedence of traditional healing over allopathic care. One animated participant rose, posed a rhetorical question, and boldly stated the case for pro-traditional medicine health-seeking that most attendees nodded in acknowledgement:

> I just want to ask my colleagues who are saying that you should start at the clinic. Do you think if you have been bewitched and you start at the clinic, you will get a chance to go to the traditional healer if the doctors cannot help you? If I were to suffer a stroke right now, **the first place that I should be taken to is the traditional healer.** The healer will work on you, and then they will transport you to the hospital. **If you start at the clinic and they give you medication first, you will not make it.** (bold ours; Female participant #2, FGD #6)

Theme 3: Ability to Reach Care

Accounts from almost all FGDs detailed how distant health facilities and poor socioeconomic status hinder the community from accessing biomedical care and contribute to poor treatment adherence. Most households in the study area live off social security payments, and some communities struggle to pay for transport to the clinic when too ill to use public transport or during evenings when public transport is not available. Although monthly mobile clinic services bring care to communities, some patients could not get their repeat prescription drugs due to economic constraints.

> Our clinic is very far. If I am really sick, I would have to hire a car for R250 (approximately USD 17 at an exchange rate of $1 = R15) to take me to the clinic. There is no clinic around our community. Walking to the nearest clinic takes me almost 5 hours through the woods, which is scary. If I do not have people to go with, I need to have R30 (approximately USD 2 at an average exchange rate of $1 = R15 during the study period) to take taxis (public transport) to the clinic. (Female participant #3, FGD #2)

> Some people cannot continue their medication or go to the clinic because of the long distances. Sometimes they do not have money for transport to go to the clinic for their check-up or to fetch their medication. (Female participant #7, FGD #6)

Discussion

We explored beliefs and health-seeking behaviour relating to hypertension, diabetes and cardiovascular disease in a traditional community composed of isiZulu speaking people in north-eastern KwaZulu-Natal. We found that although participants listed diabetes, hypertension and some cardiovascular diseases among dreaded diseases, there is limited

awareness of hypertension, diabetes, and cardiovascular-related disease burden in the Ingwavuma community, corroborating evidence of low awareness in sub-Saharan Africa reported in review studies (Boateng et al., 2017; Chikafu & Chimbari, 2019). Furthermore, there is a strong belief that diabetes and hypertension are incurable, explaining the community's fear of the diseases expressed during discussions.

Study findings suggest the marked influence of religious and cultural beliefs on health-seeking abilities and practices that result in a pro-traditional medicine health-seeking trajectory for acute illnesses. The medical plurality reported in this study corroborates findings from other studies indicating prevalent medical plurality for hypertension, diabetes and stroke treatment in South Africa (Frimpong & Nlooto, 2020; Lewando Hundt et al., 2004; Thorogood et al., 2007). However, the attribution of acute illness to witchcraft and superior ordering of traditional medicine in the health-seeking permutation exacerbates delays in accessing biomedical care. Therefore, community-based health promotion should be amplified in partnership with community stakeholders to improve health-seeking behaviour that prioritises biomedical care. This is important because timely detection and biomedical management of cardiovascular and metabolic disease risk factors improve health outcomes (WHO & Canada, 2005).

We also found gendered health perceptions and practices with widespread home-based herbal treatment for suspected hypertension and related symptoms. Males attributed their reluctance to seek biomedical care to Zulu culture masculinity that identifies manhood with endurance, among other attributes (Nxumalo & McHunu, 2020). Among males, masculinity and preference for consulting with traditional medical practitioners and home-based herbal self-care exacerbate delays in seeking biomedical care and result in poor outcomes. Importantly, females did not report a lack of autonomy in health-seeking decisions despite entrenched traditional practices in a patriarchal system in rural KwaZulu-Natal (Rudwick & Shange, 2009).

Financial constraints have been reported as a barrier to healthcare utilisation in uMkhanyakude district (Chimbindi et al., 2015) and other rural areas in South Africa (Goudge et al., 2009). Transport costs for healthcare are a major hinderance to accessing health care, particularly for most low-income families that rely on monthly social security payments for sustenance. The financial limitations potentially worsen delays in seeking care that initially result from sociocultural factors. Expectedly, direct healthcare costs were not reported as hindering health-seeking. Public sector clinics do not levy user fees in rural areas, and there are no private health facilities in the study area. The adverse effects of indirect healthcare costs observed in our study affirm evidence from a district level study (Chimbindi et al., 2015) that showed that the provision of free care, while necessary, is not a sufficient condition for healthcare utilisation in typical rural areas where health facilities are sparse, and incomes are low. Therefore, there is a need for long term strategies to extend the primary health network to moderate spatial limitations to healthcare utilisation.

Findings from this study indicate a need for sustainable community-wide social and health policy interventions. It is essential to strengthen community health promotion programs by empowering community health workers to ensure effective community-based health surveillance and culturally responsive information dissemination. Health promotion programs should also involve social and cultural actors to improve health-seeking trajectories, guided by regional practices and medical anthropology. Among other poor health-seeking practices reported in our study, social and cultural actors could be useful in addressing poor utilisation of biomedical health services among males linked to masculinity and strong belief in traditional remedies.

Formal education attainment positively influences health awareness and the utilisation of biomedical healthcare services (Andersen, 1995; Chikafu & Chimbari, 2020). Poor health

practices reported in our study could be attributable to low formal education attainment in the study area and uMkhanyakude district at large (Chikafu & Chimbari, 2020; Nell et al., 2015). Therefore, it may be helpful to improve formal education attainment in uMkhanyakude and other rural districts with poor school completion rates.

Our case study illuminates nuanced health-seeking practices in a poor and traditional rural community in South Africa. Although the community seemed aware of chronic noncommunicable diseases, negative health beliefs and distant facilities impede health-seeking. We noted that layered interactions of sociocultural factors confound health-seeking practices for biomedical care in the Ingwavuma community. In the context of diabetes, hypertension, and cardiovascular disease, late detection and poor management of illness increase the risk of avoidable disability and mortality. To achieve health policy goals to reduce the burden chronic noncommunicable diseases and achieve health equity, health administrators should consider complementary spatiocultural responsive health promotion strategies to reshape perceptions on health and health-seeking practices in traditional rural communities. While cultural influence on health practices is ubiquitous, the interaction between poor socioeconomic indicators and entrenched Zulu practices in the study area may limit the generalisability of our findings to other rural areas, hence the need for further studies.

References

Andersen, R. (1968). *A behavioral model of families' use of health services*. Center for Health Administration Studies, University of Chicago.

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(1), 1–10. DOI:10.2307/2137284

Andersen, R. M., Davidson, P. L., & Baumeister, S. E. (2014). Improving access to care. In G. F. Kominski (Ed.), *Changing the US health care system: Key issues in health services policy management* (pp. 33-69). Jossey-Bass.

Becker, M. H. (1974). The health belief model and sick role behavior. *Health Education Monographs, 2*(4), 409-419.

Boateng, D., Wekesah, F., Browne, J. L., Agyemang, C., Agyei-Baffour, P., de-Graft Aikins, A., Smit, H. A., Grobbee, D. E., & Klipstein-Grobusch, K. (2017). Knowledge and awareness of and perception towards cardiovascular disease risk in Sub-Saharan Africa: A systematic review. *PloS One, 12*(12), e0189264. DOI: 10.1371/journal.pone.0189264

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Chikafu, H., & Chimbari, M. J. (2019). Cardiovascular disease healthcare utilization in Sub-Saharan Africa: A scoping review. *International Journal of Environmental Research and Public Health, 16*(3), 419. DOI:10.3390/ijerph16030419

Chikafu, H., & Chimbari, M. J. (2020). Levels and correlates of physical activity in rural Ingwavuma community, uMkhanyakude District, KwaZulu-Natal, South Africa. *International Journal of Environmental Research and Public Health, 17*(18), 6739. DOI:10.3390/ijerph17186739

Chikafu, H., & Chimbari, M. J. (2021). Hypertension care cascade in the Ingwavuma rural community, uMkhanyakude District, KwaZulu-Natal province of South Africa. *PeerJ, 9*, e12372.

Chimbindi, N., Bor, J., Newell, M.-L., Tanser, F., Baltussen, R., Hontelez, J., de Vlas, S. J., Lurie, M., Pillay, D., & Bärnighausen, T. (2015). Time and money: The true costs of health care utilization for patients receiving "free" HIV/tuberculosis care and treatment in rural KwaZulu-Natal. *Journal of Acquired Immune Deficiency Syndromes, 70*(2),

e52-60. DOI:10.1097/QAI.0000000000000728

Frimpong, E., & Nlooto, M. (2020). Management of diabetes and hypertension among Tswana and Zulu traditional health practitioners: A comparative cross-sectional study using a mixed-methods approach. *African Journal of Biomedical Research*, *23*(2), 135-146.

Goudge, J., Gilson, L., Russell, S., Gumede, T., & Mills, A. (2009). Affordability, availability and acceptability barriers to health care for the chronically ill: Longitudinal case studies from South Africa. *BMC Health Services Research*, *9*(1), 75. DOI:10.1186/1472-6963-9-75

Krueger, R. A. (2014). *Focus groups: A practical guide for applied research*: Sage Publications.

Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health, 12*(1), 1-9.

Lewando Hundt, G., Stuttaford, M., & Ngoma, B. (2004). The social diagnostics of stroke-like symptoms: Healers, doctors and prophets in Agincourt, Limpopo Province, South Africa. *Journal of Biosocial Science, 36*(4), 433-443.

Maredza, M., Bertram, M. Y., & Tollman, S. M. (2015). Disease burden of stroke in rural South Africa: An estimate of incidence, mortality and disability adjusted life years. *BMC Neurology, 15*(1), 54. DOI:10.1186/s12883-015-0311-7

McIntyre, D., Thiede, M., & Birch, S. (2009). Access as a policy-relevant concept in low-and middle-income countries. *Health Econ Policy Law*, *4*(Pt 2), 179-93.

Murray, C. J., & Chen, L. C. (1992). Understanding morbidity change. *The Population and Development Review*, *18*(3), 481–503.

Nell, W., de Crom, E., Coetzee, H., & van Eeden, E. (2015). The psychosocial well-being of a "forgotten" South African community: The case of Ndumo, KwaZulu-Natal. *Journal of Psychology in Africa, 25*(3), 171-181. DOI:10.1080/14330237.2015.1065050

Nutbeam, D. (2000). Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International, 15*(3), 259-267.

Nxumalo, C. T., & McHunu, G. G. (2020). Zulu men's conceptions, understanding, and experiences of voluntary medical male circumcision in KwaZulu-Natal, South Africa. *American Journal of Mens Health, 14*(2), 1557988319892437. DOI:10.1177/1557988319892437

Penchansky, R., & Thomas, J. W. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care, 19*(2), 127-140. DOI:10.1097/00005650-198102000-00001

Pillay-van Wyk, V., Msemburi, W., Laubscher, R., Dorrington, R. E., Groenewald, P., Glass, T., Nojilana, B., Joubert, J. D., Matzopoulos, R., Prinsloo, M., Nannan, N., Gwebushe, N., Vos, T., Somdyala, N., Sithole, N., Neethling, I., Nicol, E., Rossouw, A., & Bradshaw D. (2016). Mortality trends and differentials in South Africa from 1997 to 2012: Second national burden of disease study. *Lancet Glob Health, 4*(9), e642-653. DOI:10.1016/S2214-109X(16)30113-9

Rudwick, S., & Shange, M. (2009). Hlonipha and the rural Zulu woman. *Agenda, 23*(82), 66-75. DOI:10.1080/10130950.2009.9676276

StatsSA. (2020). *Mortality and causes of death in South Africa: Findings from death notification*. Republic of South Africa. http://www.statssa.gov.za

Tanser, F., Gijsbertsen, B., & Herbst, K. (2006). Modelling and understanding primary health care accessibility and utilization in rural South Africa: An exploration using a geographical information system. *Social Science and Medicine, 63*(3), 691-705. DOI: 10.1016/j.socscimed.2006.01.015

Thorogood, M., Connor, M. D., Hundt, G. L., & Tollman, S. M. (2007). Understanding and managing hypertension in an African sub-district: A multidisciplinary approach. *Scand J Public Health Suppl, 69*, 52-59. DOI: 10.1080/14034950701355411

WHO, & Canada, P. H. A. (2005). *Preventing chronic diseases: A vital investment*. World Health Organization.

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