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In pursuit of preventive audiology: help-seeking behaviour patterns of adults with hearing impairment in a peri-urban community in South Africa

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2022

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TITLE: IN PURSUIT OF PREVENTIVE AUDIOLOGY: HELP-SEEKING BEHAVIOUR PATTERNS OF ADULTS WITH HEARING IMPAIRMENT IN A PERI-URBAN COMMUNITY IN SOUTH AFRICA.

MA (Audiology) dissertation submitted to:

The Department of Speech Pathology and Audiology

School of Human and Community Development

Faculty of Humanities

University of the Witwatersrand

In fulfilment of the requirements of the degree

Master of Arts in Audiology

by

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DECLARATION

I, Thobekile Kutloano Mtimkulu, hereby declare that this submission is my own original work and that the assistance which I have received is detailed in the Acknowledgements of this report. To the best of my knowledge and belief, this submission contains no material which has been accepted for the award of any other degree or diploma at any other university or institution of higher learning, except where due acknowledgement and reference has been made in the text. I am responsible for the study and the conclusions reached,



12 March 2022

THOBEKILE KUTLOANO MTIMKULU **Date**

DEDICATION

To my parents, for your hard work and the access to knowledge that you gave us towards our futures. Words are not enough.

ACKNOWLEDGEMENTS

To the only wise God, eternal, immortal, invisible, be honour and glory. You held my hand through this.

To Prof K. Khoza-Shangase and Mrs L. Petrocchi-Bartal, thank you for your guidance, support, and encouragement through this journey.

To my family, thank you.

To friends, my sisters and brothers who prayed and encouraged me through this process. You helped me to continue.

To the adults that participated in this study. Your honest inputs about your lived experiences have made me appreciate the journeys of adults with hearing impairment. Without you, this study would not have been possible.

LIST OF ABBREVIATIONS

EHDI	Early Hearing Detection and intervention
ENT	Ear, Nose and Throat
GP	General Practitioner
HCW	Healthcare worker
HICs	High Income Countries
HPCSA	Health Professions Council of South Africa
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
ICF	International Classification of Function
LAMI	Low-and middle income
LMICS	Low-and-middle-income countries
NHI	National Health Insurance
OTC	Over-the-counter
PHC	Primary Healthcare/Primary Health Clinic
PTA	Pure Tone Average
SDGs	Sustainable Development Goals
SEP	Socio-economic position
SLH	Speech-language and hearing services
UK	United Kingdom
WHO	World Health Organisation

WMA	World Medical Association

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ABSTRACT

Background: There is a wealth of research, globally, on the help-seeking behaviour patterns of individuals with a variety of medical conditions especially those that are chronic in nature. However, research related to help-seeking behaviour patterns with hearing impairment is limited and mostly found in high income countries (HICs).

Purpose: The main aim of this study was to investigate the help-seeking behaviour patterns of adults with hearing impairment in a peri-urban community in South Africa. Specific sub-aims included (a) describing the pattern of presentation in relation to one's culture and beliefs; (b) defining the process from onset of symptoms to accessing audiology services; and (c) examining elements in the participant's environment that acted as barriers or facilitators towards hearing health seeking behaviour adopted.

Method and Materials: A qualitative research design that was descriptive in nature was employed for this study. Semi-structured interviews using an open-ended interview guide were conducted with 23 participants selected through a non-probability purposive sampling method. A thematic analysis through a deductive approach was adopted to analyse the data.

Results: Participants' patterns of presentation indicated a belief in a Western bio-medical causation to explain their hearing impairment. First-time help-seekers sought help mostly from healthcare workers at all levels of care in the public and private healthcare sector, followed by a few participants consulting their social networks, with only one participant using a traditional health provider to resolve their hearing difficulties. The process from onset of symptoms to accessing audiology services was complex resulting in long as compared to short journeys. Socio-economic factors were the most significant barrier while structural and health system factors facilitated the help-seeking behaviours adopted.

Conclusions: This study identified the help-seeking behaviour patterns of adults with hearing impairment from their contexts. In a low-and-middle-income (LAMI) country, like South

Africa, the social determinants of health and the significant inequalities in healthcare influence where individuals seek help. These findings contribute to the dearth of literature on hearing help-seeking and can influence hearing healthcare policy, particularly in preventive audiology in South Africa. There is also a potential to facilitate more contextual relevancy in the way clinicians practise within the field of audiology by seeking to understand the perspectives of adults with hearing impairment in their environments.
Keywords: Hearing impairment, help-seeking, contextual factors, barriers, facilitators

1. INTRODUCTION

The patient journey towards seeking help for self-reported hearing complaints is characterised by marked social, emotional and communication difficulties (Mulrow et al., 1990; Knudsen et al., 2010). In adulthood, it leads to embarrassment, loneliness, stigma, prejudice, depression, difficulties in relationships, occupational stress, and relatively low earnings (Olusanya et al., 2014). The impact of the hearing impairment results in a sequence of events that combine to produce a 'push-pull' effect towards resolving those difficulties (Carson, 2005, p. 198). The signs and symptoms of an illness influence people to seek diagnosis and treatment after a process of contemplation about the symptoms in which they decide to take appropriate action according to the perceived severity of the disease (Musinguzi et al., 2018). This iterative process coupled with an inability to function determines decisions towards seeking help (Carson, 2005). In contexts, such as South Africa, where cultural, linguistic, and socio-economic diversity exist, these decisions could be influenced by a host of other factors.

A review of the current literature on help-seeking behaviours in general reveals a wealth of research for which help seeking behaviours of individuals with a variety of medical conditions, especially those that are chronic in nature such as mental illness and cancer, seek to be understood (Appiah-Poku et al., 2004; Broadbent et al., 2008; Chadda et al., 2001; Elobaid et al., 2016; Lam et al., 2008; Oliver et al., 2005; Salem et al., 2009). Contextually relevant findings have been reported in terms of alternative methods of treatment, causal attributions of the illness, diverse population studies, pathways of care, patterns of self-referral and cultural influences on decision making (Appiah-Poku et al., 2004; Broadbent et al., 2008; Chadda et al., 2001; Elobaid et al., 2016; Lam et al., 2008; Oliver et al., 2005; Salem et al., 2009). Internationally, research within ear and hearing health indicates only a limited number of publications reporting on help-seeking behaviours of individuals with

hearing impairment (Carson, 2005; Clements, 2015; Duijvestijn et al., 2003; Knudsen et al., 2010; Laplante-Levesque et al., 2012; Meyer & Hickson, 2012; Meyer et al., 2014; Saunders et al., 2012). The amount of research is sparse to draw any broad, all-inclusive findings across a variety of contexts. Furthermore, the published evidence is mostly focused on seeking to understand behaviour within specific populations such as the elderly, with findings expressing perspectives of those individuals from high-income contexts (Carson, 2005; Laplante-Levesque et al., 2012; Southall et al., 2010).

More specifically, limited evidence in hearing help-seeking research reports on various factors that influence help-seeking. These influencing factors can be grouped into audiological and non-audiological factors. Audiological factors include self-reported hearing difficulties, activity limitations and participation restrictions, whereas non-audiological factors include personal elements such as age, gender, attitudes of others and stigma (Carson, 2005; Clements, 2015; Saunders et al., 2012; Southall et al., 2010). Meyer and Hickson (2012) argue that most of the available evidence tends to focus on one factor such as social support or psychological factors (Cox et al., 2005; Duijvestijn et al., 2003), and excludes other important factors that may have a simultaneous impact on help-seeking behaviours of individuals with hearing impairment. Furthermore, any findings from external factors such as the influence of the environment tend to be limited to social support (Clement, 2015; Duijvestijn et al., 2003; Meyer et al., 2014; Wallhagen, 2009). Barriers related to hearing help-seeking have been reported to include time, money, or poor referral by general practitioners to audiologists (Laplante-Levesque et al., 2012; Meyer & Hickson., 2012). Having said that, Meyer and Hickson (2012) claim that there are a number of contextual factors influencing help-seeking, however evidence to support this claim is not strong in relation to many of the factors due to the limited publications in this area.

A review of these limited studies also reveals that investigations to understand this phenomenon have been conducted through using literature reviews (Clements, 2015; Knudsen et al., 2010; Saunders et al., 2012) rather than actual research. A variety of search engines are used with key words limited to help-seeking, adults, aging, hearing loss, acquired, delay and stigma. Even though the factors identified were related to the articles obtained, researchers failed to include keywords predictive of the influence of a diversity of contexts. In addition, most of the literature reviews provide more evidence on the decision to adopt hearing aid use. In a field where there is already a limited number of studies in relation to help-seeking behaviours, this type of methodology reduces the external validity of the findings (Magaard et al., 2007).

Nevertheless, in some studies, face-to-face interviews were conducted with participants using questionnaires. These participants had access to either public health or private health services (Carson, 2005; Duijvestijn et al., 2003; Laplante-Levesque., et al, 2012). In these studies, participants reported using their daily life experiences rather than interacting with hearing services when constructing the meaning of their help-seeking (Laplante-Levesque et al., 2012). For example, in a healthy, Dutch participant population, help-seeking was dependent on the degree of hearing complaints (Duijvestijn et al., 2003). The importance of events surrounding and influencing their help-seeking was stressed by most of the participants indicating that participants typically dealt with their hearing difficulties from their perspective. However, these findings are based on the populations studied which consist of a specific sample of participants from a high-income country, with homogenous samples in terms of linguistic and/or cultural diversity. Nevertheless, despite the researchers not investigating the effect of health services, they reportedly observed in their discussions with participants that hearing services in one context played an important role in seeking help, while in another context, these services did not play a role (Carson,

2005; Laplante-Levesque et al., 2012). Evidence from mental illness and help-seeking indicates that pathways of care play a major role in the decision to seek help (Chadda et al., 2001; Salem et al., 2009).

Based on the available literature in the area of ear and hearing help-seeking, the results indicated important findings in understanding what influences adults, even though mostly the elderly, to seek help for their hearing complaints. As Meyer and Hickson (2012) reflected on the importance of the context in understanding patterns towards decisions to seek help, contextually relevant hearing health research is limited. Within Africa, evidence in relation to prevalence and causes of hearing impairment was found to be limited by Mulwafu and colleagues (2016), which further impacts understanding of populations that have hearing difficulties. A review of the current literature indicates an even more limited knowledge of preventative audiology in relation to patterns of help-seeking behaviour within the South African context.

More specifically, Africa has the greatest language diversity in the world and most Africans speak more than one language (Burch, 2016). Embedded in the language diversity is the influence that culture plays across the continent. In African culture, a person does not exist in isolation but as a social entity connected with other agencies (social world, cosmic world, and self). This intermingling of language and culture cannot be ignored as it characterises ways of being a person in the world and furthermore gives meaning in relation to illness and subsequent behaviour (Kpanake, 2018). South Africa's health inequalities are overshadowed by a linguistically and culturally diverse country that is dominated by a single culture due to colonisation and apartheid. This single culture has influenced and still influences the lived experiences of the majority of the population (Khoza-Shangase & Mophosho, 2018). In addition, healthcare services are structured within that context

neglecting accommodation of the individual and their unique needs when interacting with the healthcare system (Khoza-Shangase & Mophosho, 2018).

Within the South African context, the speech-language and hearing services (SLH) find themselves in a country with 11 official languages, yet English is used as the main language of consultation with the majority of non-English speakers (Khoza-Shangase & Mophosho, 2018). According to Khoza-Shangase and Mophosho (2021) language and the associated culture of a language play an important and complex role in the SLH professions as the core function of the profession is to assess and treat patients with communication and hearing deficits. As a result, language barriers can significantly impact access to healthcare as most individuals with SLH disorders do not receive services in their first language. In addition, resources used for assessment and management lack in contextual relevance which further limits optimal care for those who need it. This has a negative impact on health outcomes including how persons with hearing difficulties seek help.

Furthermore, adults with hearing difficulties may delay in seeking help for their illness due to the limitations related to language, culture, and social context (Flood & Rohloff, 2018). Therefore, if language and culture are not acknowledged from the individual's perspective, the clinical practice risks being biased and ineffective as the professional uses their context and culture to understand the behaviour of the person who has hearing complaints (Flood & Rohloff, 2018). This may also further impact the help-seeking patterns of presentation of those with hearing difficulties. Hence it is also important that in conducting research, the researcher is inclusive of the social context within which they are collecting data to understand the illness and behaviour from the patient's perspective and avoid being unethical (Flood & Rohloff, 2018). This is referred to as being socially responsive and population focused which is important to make meaningful contributions to hearing health outcomes in a multi-lingual South African context (Kathard et al., 2011).

Hearing impairment is a silent and an invisible disability yet with the primary effect of impaired communication among those who experience it (Cunningham & Tucci., 2017; Mulwafu et al., 2016). Due to its mostly insidious onset and progression, it results in ongoing adaptation to the changes it brings which affects individuals recognising the problem and seeking help timeously (Carson, 2005). Admittedly, the psychosocial effects are variable due to its presentation but also due to the life experiences, particular to the individual's context, which evolve over time (Carson, 2005). In a multi-lingual and multi-cultural country like South Africa, this makes the journey towards seeking help and resolving those hearing and communication difficulties more complex. SLH service provision in the South African context is limited for many reasons. This is exacerbated by the incongruence between the SLH professionals and many of the patients, with most healthcare providers being English first language speakers. This impacts on quality healthcare delivery with communication impaired patients who seek help for their hearing difficulties and therefore influences where and how individuals seek help (Khoza-Shangase, 2020; Khoza-Shangase & Mophosho, 2018; Levin, 2006).

As highlighted above, help-seeking for apparent symptoms of an illness is a complex process (Scott & Walter, 2010) depending on the illness, the individual, family, and social context (Pryce et al., 2016), as well as depending on cultural beliefs (Musinguzi et al., 2018). Evidence from available literature indicates audiological elements as the strongest factor influencing hearing help seekers (Meyer & Hickson, 2012). Other factors within the journey have not obtained enough focus to establish enough evidence to indicate a behaviour pattern towards seeking help.

Current evidence only shows a one-sided view of the help-seeking behaviours of those with hearing difficulties; that of a Western, high income, healthcare resource rich context, where congruence exists between the language and culture of patients and the

healthcare providers (Carson, 2005; Laplante-Levesque et al., 2012). Generally, there is limited consideration of the contextual factors specific to the environment that influence the individual to seek help. In other contexts, education, access to healthcare, unemployment, culture, and other socio-economic conditions play a significant role in health-seeking behaviour (Musinguzi et al., 2018). Musinguzi and colleagues (2018) believe that such evidence can only be correctly gathered when research is conducted with individuals from their own environments and findings are based on their experiences, hence the importance of the current study within the South African context.

Ataguba et al. (2015) assess health outcomes in South Africa and conclude that health outcomes are not only affected by healthcare specifically but also by where one lives, works, their education and income status. Flood and Rohloff (2018) also argue that health outcomes are influenced by language and culture as they are salient in conceiving and implementing health initiatives. Khoza-Shangase and Mophosho (2021) contextualise this to the SLH Professions within the South African context by identifying similar challenges to the provision of equitable SLH services because of a 'single story' that creates narratives and stereotypes that are not inclusive of the context. Specific to audiology, de Andrade and Ross (2005) investigated beliefs and practices of traditional healers regarding hearing impairment within Gauteng, South Africa. The authors found that those with hearing difficulties sought help from traditional healers for cultural reasons, communication with ancestors and for spiritual healing. This indicated the influence of cultural factors in the hearing-impaired adult's health seeking patterns. Traditional healers also emphasised the importance of considering not just the linguistic group and their cultural belief regarding an illness but also the cultural beliefs common to an area where the patients live. In South Africa, these aspects account for large disparities in health and have been found to determine access to and use of healthcare services among other things (Abaerei et al., 2017; Skordis-Worrall et al., 2011).

To understand help-seeking behaviour, client-based, provider-based, socio-demographic factors, cost, and social networks all work together to produce a pattern by which individuals make decisions to seek help (Oberoi et al., 2016). In view of these complex factors that play a role in health outcomes, this current study seeks to investigate help-seeking behaviour of individuals with a hearing impairment in the North-West, South Africa.

1.1 Literature Review

1.1.1 Hearing Impairment in Adults: Causes, Detection, Identification, and Intervention

Hearing impairment has been ranked as the fifth contributing factor to the global burden of disease (The Lancet, 2016). According to the recently published World Report on Hearing, one in five people worldwide live with a hearing impairment (WHO, 2021). Low-and-middle-income countries (LMICs) carry the greatest burden of the disease, with nearly 80 percent of those living with a disabling hearing impairment residing in these countries (WHO, 2021). In South Africa, the Statistics South Africa Census (2014) reported that hearing loss is the third highest disability.

Untreated disabling hearing impairment in adults results in serious communication problems and significant levels of participation restrictions in daily activities (Cunningham & Tucci, 2017; Malgahaes & Iorio, 2011). In a study by Strawbridge et al. (2000) in which they were investigating adverse consequences of hearing impairment in older adults, they found the strongest impact of hearing impairment to be on interactions with others. It was reported that conducting normal business, such as shopping; joining in humour during conversations and participating in social activities is effortful and difficult. As a result, this leads to frustration, fatigue, and social isolation (Laplante-Levesque et al., 2012; Strawbridge et al., 2000). Despite these everyday negative consequences, Kochkin (2008) reported that only a

small proportion of people choose to seek professional help and follow up with suitable rehabilitation services (Kochkin, 2008).

Even though rehabilitation uptake is reportedly low, adult-onset hearing impairment is a chronic problem caused by noise exposure, aging, family history, ototoxic medication, and chronic diseases (Cunningham & Tucci, 2017; McMahon et al., 2013; WHO, 2021). From these aetiologies, age-related hearing impairment has been identified as the leading cause of adult-onset hearing impairment. This is due to the effects of aging on the auditory system (Cunningham & Tucci, 2017). In addition, evidence indicates that the prevalence of age-related hearing loss increases with age, particularly after the mid 50's (Dawes et al., 2014). Strong associations have also been reported between hearing impairment and cigarette smoking, diabetes mellitus and other cardiovascular diseases with causality remaining uncertain. Nevertheless, some of these associations can be modifiable through lifestyle changes, reducing the risk of hearing impairment (Cunningham & Tucci, 2017). In a United Kingdom (UK) study of hearing in middle age conducted on 40 - 69-year-old adults, Dawes et al. (2014) reported that 1 in 10 adults have substantial hearing impairment, with occupation-related exposure accounting for part of the increased risk. Nevertheless, as the risk of hearing impairment increases in many adults, early detection and management is critical to minimise longer-term effects (McMahon et al., 2013).

Ideally, detection and identification of hearing impairment through hearing screening and diagnostic audiology evaluation, should be conducted early while symptoms are mild to decrease the impact on quality of life (Johnson, 2018). According to Davis et al., (2007) persons with hearing difficulties have been reported to have a delay of about 10 years until they recognise that they have a hearing problem hence the need for early identification. A variety of screening programmes that includes involvement of general practitioners (GP), questionnaires, audiometric screens, telephone or internet-based programmes and speech-in-

noise tests have been recommended as strategies for early identification (Davis et al., 2007; McMahon et al., 2013; WHO, 2021). Yet, hearing screening is not routinely implemented in general globally and less so for asymptomatic persons (Cunningham & Tucci, 2017; McMahon et al., 2013). In a review study on the need for improved detection and management of adult-onset hearing loss in Australia, McMahon and colleagues (2013) acknowledged the lack of an effective and sustainable hearing screening strategy in the Australian public health system, despite the increasing prevalence and disease burden of hearing impairment. In this high-income country, only three in every 1000 consultations to the GP were screened for age-related hearing impairment (Schneider et al., 2010). This is despite GPs being the first point of access for health problems. For this country, GPs play a pivotal role in early detection and identification of hearing impairment before referral to audiologists.

In many LAMI countries like South Africa, hearing care services are limited or absent, which decreases the likelihood of having a detection and identification programme for the population (Louw et al., 2017). In addition, these services are not prioritised by health systems in these regions due to hearing impairment being a non-life-threatening condition, with allocation of resources to more life-threatening diseases such as human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) (Louw et al., 2017). However, the primary healthcare clinic is an ideal setting to target management of hearing impairment (WHO, 2021). A South African study by Louw and colleagues (2018) evaluated the performance of two screening programmes in which the self-report measure was administered in isolation then combined with a pure tone audiometry tool in the screening process. The researchers found the use a combined screening method had high specificity and test accuracy for identifying hearing impairment than the self-report measure in isolation, which was not sufficiently accurate for identifying hearing impairment. This

study was conducted in a primary healthcare (PHC) facility of a LAMI country where the PHC is the only direct entryway to some form of healthcare (Tanser et al., 2006). According to Louw et al. (2018), findings indicated that the combined screening method was useful particularly in resource-starved countries where hearing healthcare access is limited and therefore provided a timely referral for audiological rehabilitation. Such interventions to prevent and identify hearing impairment have been reported to be cost-effective with great benefit to individuals (WHO, 2021). The current researchers also believe that a self-report measure is cost-effective, particularly in resource constrained contexts where audiological screening services might also not be easily available; hence the importance of understanding what influences help-seeking.

For the purposes of diagnosing hearing impairment from the screening results pure tone threshold audiometry is used (ASHA, 2020). The audiologist seeks to establish the patient's hearing thresholds and to determine largely whether an individual is a candidate for hearing rehabilitation (McMahon et al., 2013). However, there have been challenges in providing efficient hearing healthcare through diagnostic assessments. These have been reportedly due to audiometry being expensive and not easily accessible to everyone who needs it (McMahon et al., 2013). In addition, Barnett et al. (2007) reported that the availability of equipment is poor, there is a high cost of the service, the health facility location may not be convenient and travel time to the specialised service is long. Some of these factors are applicable to LAMI countries, such as South Africa, where even the number of audiologists is limited and distribution of services is inequitable in a growing population (Mulwafu et al., 2017). Khoza-Shangase (2021) reports that in January 2020, there were 788 audiologists and 1 612 speech therapists and audiologists registered with the Health Professions Council of South Africa (HPCSA) to practice in South Africa: a clear demand

versus capacity challenge. Nevertheless, the appraisal of symptoms is still the primary barrier towards management of hearing impairment (Rolfe & Gardner., 2016).

Once the hearing difficulties are accepted and help is sought, quality of life benefits for adults with hearing impairment can be improved considerably through audiology rehabilitative services (Chisolm et al., 2007). This has included provision of hearing aids, cochlear implants, other assistive devices, sign language as well as educational and vocational support (WHO, 2021). A systematic review was conducted by Chisolm et al. (2007) on quality of life benefits for adults with amplification. From the a priori criteria used to select relevant studies, the review yielded 16 research papers sourced from several databases in relation to the objectives of the study. Results indicated that hearing aids reduce the psychological, social, and emotional effects of an acquired hearing impairment. A study by Lotfi et al. (2009) exploring the effects of hearing aids on quality of life using a hearing handicap questionnaire before and after hearing aid use found improvement in activities of daily living from the 207 participants involved in the study. Participants' emotional and social scores, which were high before hearing aid use, significantly decreased three months after hearings aid fitting. This illustrated the benefits of rehabilitation on mitigating the effects of hearing impairment.

However, there is evidence indicating that uptake and use of hearing aids is generally poor due to factors such as stigma, cost, acceptance, and benefit – real and/or perceived (Dawes et al., 2014; McMahon et al., 2013; Rolfe & Gardner, 2016). This has not only been reported in HICs, but WHO (2018) identified an 83 percent gap in hearing aid need and use globally. Specifically, in many LAMI settings there is a lack of availability of services for fitting and maintaining assistive devices where statistics indicate the majority of people with hearing impairment reside (WHO, 2021). In a non-experimental, descriptive study on practices and views of aural rehabilitation services among audiologists in South Africa,

Makhoba and Joseph (2016) found that service provision was overall unequal which implied that holistic and comprehensive rehabilitative services were not optimal. The reasons given by the authors included financial constraints, lack of contextually relevant resources, time and limited undergraduate level training of practitioners. Despite these findings, the target goal of aural rehabilitation is to reduce hearing loss induced deficits of activity, participation, and quality of life which evidence supports that it is achievable (Boothroyd, 2007). This is particularly important within the South African context where quality of life is impacted by several other factors, including burden of disease.

Within the South African context, according to the second National Burden of Disease Study, South Africa is facing a unique and persisting quadruple burden of disease (Pillay-van Wyk et al., 2016). This quadruple burden of disease includes human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and tuberculosis, cerebrovascular diseases, maternal and child mortality and interpersonal violence and injuries (Coovadia, 2009). Some of these conditions have been documented to have links with hearing impairment. Khoza and Ross (2002) explored the auditory function of a group of 150 adults diagnosed with HIV/AIDS in an outpatient clinic in Gauteng, South Africa. Their data analysis indicated the prevalence rate of hearing loss was around 23 percent. In addition, findings also indicated the hearing impairment occurred at any phase of the disease with varying degrees and types. Ensink and Kuper (2017) conducted a systematic literature review on the prevalence of hearing impairment among people living with HIV in LAMI countries. Four electronic databases were used to source relevant research papers, of which 21 studies were included according to their criteria. Results from this study indicated a higher prevalence of hearing impairment among people living with HIV than in HIV-uninfected controls. With regards to tuberculosis, Appana et al. (2016) profiled 52 patients infected with multi-drug resistant tuberculosis over a period of six months in a Kwazulu-

Natal, South African hospital and found the most common audiological symptom to be decreased hearing, presenting bilaterally as a high frequency hearing loss. Within the South African context, Khoza-Shangase (2010) recommended that ototoxicity monitoring should form part of HIV/AIDS management with a recommended ototoxicity monitoring protocol (Khoza-Shangase, 2020); and more recently also highlighted the need for vestibular assessment and monitoring in this population (Khoza-Shangase, 2018). These conditions exist in the context of correspondingly large inequalities in socio-economic status and access to social services between population groups, provinces, and socio-economic groupings (Ataguba & Akazili, 2010). This is referred to as social determinants of health (WHO, 2020).

Social determinants of health are conditions in which people are born, grow, live, work and age (WHO, 2020). These circumstances are shaped by the distribution of money, power, and resources at the global, national, and local levels (WHO, 2020). This distribution of resources across provinces influences patterns of health inequity especially if resources are not allocated according to these determinants of health. The deprivation index as a measure of social and material disadvantage indicates that areas with a high deprivation index will be the most deprived in terms of socioeconomics and the opposite applying to an area with low deprivation (Day & Gray, 2008; McIntyre, 2002). Therefore, these conditions and circumstances influence susceptibility to ill health as well as decisions towards seeking healthcare. In a South African study explaining the role of social determinants of health-on-health inequalities, Ataguba and colleagues (2015) found that disparities in good health favour the rich and other sectors of the country such as education and employment contribute significantly to inequality in good health. A South African cross-sectional population study on depression which sampled urban and rural participants in the Eastern Cape found that young adults and those with low or no income were less likely to seek help for their illness (Andersson et al., 2013). Yet, a study by Benova et al. (2015) on socioeconomic position

(SEP) and health-seeking behaviour in a HIC, found that those with a lower SEP were not disadvantaged by the healthcare system and all participants still received an equitable level of care when reaching a health professional. This was despite results indicating the odds of a hearing loss, which is also a chronic condition, were higher among those with a lower SEP. This points to the influence of the socio-economic characteristics of a country as diverse as South Africa and the significant impact that it makes towards managing an illness and seeking help.

Further research in hearing health shows conflicting results in relation to the influence of social determinants. Saunders and colleagues (2012) reviewed current literature related to hearing impairment and help-seeking in older adults. Without indicating how they sourced the articles, the results of their review indicated one study out of 16 showing age as a factor in influencing help for hearing impairment. However, Ramma and Sebothoma's (2017) South African based cross-sectional survey on a predominantly disadvantaged community of the Western Cape found no association between some of the social determinants such as age, gender, level of education, employment status and seeking audiology services. Despite their (2017) study being conducted in an urban area of the Western Cape; it was limited in that it was a survey and only one type of urban community was used to gather data. The different findings of the two South African studies (Anderson et al., 2013; Ramma & Sebothoma, 2017) highlight a need to investigate the influence of the social determinants of health in health studies. Even though conducted in one country, differences may be due to research context where data was collected, in terms of distribution of resources, cultural factors, availability of healthcare and knowledge about diseases. In addition, the limited research as evidenced by the literature review further supports this need. These social determinants as mentioned above, influence illness behaviour and therefore health outcomes and must be

considered in health research particularly related to the South African context and its health provision.

Mayosi and colleagues (2009) described South Africa as going through a profound health transition in terms of healthcare provision and access to health services. This transition is currently continuing in the National Health Insurance (NHI) Bill (2019) which seeks to provide access to quality affordable personal health services for all South Africans irrespective of their socio-economic status. The United Nations' Sustainable Development Goals (SDGs), specifically SDG 3 which aims to ensure good health and well-being for all supports this transition for all economies and societies (United Nations, 2022). This is primarily because healthcare is a fundamental human right and the state must take reasonable steps to achieve this basic principle. While the NHI is being implemented in phases, beginning at the primary healthcare level, which will strengthen the healthcare system and reduce the burden of disease, the goal is to achieve universal health coverage for the population (Girdwood et al., 2019; "National Health Insurance (NHI) Bill - Parliament of South Africa", 2020). Reflecting on the disparities found in access to healthcare, Gordon and colleagues (2020), noted that the NHI will address these inequalities, in as far as affordability and supply of required care so that healthcare users' needs are met. In their research paper, they also recommend the inclusion of health literacy to address barriers related to help-seeking (Gordon et al., 2020). Nonetheless, while plans to implement the NHI are afoot, the current South African healthcare context remains with significant challenges for universal access to healthcare by its citizens.

More specifically, the South African healthcare system is historically and currently divided into the private and public sector. Over 70 percent of the population is serviced in the public sector with the rest receiving medical care in the private sector (Khoza-Shangase, 2020). In addition, the healthcare professional-to-patient ratio is unfavourable in the public

sector for the number of patients that are seen, which may result in some healthcare services being limited or not available (Khoza-Shangase, 2020). This points to an incongruence of demand versus supply which poses a significant challenge on the majority of the population in accessing quality healthcare (Khoza-Shangase, 2020). In a study on early hearing detection and intervention (EHDI) at various levels of public healthcare in two provinces in South Africa, Khoza-Shangase and colleagues (2017) found a lack of implementation of the EHDI programme largely due to limited human resources, financial constraints, and lack of equipment. In addition, the authors highlighted that the South African Department of Health has prioritised focusing on life-threatening conditions such as HIV/AIDS to save lives rather than improving quality of life for conditions such as hearing impairment hence the distribution of resources is unequal for all healthcare needs. From the caregiver's perspective, Khoza-Shangase (2019) conducted a qualitative study exploring factors influencing service delivery for children with hearing impairment in South Africa. The caregivers reported challenges related to location of service, appropriate health service availability, waiting times and professionals' skills and knowledge. Although these challenges and constraints have been found specifically within hearing health, they reveal the complexities of the South African healthcare system in a socio-economically diverse context (Khoza-Shangase, 2019). Consequently, all this also impacts on the health-seeking practices of those who suffer from any ill health, including hearing impairment.

1.1.2 Health-Seeking Behaviour

Health seeking behaviour has been defined as the way in which people behave in relation to their health (Abaerei et al., 2017). Carson (2005) described it as the way that symptoms of a medical condition affect one's functioning that determines decisions towards seeking help (Carson, 2005). These decisions are viewed as a pathway, a timeline or a series of steps taken towards resolving one's hearing difficulties (Laplante-Levesque et al., 2002).

According to Scott and Walter (2010) help-seeking involves a process of symptom perception, interpretation, appraisal, and decision making with the decision making based on the ability and the motivation to visit a healthcare professional. In a variety of contexts, individual preferences will dictate whether to seek formal or informal healthcare or a combination of both (Cornally & McCarthy, 2011; Scott & Walter, 2010).

Cornally and McCarthy (2011) used a concept analysis method to define help-seeking as a complex decision-making process in which health-seekers take an intentional action to solve a problem that challenges their personal abilities. Mackian et al. (2004) support this definition by saying that help-seeking is not a once-off, life event but a social process that involves interaction with the social network. This social network involves: the help-seeker, the problem, and the helper (Nadler, 1987) in which there are relationships of power that operate to exchange social resources, including the division of the labour of care and support (Saint Arnault, 2009). A further differentiating is between the usage of the term health-seeking versus help-seeking. Health-seeking is explained as seeking health with or without a health problem whereas help-seeking is the seeker responding to an identified problem (Cornally & McCarthy, 2011). Much of the literature uses both terms interchangeably to encompass the response and management of illness behaviour by an individual, hence for the current study both terms are used interchangeably (Sirri & Grandi, 2011).

As Cornally and McCarthy (2011) state the complexity of help-seeking behaviour in their analysis, Olenja (2003) reflected on this in his editorial by stating that health-seeking is not homogenous across all contexts such that one-single method can be used to explain or establish a pattern of this concept. He argued that there is an interplay of factors that are central in the final choice of seeking help and as a result, he recommended that health-seeking behaviour be viewed from a broader socio-cultural and economic context (MacKian et al., 2004; Cauce et al., 2002).

Nevertheless, an overview of the literature on help-seeking reveals a tendency to focus on help-seeking as defined in a particular context (MacKian et al., 2004). In these particular contexts, mostly in high-income countries, studies have emphasized either the 'end point' (p 138), in other words how persons use the formal health system, or they focused on the wider process of health-seeking by looking at the perceptions of the social environment. For example, studies would report on the individual seeking to consult a medical doctor but would experience stigma and limited social support (MacKian et al., 2004; Zhao et al., 2015). Furthermore, evidence indicates that contextual factors are not broadly investigated which limits understanding of help-seeking in a multicultural country like South Africa. Magaard and colleagues (2017) conducted a literature review on factors associated with help-seeking behaviour among individuals with major depression. Through a systematic search of selected databases, only eight studies were found focusing on contextual factors. These studies, mostly from developed countries, focused only on participants living in an urban or rural area. Although literature reviews have their value in providing a better understanding of available evidence on a given topic, they may exclude other relevant findings due to the researcher's preferred search strategy and use of keywords thus only providing findings from a particular view.

Another characteristic of help-seeking research from high-income countries is that it focused exclusively on the individual as a decisive agent in their health seeking behaviour (MacKian, 2003). According to MacKian (2003) help-seeking behaviour research is conducted predominantly on the individual and their immediate environment. This view ignores the social context from which the individual resides and its influence (MacKian, 2003). Magaard and colleagues (2007) demonstrated this gap in that studies retrieved investigated more individual than contextual factors. In a culturally diverse country such as South Africa, health seeking behaviour can be better understood from the social and cultural

realities of the individual as well as the influence of the healthcare structure (MacKian et al., 2003).

Further to this, symptom interpretation may not be similar between HICs and LAMI country contexts. Ahmed and colleagues (2000) reported that in some LAMI countries, depending on the context, the symptoms of an illness may not only be identified in biomedical terms and the decision to seek help may not result in action related to 'scientific medicine'. Many more factors such as illness type and severity, pre-existing beliefs about illness causation, the range and accessibility of therapeutic options and their efficacy are involved in the decision-making process when symptoms are experienced. Therefore, when considering the marked social, emotional and communication difficulties of those with untreated disabling hearing impairment (Mulrow et al., 1990) within the context of South Africa as described it is imperative that we study individuals' behaviours towards health-seeking within their contexts.

Despite this stated importance of investigating health seeking behaviours, limited evidence comes from LAMI contexts. Most of the research on health-seeking has been conducted in HICs (Mackian et al., 2004). In addition, studies are minimal that investigate health-seeking behaviours with a chronic condition such as hearing impairment (Carson, 2005; Clement, 2015; Knudsen et al., 2010; Laplante-Levesque et al., 2012; Meyer & Hickson, 2011; Saunders et al., 2012). Meyer and Hickson (2012) reported to have only found nine out of twenty-two articles relevant to the study of help-seeking in hearing health whereas forty studies were found related to major depression, a chronic health condition, and help-seeking (Magaard et al., 2017).

More specifically, Laplante-Levesque et al. (2012) investigated help-seeking and the perspectives of 34 adults with hearing impairment. Their data was gathered from four

westernised industrialised countries with dissimilar healthcare systems through in-depth interviews with a variety of participants recruited from various sources such as electronic and print media, and word-of-mouth. From analysing data through an inductive approach, they concluded that individuals with hearing impairment describe help-seeking within the context of their own lives. They further reported that most of the participants' first entry point to seeking help was a general medical practitioner.

Despite these countries having dissimilar healthcare systems, their economies cannot be compared to that of South Africa. South Africa is not a highly industrialised country and its healthcare system, with its unique challenges, is influenced by a myriad of socio-economic factors (Coovadia et al., 2009). In addition, the pathway of the medical practitioner being the first contact is exclusive to those countries which influences how those with hearing impairment seek help within those industrialised contexts. The authors also highlighted that the participants stressed the importance of the events surrounding and influencing help-seeking, yet they did not explore this further. This might have provided a richer understanding related to contextual differences in the four countries. Nevertheless, similar conclusions from these studies in reference to help-seeking with regards to a LAMI country like South African cannot be drawn (Carson, 2005; Laplante-Levesque et al., 2012).

Nevertheless, all the authors (Clements, 2015; Laplante-Levesque et al., 2012; Saunders et al., 2012) argued that the decision to seek help is strongly influenced by factors independent of a specific condition. While this may be true, there is no evidence of the individual's context or setting having been investigated to contribute to the body of knowledge regarding hearing help-seeking. In addition, the method used to access the information required has not enabled the researchers to study the phenomenon closely and therefore provide context-specific conclusions.

One study by Ramma and Sebothoma (2017) conducted in Cape Town, South Africa investigated factors associated with a higher likelihood of seeking audiology services. Participants were sourced using random cluster sampling from a predominantly historically disadvantaged community. Audiometric thresholds were obtained together with a pre-set questionnaire to gather relevant data. Results indicated self-perceived hearing impairment as the only factor that influences help-seeking. Personal factors such as age and gender were not associated with a likelihood of seeking hearing help. Ramma and Sebothoma's (2017) article, though placed within the South African context, is limited in its application. Firstly, participants were selected from one community, through a random sampling. This limits the possibility of selecting a variety of participants with maximum variation from which to draw conclusions about the effect of hearing impairment on individuals. Secondly, in this study participants were not required to have a hearing impairment which could have yielded more information to explain this phenomenon. More importantly, the researchers did not investigate the contextual factors leading to individuals possibly seeking help.

The above-mentioned research articles (Carson, 2005; Clements, 2015; Laplante-Levesque et al, 2012; Saunders et al., 2012) highlight the lack of research conducted widely and in diverse contexts in which health-seeking behaviours can be fully understood. Ramma and Sebothoma's (2017) study indicates the need to conduct more contextually relevant studies on hearing help-seeking.

1.1.3 Help-Seeking Behaviour and Culture

To understand the influence of the context within which help-seeking occurs, culture must also be considered. This is because context and culture are intertwined and to a large extent culture develops because of specific contextual demands (Cauce et al., 2002). Cauce and colleagues (2002) state that culture is one of the contexts that people emerge from and

that a context is made up of cultural dimensions. The world health body's (WHO, 2001) proposed International Classification of Functioning, Disability and Health Framework (ICF) acknowledges the role of culture in health and illness by encouraging those working with any illness to consider the impact of personal and environmental factors (Hickson & Scarinci, 2007; Zhao et al., 2015). Furthermore, the health organisation says that to measure and describe health and disability comprehensively, illness must be viewed as a combination of the health impairment and the contextual factors which includes cultural components (WHO, 2001).

Culture refers to socially shared concepts, attitudes, beliefs, principles, and practices which influences peoples' worldview in terms of their choice selections and subsequent actions (Smith et al., 2006). In relation to ill health, the cultural meanings of an illness have real consequences for motivation to seek treatment, coping with symptoms, family, and community support, seeking help, pathways to access services and the effect of treatment (*Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General.,* 2001). For example, symptoms of an illness that warrant help-seeking will not be experienced, understood, and communicated in the same way across all cultural groups (Saint Arnault, 2009). In one culture, symptoms are more acceptable whereas in another culture they must be avoided or not expressed. The perception and recognition of the 'problem' as seen in some cultures and its interpretation within the cultural norms informs how the seeker deals with the 'problem' and this may not always be through medical intervention (Cauce et al., 2002; Saint Arnault & Woo, 2018). Pillay and Serooe (2019) state that within any context, it is important to consider the spiritual, traditional, and religious beliefs of the help-seeker as in some contexts, individuals hold to more than one belief to explain ill health (Naik et al., 2012).

To illustrate the above point, Legg and Penn (2012) conducted a study on cultural interpretations in aphasia in a group of five adults through participant observations and interviews in a township community outside of Cape Town, South Africa. Families and healthcare workers were also part of the study as data was collected in homes, clinics, and day care centres. The results revealed that causation was an important factor to explain aphasia as participants sought to understand the illness from multiple realities that were linked to their cultural frameworks. In this case, aphasia was experienced from a socio-cultural context through associating it with ancestral reprisals, witchcraft and sorcery, biomedical explanations, and social causes. Similarly, Saint Arnault and Shimabukuro (2016) found that Japanese women experienced significant symptom burden to their health but did not necessarily interpret those symptoms as an indication of needing help or intervention. This was because of their cultural value of self-reliance and personal competence in the Japanese community (Saint Arnault & Roles, 2012).

These two studies (Legg & Penn, 2012; Saint Arnault & Roles, 2012) illustrate how illness interpretation and consequences are influenced by cultural norms. In both communities, the experience of illness was understood and responded to differently. As a result, this can influence or inhibit help seeking patterns.

To further illustrate the importance of investigating culture and help seeking, many research papers specifically related to the chronic condition of mental illness have studied the influence of culture on help-seeking (Hui et al., 2014; Mojaverian et al., 2012; Naik et al., 2012; Sorketti et al., 2013). These studies have indicated that there are cultural differences in help-seeking depending on where you live, your beliefs, attitudes, and perception of the illness. For example, Mojaverian and colleagues (2012) studied professional help-seeking for mental illness between Asians and Asian Americans using two structured questionnaires in Tokyo and Los Angeles. They found that the Asian participants were more reluctant to seek

help from professionals than the Asian American participants but rather preferred to seek social support among those close to them. This is not an anomaly but rather consistent with the dominant cultural model of social relationships and interactions in Asian cultural contexts (Mojaverian et al., 2012).

Therefore, even with a chronic condition such as mental illness, studies have been conducted on the role that culture plays in different countries on decisions to seek help. Patterns of presentations at first contact-whether by social support, a traditional health worker or a faith healer followed later to a Western medical professional-display the influence that culture plays in finding solutions for an illness. In addition, it is evident that culture and the process of seeking help were not linear, as seen by patients going back and forth in this process. Despite the methods used to gather data, the studies presented also appear to highlight that in some countries or communities there is a preference towards non-medical health providers notwithstanding participants were from an urban or rural area. Unfortunately, these studies reveal patterns associated with mental illness which cannot be attributed to hearing impairment.

The same research evidence in hearing help-seeking and culture is lacking. Only one study (Zhao et al., 2015) was found that explored the influence of culture on hearing help-seeking. Zhao and colleagues (2015) conducted a literature review and found that there were no studies on the cultural influences on seeking help for hearing impairment. Instead, research articles found were rather focused on investigating seeking help in relation to ageing and hearing aid uptake. As a result, this one study (Zhao et al., 2015) focused its discussion on research done on the availability of audiological services in four countries – two high income and two middle income countries - as well as cross-cultural research in other chronic conditions.

The authors found a lack of provision in terms of access and affordability in the rural areas of India and China being a hindrance to seeking help while in the westernised countries of UK and Sweden the low help-seeking was associated more with psychological factors related to the hearing impairment. In a diverse and LAMI country like South Africa where there are large income inequalities and corresponding disparities as well as where healthcare is accessed in both the private and public health sector, it cannot be confirmed that the findings above will be similar to those countries mentioned (Ataguba et al., 2015; Coovadia et al., 2009).

In reviewing available cross-cultural research on other diseases from other countries the authors found the construct of individualism versus collectivism as an important value in understanding differences in cultural orientations. Those who were influenced by individualism - giving regard to individual needs more than the group's needs had a greater chance to seek help for their health condition than those in the collectivism group. In addition, the former was more likely to assume that problems arise from a combination of the environment and personal factors whereas the latter associated their health issues to internal causes. According to the researchers, this implied that differing nations or physical locations could have distinct ways of interpreting situations related to hearing impairment. This implication does not consider that some nations, such as South Africa, may share the same cultural orientation within geographic locations - both individualism and collectivism - because of contextual and cultural influences such as the effects of racial segregation, migrant labour, destruction of family life and urbanisation (Coovadia et al., 2009). These influences could have an impact on the help seeking behaviours of adults with a hearing impairment (van der Hoeven et al., 2012).

Nevertheless, despite the researchers' efforts (Zhao et al., 2015) in highlighting the importance of cultural influences in understanding hearing help-seeking, they do not include

one African country in four countries' comparison of audiological services. In addition, in their search to investigate this concept, the methodology used is limited to a literature review on other diseases, which further limits an in-depth understanding of the phenomenon of help-seeking. Implications are also drawn for hearing impairment based on other diseases from other countries which is not suitable to the South African context.

1.1.4 Help-Seeking Behaviour Patterns of Presentation

As any disease starts to challenge personal abilities, individuals eventually decide to seek help. In so doing they present their symptoms to the social network around them in order to find solutions for their bodily dysfunction. These social networks can be formal (healthcare worker) or informal sources (family) of help (Cornally & McCarthy, 2011) depending on the individual, the disease, the context, and cultural factors (van der Hoeven et al., 2012). As a result, due to the iterative nature of help-seeking, the help sought can result in a pattern especially in countries with multiple health services, challenges in access and availability of healthcare, beliefs about the illness and differences in socio-economic characteristics like South Africa (Carson, 2005; Sorketti et al., 2013; van der Hoeven et al., 2012). Although conducted on mental illness, Sorketti and colleagues' (2013) study described the pattern of presentation in LAMI countries as different. In HICs, GPs and mental health professionals were central to seeking help whereas in LAMI countries traditional healers were predominantly the first point of contact.

Studies conducted in hearing help-seeking provide support for Sorketti and colleagues' (2013) findings. In HICs where help was sought for hearing difficulties, adults indicated mainly consulting with Ear, Nose, and throat (ENT) specialists, GPs, and audiologists as their first step towards hearing services or because of the model of hearing services delivery in that specific country (Carson, 2005; Duijvestijn et al., 2003; Laplante-

Levesque et al., 2012). These studies indicated the pattern of first contact for hearing impaired adults being a Western medical health professional. The formal source of help appeared to be directly related to those patients interviewed and their socio-economic group. Nevertheless, none of the studies investigated other possible help providers that individuals might have contacted before consulting a GP. They mentioned that participants were influenced by families to seek help, which is significant, but as MacKian et al. (2004) state, there is a tendency for studies to focus on the act of seeking healthcare as defined in a particular context. There is a need to be more sensitive to the realities of healthcare seeking behaviour in a variety of contexts, which these studies lack in doing.

Research on other diseases conducted in South Africa and other similar nations provides more information on the pattern of presentation by those seeking help **(**Nonye & Oseloka, 2009; Pirani et al., 2015; Pronyk et al., 2001; van der Hoeven et al., 2012). van der Hoeven et al. (2012) explored differences in health seeking behaviour between rural and urban communities in the North-West, South Africa using a cross-sectional research design. 206 participants were selected and underwent structured interviews in which multiple-choice and open-ended questions were asked. Results indicated that individuals from a rural community in South Africa, who mostly had a lower income, preferred to visit a public health clinic whereas those from urban communities preferred to visit a private medical doctor. According to the researchers the reason for this difference is due to the available income and the choice of accessing healthcare according to one's financial status. A health clinic offers free healthcare whereas a private doctor requires payment for services rendered. Pronyk and colleagues (2001) examined patients with tuberculosis from a rural community in South African and found that adults with tuberculosis who were from a South African rural area first presented to the public hospital then less so to the traditional healer. According to

Nonye and Oseloka (2009) Nigerian patients with mental illness, who were predominantly religious, were found to have first presented to prayer houses.

These three African studies demonstrate how the context and culture of the participants influenced where they sought help. More importantly, the pattern of presentation was not similar as compared to the Western consultations (Carson, 2005; Laplante-Levesque et al., 2012). Individuals from a rural area and some from urban areas depending on the events of their lives and the interaction with the illness would first seek help from either a public hospital, a public health clinic, prayer houses or a private medical doctor. Despite the differing results from different health condition, it cannot be assumed that similar findings will be gathered from hearing help seekers. van der Hoeven and colleagues' (2012) study is based on participant's future help-seeking behaviour, should they be ill, by using structured interviews which reduces the amount of information received from participants. Pronyk and colleagues' (2001) results may have been influenced by the delay and subsequent severity of the disease hence attending to a hospital first. Patients recall also limits how much can be remembered especially in sick hospitalised patients who delay help-seeking. Nonye and Oseloka (2009) used a cross-sectional study method which limits analysing behaviour over time (de Vos, 2002). They also conducted structured interviews which often produces quantitative data and therefore prevents delving deeper into issues related to the subject matter (DiCicco-Bloom & Crabtree, 2006). Furthermore, mental illness and tuberculosis are diseases that present differently in their signs and symptoms. For this reason, it does not appear that there is a single pattern to describe the pathway of presentation among non-auditory diseases hence research is required in hearing help-seeking in order to understand patterns of presentation particularly in the South African context.

1.1.5 Help-Seeking Behaviour Pathways to the Healthcare Provider

An in-depth understanding of help-seeking also means understanding the process the seeker undergoes from the first contact to reach the healthcare professional who provides a medical diagnosis. As help-seeking is a process, there are several steps that those who are ill take in their search for an ideal caregiver (Mkize & Uys, 2004). Mkize and Uys (2004) refer to this ongoing process as pathways which can be short or long depending on a wide range of bio-psychosocial factors including cultural background. According to Mkize and Uys (2004) this cultural background determines 'who and where to go for help' (p. 68). When considering the South African socio-economic conditions together with the influence of culture, this highlights a need to investigate the process of help-seeking within context. Yet, globally, there is a research gap in relation to, hearing help-seeking and the process of specifically reaching audiology services. However, a few studies have investigated the process of help-seeking beyond the first contact with other chronic conditions (Mkize & Uys., 2004; Moodley et al., 2016; Pati et al., 2019).

Pati and colleagues (2019) investigated help-seeking pathways in a group of 113 women with rheumatoid arthritis in a tertiary healthcare facility in India. Through using in-depth interviews, they found that participants reached health specialists after seeking care from multiple providers. The researchers were able to map the pathway that participants took to eventually reaching a rheumatologist through the principles of grounded theory. While only eight participants visited the specialist as their first contact, most of the participants sought care from a combination of untrained and trained providers before reaching the specialist. Untrained providers included indigenous care, home-based care, informal healthcare provider and over-the-counter drugs whereas trained providers included Indian alternative healthcare, allopathic providers, and community health centres. The reasons for the majority using different providers were in part due to access, availability, and

affordability of the healthcare service but mainly because of the pluralistic healthcare system. This pluralistic system consists of multiple health service delivery that includes alternative medicine with other Western medical healthcare. Evidently, the pathway to the rheumatoid specialist services was complex. While South Africa has similar challenges in its healthcare system (Coovadia et al., 2009) the process taken by the women participants in this study cannot be assumed to be similar to those in South Africa despite both countries being LAMI countries (The World Bank, 2021). In addition, this study was only focused on women from a rural area in India, who reportedly lived in a patriarchal social system. Moreover, the disease manifestation of rheumatoid arthritis -severe pain, swelling and stiffness - is different to that of hearing impairment and as a result the same pattern of help-seeking cannot be concluded (Pati et al., 2009).

Mkize and Uys (2004) explored pathways to mental healthcare among first-time admissions to a hospital in KwaZulu-Natal, South Africa. A purposive sampling of 15 patients was selected and interviewed using open-ended questions. Results indicated that pathways - described as steps or consultations - taken by the participants before reaching the mental health institution were defined as first pathways and then subsequent pathways. Individuals with a mental illness sought help primarily from the faith or traditional healer as a first pathway, then the subsequent pathway was to the primary health clinic or district hospital before being referred to the mental health institution to be seen by the mental health professional. This could also be described as a long pathway. Five participants from the study had a different pathway in that they were taken to the GP who then referred them directly to the mental health institution (short pathway). The authors reported that these five participants first went through the police before being taken to the GP. This demonstrates that the process of seeking help is not linear from the onset of symptoms to reaching the 'ideal caregiver'. Despite investigating one illness, this study demonstrates that the pattern

towards seeking help even within one province and one city was not the same. Although this research study provided more detail on contextual factors since it was conducted with a South Africa population, data collection was limited to only three weekends with participants being interviewed post discharge from the hospital instead of pre-admission which could have yielded more information without the possible influence of memory recall. In addition, the researchers could have yielded more information if they had interviewed more participants.

The above two studies based on chronic medical conditions - rheumatoid arthritis and mental illness - reveal the dynamic process and journey that individuals take in their path to seeking help for their illness. The interaction with the healthcare system and other contextual factors played an important role in determining the relevant sources of help. In a country with an inadequate healthcare capacity coupled with substantial health inequities and an uneven distribution of resources across provinces (Coovadia et al., 2009), there is a need to investigate hearing help-seeking as a process as these challenges influence where individuals seek help for their ill health and how they eventually reach the audiologist.

1.1.6 Barriers and Facilitators Towards Help-Seeking Behaviour

South Africa's health inequalities together with the disparities in the social determinants and the high burden of chronic diseases are challenges that limit adequate provision and access to healthcare (Coovadia et al., 2009; van der Hoeven et al., 2012). Those with a lower income have less money available to spend on good healthcare and therefore wait longer to consult a health provider (van der Hoeven et al., 2012). Access to the required care is difficult and services provided by a healthcare facility are not similar between public and private health services (Abaerei et al., 2017; van der Hoeven et al., 2012). Chronic diseases have a large impact on the daily lives of those affected from rural and urban communities with its effect being worse than that of any other disease (van der Hoeven et al.,

2012). As a result, all these different factors contribute towards how the individual manages their illness. Further to this, these factors can act as either barriers or facilitators towards help-seeking depending on the individual, beliefs, disease, lifestyle, and socio-economic characteristics, particularly in a diverse country like South Africa where these characteristics influence everyday life decisions (van der Hoeven et al., 2012).

A research gap in hearing help-seeking research was identified by Meyer and Hickson (2012) with a subsequent investigation into the contextual elements influencing hearing help-seeking and adoption of hearing aids were considered. They reviewed the available literature and conceptualised the factors using the ICF Framework into function and disability and contextual factors. As a result, they found only six studies that explored different factors related to hearing health-seeking and three studies that investigated both hearing health-seeking and hearing aid adoption applicable to the concept. They found the contextual influences that acted as facilitators towards help-seeking were perceived severity of hearing loss, self-reported hearing difficulties, older age, benefits outweighing the costs, and family support. The barriers were reportedly stigma and management of hearing impairment by health professionals. According to the authors, the use of the ICF framework was valuable in outlining specific contextual factors, however the articles reviewed were limited despite using a variety of search engines. Moreover, all the sourced journal articles were from high-income countries which reduced applicability to other contexts such as South Africa. It is therefore possible that there are other factors including those from a multi-lingual society in the journey towards seeking help that act as barriers or facilitators but have not been studied due to the limited research in this area.

Despite focusing on more contextual factors, Meyer and Hickson's (2012) study revealed some similarities in findings to the above two studies (Clements, 2015; Saunders et al., 2012, Ramma & Sebothoma, 2017). In addition, much of the literature reported more on

personal factors such as age, gender, attitude of others and self-reported hearing difficulties than environmental factors as either barriers or facilitators (Knudsen et al., 2010). Even so, not all studies were consistent regarding personal factors and their influence on hearing help-seeking (Carson 2005; Duijvestijn et al., 2003; Wallhagen, 2009; Southall et al., 2010). Furthermore, very little is known about the influence of environmental factors because it has been investigated less frequently than personal factors (Hickson & Scarinci, 2007).

A study on help-seeking behaviour and depression was conducted by Anderson et al. (2013) in the Eastern Cape, South Africa and it revealed useful contextual information in relation to the factors that influence help-seeking in this chronic condition. Data was collected through a translated questionnaire which was administered via semi-structured interviews with 977 participants. Random sampling was used to select participants from urban and rural areas in the Eastern Cape. Their results revealed, firstly, that living in an urban or rural area was not a barrier or a facilitator towards seeking or not seeking help. Secondly, the younger the age and the lower the level of income the less likely to seek help. Thirdly, the greater the emotional distress the more inclined to seek help. A notable finding was that having a comorbid illness of tuberculosis increased the likelihood of seeking help for depressive symptoms. In addition, those with social support were more likely to seek help than those lacking support.

Though living in an urban or a rural area did not influence patterns of seeking help in Anderson and colleagues' (2013) study van der Hoeven et al. (2012) found in their study that rural participants delayed in seeking help because of their socio-economic conditions and the belief that one had to be 'really sick' to seek help for their illness. In a country with a high chronic burden of disease, the finding that an existing chronic illness had an impact on the patterns of help-seeking was also supported by van der Hoeven and colleagues (2012). These environmental factors speak to the South African context in terms of where people are in

relation to healthcare, travelling costs, availability of the service and ease of access to the healthcare professional and therefore how to manage their illness. A combination of these factors will influence seeking help as either barriers or facilitators among those who are ill. However, there is a lack of evidence from the studies on hearing help-seeking with regards to some of the factors discussed. Anderson and colleagues' (2013) study has indicated relevant data in relation to the South African context, but it is to be noted that the findings were based on a mental health illness which presents differently to hearing impairment. The variety of other sources of help sought was not investigated as a possible barrier or facilitator and the impact of cultural beliefs was not considered in the study. Moreover, participants in the study were selected randomly and had not been clinically diagnosed with depression prior to the data collection. As Clements (2015) noted in her study, there are several different factors that influence seeking help in any disease, but limited studies exist in hearing health to understand the process that individuals take in their journey to seeking help, within the context of their lives.

In view of the above, within the South African context, and as previously mentioned, limited contextual information pertaining to hearing health seeking behaviour appears available. It is here where this current study is placed anchored within preventive care and aimed at investigating help-seeking behaviour patterns of adults with hearing impairment in a peri-urban community in South Africa.

2. RESEARCH METHODOLOGY

2.1 Aims:

The main aim of this study was to investigate help-seeking behaviour patterns of adults with hearing impairment in a peri-urban community in South Africa. The following were the sub-aims:

- To describe the pattern of presentation of symptoms in relation to cultural practices or beliefs.
- To define the process from onset of symptoms to accessing audiology services.
- To examine elements in participants' environment that act as barriers or facilitators towards hearing help-seeking behaviour adopted.

It was envisaged that patterns of help seeking are strongly associated with the patient's environment. At presentation of the symptoms, it was anticipated that patients would consult or be influenced according to their cultural practices and beliefs. The process of eventually consulting an audiologist is anticipated to be complex. In addition, factors in the environment may act as barriers or facilitators towards seeking help.

2.2 Research Design

A qualitative descriptive research design was adopted for the current study. A qualitative research design assists in accessing the thoughts and feelings of research participants which enables development of understanding of the meaning that people ascribe to their experiences (Sutton & Austin, 2015). In addition, Knudsen et al. (2012) advocate for using qualitative research in audiology as it provides for a better understanding of the views of people with hearing impairment. The design was descriptive in nature because this offered a comprehensive summary of an event by staying closer to the data and to the surface of

words. Although the disadvantage was that the researcher would have to work with large amounts of data, descriptive research would lead to thicker descriptions and deeper meanings (Chenail, 2011; de Vos, 2005). This design was therefore well suited to this study.

2.3 Research Context

The current study was conducted at Witrand hospital in the North-West province, South Africa. Witrand hospital is a specialised hospital that renders psychiatric and rehabilitative services for the entire North-West province (North-West Department of Health, 2018). The hospital is situated in Potchefstroom, a town located just over 100 kilometres outside Johannesburg with a population of 162 762 (Statistics South Africa, 2014). Salili and Hoosain (2005) describe the town as a steadily growing peri-urban community within a university town, with a mixed and multilingual group of inhabitants, partly due to the economic activity of mining in the southern region of the town ('North-West Municipalities', 2020). The hospital offers a range of services including psychiatry, psychology, occupational therapy, and physiotherapy as well as SLH services. The SLH services are specifically for the population of Potchefstroom and surrounding areas. All inhabitants of Potchefstroom who require audiology services from the public health system are referred to Witrand hospital for hearing management. This hospital was selected because it offers feasibility to recruit participants within the timelines available for the research, and its audiology department offers a wide range of services for those patients with hearing impairment and related disorders.

2.4 Description of Participants

2.4.1 Study Population and Sample size

A portion of the population of adults presenting with hearing impairment, called a sample, was drawn for the purposes of the research study (de Vos, 2005). Sampling increases

feasibility, cost-effectiveness, accuracy, and manageability of the study. For the current study, the sample, considered representative, consisted of participants from the community of Potchefstroom and surrounding areas. Participants who attended the Audiology department for their first consultation for assessment of their hearing impairment comprised the participants of the current study according to a set of inclusion and exclusion criteria (de Vos, 2005; Robinson, 2013).

Since the researcher drew a sample from the population to be studied it was important to consider the sample size (de Vos, 2005). Morse (2000) recommends a large sample size to obtain the richness of data, albeit with fewer questions. However, there are many factors to be considered such as time, resources, the nature, and scope of the study as well as the quality of the data in deciding about sample size (Morse, 2000). Research studies in help-seeking have used sample sizes between thirty to over one thousand, which did not give guidance to this current study. Nevertheless, because of the qualitative nature of the study, in that the data was more descriptive and experiential, the researcher aimed to have a sample size of 30 participants with 15 being the minimum goal (Morse, 2000; Robinson, 2013). This helped with maximum variation sampling to account for different perspectives and different variations in the study of help-seeking in this population (Cresswell, 2007). This sample size was also influenced by data saturation (Morse, 2000).

2.5 Sampling Procedure

In this qualitative study and based on evidence informing the study, non-probability purposive sampling was used to select participants (Sargeant, 2012). A non-probable sampling method indicates that the researcher selects individuals or groups where the processes are most likely to occur (de Vos, 2005). In this case, according to clear criteria, the researcher sampled participants from a hospital with an audiology department, where it was

likely that patients would come and consult for hearing impairment challenges (de Vos, 2005). According to de Vos (2005), purposive sampling is feasible, when considering the large number of available data and the time available to access, collect and analyse the data for the nature of the research problem. Hence, in purposive sampling the researcher has a smaller amount of data to collect and analyse more accurately which helps to increase the accuracy of the information obtained (de Vos, 2005). It is also not possible to evaluate the whole population of hearing-impaired adults, therefore purposive sampling was suitable and allowed the researcher to obtain cases that were deemed information rich (Sandelowski, 2000).

It is noted that this type of sampling is based on the judgement of the researcher in which they decide on those characteristics that are representative of the sample population (de Vos, 2005). In addition, this judgement is too prominent a factor in this type of sampling, however, Creswell (2007) points out that the intention in qualitative research is not to generalise but rather to understand the phenomenon under study, through detail and in-depth information (de Vos, 2005), hence the appropriateness of this sampling strategy for this study.

2.6 Participant Selection

Cresswell (2007) states that it is important to identify appropriate participants in order that they may enhance understanding of the phenomenon that is being studied (Cresswell, 2007). Therefore, in the current study, the researcher used the following criteria for participant involvement:

2.6.1 Inclusion Criteria

- **18 years and above**

Adult participants with various ages who had the ability to give consent in accordance with medical ethics, were included in the study to increase the heterogeneity of the study and to acquire diverse responses in relation to the research question (Curtis et al., 2000; Robinson, 2013). The selection of adults generated rich information on the phenomenon being studied pertaining to the research aims as adults can describe their own personal journeys more than children (Curtis et al., 2000). Although it is difficult in qualitative studies to ensure external validity due to a focus on depth more than breadth (Bengtsson, 2016), the use of participants with a variety of ages instead of a particular age group is reported to strengthen the external validity of the study (Malterud, 2001).

- **Male and Female**:

This study included participants of both genders, as ascribed at birth, in order to increase the maximum variation of participants and increase the likelihood of different perspectives in the data collected according to the aims of the study (Cresswell, 2007). This selection allowed for the establishment of evidence if findings were solely from a particular group of people or not (Cresswell, 2007). Research into help-seeking has shown conflicting results related to the influence of gender. Some studies have indicated that gender did not influence help seeking behaviour (Duijvestijn et al., 2003; Ramma & Sebothoma, 2017) whereas other studies indicated that women more than men tended to seek help (Anderson et al., 2013; Magaard et al., 2017). The social context, much like in South Africa, played a role in the contribution of gender towards help-seeking behaviour (Mojaverian et al., 2012; Pirani et al., 2015).

- **Initial audiology consultation**

To increase the homogeneity of the type of participants selected and therefore answer the research question, only initial audiology participants were interviewed (Robinson, 2013). First time audiology consultations were deemed part of the key features of the target

population to answer the research question because there were less variables that interfered with the subject matter such as returning patients, patients that have already been through the audiology system and have been fitted with hearing aids, as well as the impact of memory recall (Scott & Walter, 2010). The researcher also hoped to capture the initial journey of seeking help that first-time participants were expected to have in responding to the aims of the study.

- **Participants who present with a hearing loss regardless of type, degree, or severity**.

Disabling hearing loss is defined as a hearing loss that is greater than 40 dB in the better hearing ear in adults (WHO, 2021). It can vary in degree and severity according to audiometric threshold evaluation. As a result, due to the impact of the hearing loss on participation in life events, those affected are bound to seek solutions for their presenting symptoms even at mild thresholds (ASHA, 2020; Carson, 2005). In addition, according to Knudsen et al. (2010) hearing sensitivity, regardless of the severity, has been reported to be significantly associated with help-seeking, hence all types and degrees of hearing loss were included in this current study.

The following were used as criteria for participant exclusion:

2.6.2 Exclusion Criteria

- **Participants younger than 18 years**

The researcher excluded participants younger than 18 years of age because they were not adults legally (South African Government, 2020). In addition, the aim of this study was to have the lived experience of the journey to seeking help communicated by the individual

themselves not by the supported communication partner such as a family member, which may happen if anyone under the age of 18 is included in the study.

- **Inability to consent and participate in the study due to cognitive and linguistic challenges.**

This study excluded participants that were unable to give consent and participate in the study due to cognitive and linguistic challenges because this is unethical and it may bias the results of the study (Patino et al., 2018). Linguistic challenges include an impairment in effectively communicating a message despite the participant using their own language. There is also the possibility that due to these challenges that the manner of the interview questions may increase the risk of an adverse event which the researcher wanted to prevent from happening (Patino et al., 2018).

2.7 Test Protocol

2.7.1 Measures and Materials

In-depth semi-structured interviews using open-ended questions was the method adopted for the research study. In depth interviewing was selected as it allowed the researcher to explore meaning and perceptions to gain a better understanding of the phenomenon being studied as the participant shared rich descriptions of their experiences (DiCicco-Bloom & Crabtree, 2006). Semi-structured interviews also allow for the researcher to probe further the participants' responses whereas structured interviews will often produce quantitative data, which was not the purpose of the current study, nor would it answer the aims of the study as stated (DiCicco-Bloom & Crabtree, 2006; Peters & Halcomb, 2015).

This study adopted individual rather than group interviews because evidence indicates that it is advantageous to conduct individual interviewing as it allows for the researcher to delve deeper into the social and personal matters, whereas it may be limited to do so in a

group interview (DiCicco-Bloom & Crabtree, 2006). Limitations of individual interviews were acknowledged and were taken into consideration during the study. These included the fact that interviews pose high demands on the participant's memory and recall especially when retrospective questions are used; and there are also limitations of participant cooperation, an unwillingness to share or evoking the wrong responses (de Vos, 2005). However, interviews produce powerful insights into the participant's experiences, perceptions, and opinions (Peters & Halcomb, 2015; Vaart, 2004).

Open-ended questions (Appendix A), developed in relation to the research questions and according to the aims of the study as well as guided by questionnaires from similar previous studies, were used. Although, open-ended questions can be time-consuming, they were ideal for this current study as they provided for the variety of responses that existed on the ear and hearing health seeking behaviour patterns of adults within this context (De Vos, 2005).

2.8 Data Collection Procedures

2.8.1 Participant Recruitment

Participants were recruited according to maximum variation sampling to capture a broad range of perspectives from adults with hearing impairment. This type of sampling is suitable when seeking to select a variation of participants according to a set criterion in order to increase the likelihood that findings will reflect different perspectives yet also being able to identify important common patterns (Cresswell, 2007). Variations included age, gender, income, occupation status, cultural beliefs, variety of referral sources, degree of hearing impairment and experiences with seeking help. Knudsen et al. (2012) recommends that for qualitative health research, participants can be conveniently reached through clinical settings.

Hence, for this study, recruitment of participants was from a hospital with an audiology department.

Using the hospital audiology departmental diary as a reference, all new patients as documented in the diary were pre-selected as potential participants in the study. Once identified, on the day of their appointment, they were approached and the purpose of the study was explained to them, and they were then invited to participate in the study. If they agreed to participate, written consent was secured.

In view of the current global COVID-19 pandemic declared by the WHO (2020) and precautions that have been recommended to reduce the spreading of the disease, the challenges of participant recruitment were considered. WHO (2021) has recommended maintaining a 1 metre distance between two people, avoiding crowded places, use of facial masks, and other infection control measures which has an impact on face-to-face interviewing as well as the size of the sample. As participants were recruited within a hospital, already attending a clinic, the researcher took all precautions as stipulated by the WHO (2021) and the South African Government (2021) during the interviews. Permission was also requested from the participants to conduct telephonic interviews as they gave consent to participate in the study and the circumstances dictated that face-to-face interviews were not permissible. The degree of the participant's hearing loss was taken careful cognisance of for telephonic interviews to ensure that the hearing impairment was not a communication barrier.

2.8.2 Interviews

Semi-structured interviews were conducted, and audio recorded with each participant, as they described their experiences and perspectives on the process of seeking help for their hearing loss, according to predetermined open-ended questions. Participants were

interviewed by the researcher on the day of the audiology appointment in the hospital, in a separate room, at a time convenient to the participant (McGrath et al., 2018). An interview schedule with all the questions was prepared prior to the interview. Each interview took an average of 20 minutes, allowing also for probing as the participant responded (Peters & Halcomb, 2015). The purpose of the interview was explained to all potential participants with written consent requested once agreement to participate was given. Once the participant was made to feel comfortable and at ease, interviews were conducted in English, Setswana, isiZulu and seSotho depending on the participant, with facilitation and guiding instead of dictating the encounter (de Vos, 2005). The researcher is fluent in all African languages listed, and these are the languages spoken in the area where the hospital is located. The researcher conducted the interview as when the participant preferred whilst making sure to avoid any biased responses that may have arisen to influence the audiology consultation (Cresswell, 2007; McGrath et al., 2018). It was also important that the researcher was sensitive to the context within which participants' cultural and ethnographic background are embedded (de Vos, 2005). The current researcher was familiar with the context, cultural and ethnographic background from where the participants came from as an African woman from this context. De Vos (2005) argues that this makes the interviewing and the responses provided more relevant and meaningful to the research. The telephonic interviews were conducted in the same manner as the face-to-face interviews with verbal consent given by the participant before participating in the interview.

However, being familiar with the context was a challenge for the researcher as she had to remain an investigator in the same setting where she is employed. Participants were not only seen as participants but also as patients, particularly when they communicated their experiences about the audiology session. Therefore, the researcher had to constantly remind herself of her position in the recruitment and interviewing process to minimise bias.

Interviewing without being emotionally attached to the participants' stories was also important to limit influencing participants' experiences.

2.9 Ethical Considerations

The fact that human beings were the objects of the study in this research, the researcher was obligated to consider the ethical issues that arose in the process of the study (de Vos, 2005). Ethically responsible decisions must be made by the researcher to ensure proper conduct and practice for all those involved. Therefore, the researcher applied to the ethics committee of the university for approval to conduct the study prior to the study being carried out (Appendix B). From then, a formal request from the provincial department of health and the hospital was also submitted as part of contracting in order to protect, account and be responsible for the information gathered (Appendix C) (de Vos, 2005). It was only once there was ethical approval and permission from the institution that the study commenced (Appendix D).

In addition, ethical considerations that guided the current study were based on the World Medical Associations (WMA) Declaration of Helsinki (2013). Specifically, the following ethical principles were adhered to throughout the study, namely: informed consent, confidentiality, anonymity, autonomy, beneficence, non-maleficence, justice, risks, burdens, and benefits. These are discussed in more detail below:

- ***Informed Consent***

Participants were informed of the nature of the study including all details pertaining to the aims, methods, benefits and risks, affiliations of the researcher, possible conflicts of interest, outcomes, and other relevant aspects of the study in order for an informed choice to be made regarding participating in the study (Appendix E). For those willing to participate, written consent was required before the interview took place and the right to withdraw from the study

at any point during the interview was provided to the participants. In the case of telephonic interviews, verbal consent, which the researcher noted, was required in order to be interviewed.

- ***Confidentiality***

Participants were interviewed in a private room for confidentiality and privacy. Information gathered during the process of the interview was shared with anyone and data collected was kept private and only the researcher had access to it. No identifying information was used in the data, but instead codes were used – to ensure confidentiality.

- ***Anonymity***

The identity of participants was safeguarded by being unidentifiable in the research study. Personal names were not used in the research study. Participants were coded with numbers.

- ***Autonomy***

The purpose of the study was described to all participants including providing information on any anticipated risks, burdens, and potential benefits of the research in order that participants make their own informed choice regarding participating in the study. Participants were enabled to have the capacity for self-determination without any adverse negative consequences (HPCSA, 2020). The researcher did not relate or respond to the participant from a position of superior expertise and status but honoured their beliefs, values, and preferences (de Vos, 2005; HPCSA, 2020).

- ***Beneficence and Non-maleficence***

The health and rights of the participants were protected by adhering to the regulations and rules of the hospital in terms of patient care. The study did not take precedence over the needs of the participants. Participants were also not prejudiced in any way in their

consultation with the audiologist before or after the study when they were or when they were not willing to participate in the study. The rights and the interests of participants were not infringed upon in keeping with the participants' primary purpose for visiting the hospital. It was also hoped that the research would be beneficial to understanding hearing health within the South African context. Those who had telephonic interviews were informed of their rights and that the interview would not bear negatively on them and their relationship with the audiologist.

- ***Risks, Burdens, and Benefits***

The researcher endeavoured to minimise any risks to the participants by monitoring, assessing, and documenting them during the research process. For this current study, psycho-emotional risk was possible. When the risks outweighed any benefits, a decision was made to either continue, modify, or stop the study. If any burdens were observed by the researcher, they were assessed and managed to prevent any adverse effects. The psycho-emotional services of the hospital were not utilised to refer any participant requiring counselling. In addition, any potential benefits were communicated to the participants.

- ***Justice***

Justice refers to the right that all individuals and groups should be treated in an impartial, fair, and just manner (HPCSA, 2020). In this current study, any participant who fitted the criteria were considered without being excluded based on their language, culture, race, ethnicity, gender, age, and disability. The use of non-probability sampling also ensured that justice was maintained (de Vos, 2005).

2.10 Rigour and Trustworthiness

All research must be open to evaluation and the procedures used to generate findings must be as trustworthy as possible (Graneheim & Lundman, 2004). Rigour and trustworthiness are two measures used in qualitative research for assessing the soundness, accuracy, and integrity of a study (Graneheim & Lundman, 2004; Long & Johnson, 2000). In the context of measurement, it is important that the criteria for evaluating rigor be appropriate to the research and the type of research methods used. In qualitative studies, the aim for measuring reliability and validity of data is based on consistency and care in the application of research practices as well as in the analysis and conclusions reflected in the findings (Davies & Dodd, 2002). This current study was guided by this.

Credibility and dependability are two concepts that are used to describe the trustworthiness of qualitative research studies (Bengtsson, 2016). Credibility refers to the study process, whereby the researcher seeks to establish how the data and the analysis procedures are carried out and to ensure that no relevant data is excluded (Bengtsson, 2016). Dependability is concerned with the extent to which data changes over time and the alterations made during the analysis (Bengtsson, 2016). This refers to the consistency of an instrument (de Vos, 2005). The more reliable the instrument, the more consistent and dependable our results (de Vos, 2005). Both concepts are discussed below in relation to the relevant research procedures in this study:

2.10.1 Participants

The sampling approach and the recruitment of participants using inclusion and exclusion criteria enabled the research question to be addressed appropriately and to reduce the potential of a biased sample, thus ensuring credibility (Long & Johnson, 2000; Sargeant, 2012). In addition, adult participants of various ages and genders as well as different

perspectives were included in the research study to provide a richer variation of the phenomenon being studied (Graneheim & Lundman, 2004). Another strategy to ensure credibility, according to Forero et al. (2018) is by prolonged engagement with the participants during the study to be acquainted with them to aid in the interview process. However, this was not possible due to time constraints, the setting, and the current COVID-19 pandemic regulations. Hence, the researcher conducted individual in-depth interviews with all participants.

2.10.2 Questionnaire and Interviews

To ensure that data collection was undertaken in a consistent manner, free from undue variation, the structure of the questions remained the same throughout the interview for all the participants (Long & Johnson, 2000). Questions were asked in an unbiased or leading manner to increase the quality of the participant responses (Sargeant, 2012). Dependability covers how much data is collected and in how long a length of time. If the data is extensive and collected over a long period of time, the reliability and accuracy of the study may be compromised. This is because in-depth interviews can be extensive, generating a large amount of data (de Vos, 2005). Therefore, a small sample size was used, and data collection was planned for a reasonable amount of time to reduce the negative impact on rigour. Data collection took three months with interviews lasting no longer that 20 minutes. In so doing, the researcher reduced the risk of instability and any inconsistencies in this process (Graneheim & Lundman, 2004).

Semi-structured interviews increase the credibility of the study as the participants share their perspectives in their own words (Graneheim & Lundman, 2004; Cresswell, 2007). Although the risk of open-ended questions is that participants can provide more information than what is required with the possibility of digressing from the research questions, for the

purpose of this study, open-ended questions were suitable to understand the phenomenon being studied through the participants' own words.

During data collection, the researcher sought clarification from the participants' responses through probing and prompting and after the study when required to enhance credibility. Yet, due to the nature of the study it was not always possible to contact participants after the interview when further clarification or additional information was required (Graneheim & Lundman, 2004). Nevertheless, Long and Johnson (2000) caution regarding the effects of memory or participant's changing their responses when undertaking validation after interviews.

2.10.3 Data Analysis

All transcribed data was analysed consistently using the same deductive process for all participants to ensure that no relevant data was excluded, or irrelevant data was included (Long & Johnson, 2000). All this was done by the researcher independently due to the nature of the study, however this was a disadvantage in terms of reliability. This was improved by multiple readings and coding of the data during analysis. In addition, summary categories came from the text as transcribed (Bengtsson, 2016). Furthermore, rich, thick descriptions from the interviews, as transcribed, were used to give evidence to the credibility of the data collected in relation to the focus of the study (Cresswell, 2007).

It was important to acknowledge the researcher's involvement in the study as presenting a bias due to the setting of the data collection. The researcher conducted the interviews and also analysed the data that she collected. Hence, she continually reflected on her own beliefs and bias during the data analysis process (Long & Johnson, 2000). The reliability of the analysed data was also increased by having an independent person not involved in the current study re-transcribe the transcribed data. The purpose of this was to

confirm and seek agreement in the way that the researcher had labelled and sorted out the data. The assigning of code words and categories or themes must be the same between the researcher and the independent person to increase accuracy of the transcribed data (Cresswell, 2007; Graneheim & Lundman, 2004). An independent person transcribed the data and assigned the same codes and categories as the researcher therefore confirming the accuracy and the reliability of the findings. In cases of disagreement, the researcher and independent person openly discussed the data, pointed out apparent biases and gave an explanation based on the transcription.

2.10.4 Pilot Study

Prior to the main study, a pilot study was conducted to ascertain that the chosen procedures were suitable, reliable, and valid as well as free from any errors (de Vos, 2005). The pilot study is an integral part of the research process in which the researcher tests the various aspects of the study on a small scale to contribute to the credibility of the study (de Vos, 2005). Therefore, using the same criteria for participant selection, the nature of the interview questions was tested in order to determine that relevant data was collected, and irrelevant data was excluded according to the research aims. Once the nature of the questions was tested, the researcher was able to reliably make modifications to the data collecting tool with a view to quality interviewing during the main investigation (de Vos, 2005). The pilot study was conducted on three participants who met the inclusion criteria and as de Vos (2005) recommends a few relevant interviews be conducted in this regard (Appendix F).

Pilot Study participant 1

Participant description.

Pilot study participant one was a 73-year-old unemployed male who presented with a moderate to profound sensori-neural hearing loss in the right ear and a moderate to severe

sensori-neural hearing loss in the left ear. The onset of hearing complaints was experienced as mainly self-reported hearing difficulties that limited his activities and restricted participation in daily life. He was referred by a tertiary public hospital audiologist to the audiologist near his place of residence. He was being managed at this hospital for a non-audiology medical condition, from which the medical doctor referred him for an audiology consultation.

Procedure

Participant one was informed of the nature of the study and all details pertaining to the current study. Once he had made an informed choice to participate, he gave written consent to be interviewed. He was interviewed face-to-face after the audiology consultation in a private room and the interview took 15 minutes to complete all the open-ended questions.

Findings and research alterations

Participant one did not experience any difficulties in answering most of the questions and sharing his perspectives and views on the journey of seeking help for his hearing difficulties. Yet, because of the nature of the hearing impairment, he required repetition and occasional rephrasing during the interview. It was also observed that he answered the question related to the influence of his culture and beliefs upon the first consulter; by reflecting on his health, the available family medical assistance, the poor quality of his life and the participation restrictions from the hearing impairment. The researcher then rephrased the question by also giving examples, yet the participant responded by reporting that he found help at the nearest available medical centre. The researcher then took this into account as part of the piloting for the next 2 participants by rephrasing the question for clarity. Overall, the participant expressed that the questions were understandable and related to the main goals of the study.

Pilot Study Participant 2

Participant description.

Participant two was an 89-year-old unemployed female, who was accompanied by her daughter. She presented with a severe sensori-neural hearing loss bilaterally. It was reported that she started having physical ear symptoms followed by communication difficulties with significant others in her life. After consulting a private health medical doctor, she was referred by a community friend, who worked as a healthcare worker in the hospital where the audiology department is for a hearing assessment. According to the participant, medical doctor failed to refer them to an audiologist due to a lack of knowledge regarding where to refer.

Procedure

Participant two made an informed choice to participate and gave written consent to be face - to-face interviewed with the support of her daughter. The open-ended questions were answered by the participant with the daughter adding to the information provided.

Findings and research alterations

Participant two was able to relate her experience regarding help-seeking for her hearing difficulties during the interview. The question related to the cultural influence of the first person they sought help from required rephrasing and elaboration. From the rephrasing of the question, they were able to explain that the influence of consulting a medical doctor was due to their pre-existing experience and belief that a medical doctor has the knowledge regarding illness.

From this, the question was altered in order that participants may respond without any bias or influence from the researcher contributing to the credibility of the responses and findings.

Pilot Study Participant 3

Participant description.

Participant three was a 53-year-old female who came alone for the audiology consultation. She reported that she had had physical ear and hearing symptoms, which were noticed by her family. She was eventually referred to the audiologist by her sibling, who is a healthcare worker in the hospital. Participant three presented with a moderately-severe to severe mixed hearing loss in the right ear and a severe sensori-neural hearing loss in the left ear.

Procedure

Participant three gave written consent to participate in the research study. An interview was also conducted with the participant after her audiology consultation in a separate room.

Findings and research alterations

Participant three was able to relate her journey towards seeking help for her hearing complaints. The researcher was able to ask all the questions including the altered question and the participant was able to respond. She was influenced to seek help from the medical doctor because she believed in doctors to be able to diagnose the hearing difficulties despite having encountered a family member who encouraged her to consult ancestors.

2.11 Data Management

All interview material was audio recorded using a voice call recorder and transcribed verbatim. It is advantageous to record than taking notes as the researcher can concentrate on the content and process of the interview and where to go next (de Vos, 2005). Data that was

in another language was translated into English using Google Translate. Data for this current study was stored and analysed using an Excel spreadsheet.

Audio recording does have its disadvantages in that it may distract the interview process or result in participants wanting to withdraw. Therefore, the researcher placed the recorder inconspicuously so as not to unnerve the participant or interrupt the interview process (de Vos, 2005).

2.12 Data Analysis

As the current study was specifically qualitative in nature, the researcher used a thematic analysis method through a deductive approach as a procedure to analyse the raw data (Bengtsson, 2016). This type of method makes it possible to analyse the data qualitatively and quantify it (Vaismoradi et al., 2013). Therefore, text data was represented in the form of frequencies as well as presented in words or themes as part of interpretation of the results (Bengtsson, 2016). If the researcher only counts the frequency of the words, they may miss the context of the data, which is important for this study (Vaismoradi et al., 2013).

Once all the interviews were transcribed, the researcher first familiarised herself with the transcribed data by conducting multiple readings of the raw data to know the depth and breadth of the content before the data could be broken down (Bengtsson, 2016; Braun & Clarke, 2006). In this way the researcher was looking at what the text says by preparing to describe the visible, obvious components of the text. This is called a manifest analysis as the researcher stayed close to the text and used the words themselves from the transcribed data. This contrasts with a latent analysis method where the researcher interprets the data by looking at the underlying meaning of the text, including silences, posture, and laughter of the participant. (Bengtsson, 2016; Elo & Kyngas, 2008; Graneheim & Lundman, 2004). Hence,

for this study the researcher was guided by the aims and research question in order to correctly interpret the transcribed data (Elo & Kyngas, 2008).

Secondly, after getting a sense of the whole text, the data was broken down into smaller meaning units labelled into codes in relation to the context (Bengtsson, 2016). By coding, the researcher identified topics, issues, similarities, and differences that were revealed through the participant's narratives thereby enabling an understanding of the experience from the participant's perspective (Sutton & Austin, 2015). As a result of the researcher wanting to re-test existing data in a new context, based on previous knowledge, coding was conducted to correspond with identified categories in the literature (Elon & Kyngas, 2008). Yet, this coding was not only limited to the identified categories, as the researcher was aware that new categories could emerge from the data based on the context (Elon & Kyngas, 2008). Finally, the codes were then collated and condensed to develop categories that represent similar meanings and based on the questions used when the data was collected in order to provide an understanding of the help-seeking behaviour patterns of adults with hearing difficulties (Bengtsson, 2016; Hsieh & Shannon, 2005). It was important that all categories be rooted in the data from which they arose (Bengtsson, 2016).

As a result of the amount of data that is generated a category can include several sub-categories hence the researcher refined and revised the categories in order to reduce redundancy and overlap without losing the content (Graneheim & Lundman, 2004; Thomas, 2006). No data useful for the current study was excluded due to a lack of a suitable categories (Graneheim & Lundman, 2004).

These categories or themes formed the basis for writing and discussing the findings in relation to the participants' lived experiences in the current study (Braun & Clarke, 2006). The researcher included the participant's words in quotations as part of a manifest analysis in

order to reflect a richer understanding of the phenomenon being studied, grounding the content analysis in the actual data (Bengtsson, 2016; Hsieh & Shannon, 2005; Sutton & Austin, 2015).

As part of thematic analysis, the researcher also quantified the codes that emanated from the transcribed data to illustrate the magnitude of the phenomenon being studied more clearly (Bengtsson, 2016). Furthermore, the socio-demographic information gathered was quantified as part of the data analysis. Measures of central tendency were used to calculate the quantitative data from the participants' socio-demographic information using mode, median and mean measures (de Vos, 2005). The mode is the simplest measure of central tendency as it measures the value that occurs most frequently in the nominal data that is collected, which is often described as the typical value. It is not affected by extreme scores, nor does it depend on all the scores of the distribution (de Vos, 2005). On the other hand, the median is the middlemost point in a distribution of data capturing the central point of two equal parts and the mean is the total amount of the measurements divided by the number of measurements that stipulates the balance point of the distribution (de Vos, 2005). The median and mean are used to describe the average value (de Vos, 2005).

The disadvantage of a qualitative study is that it does not rely on the measurement and analysis of causal relationships between variables to interpret results hence it was important that the researcher was recursive and frequently reviewed the collected data during the analysis stage to capture the participants' stories truthfully in relation to the research questions asked (Vaismoradi et al., 2013). In addition, to evaluate the analysis process, one independent person coded the data independently as a measure of establishing truthfulness of the findings (Sutton & Austin, 2015; Vaismoradi et al., 2013).

3. RESULTS

The results of the study are presented in accordance with the aims of the study as presented in the methodology section, preceded by the description of the sample of the study to contextualise the reader.

3.1. Demographic Information

Of the number of participants invited to participate in the study, a total of 25 participants volunteered to take part. However, of this 25, two did not meet the inclusion criteria of the study as the first participant had poor recall of the events that led to seeking help and the second participant was not an initial consultation for audiology. Therefore, a final sample of 23 participants *(N = 23)* were interviewed, with their age ranging from 28 years to 89 years (M = 67,8; SD±15,6). Table 1 below reflects the sample characteristics of the participants in the study. It is evident that the majority of the participants (73,9%) in this cohort were senior citizens. This indicates that despite the study inclusion criteria for age being from 18 years, only six (26%) participants were below the age of 60 years.

With reference to gender, 12 participants were male (52%) and 11 were female (48%).

Table 1

Participant Sample Characteristics (N = 23)	
Age, years (M±SD)	67,8 ± 15,6
Gender %	
Male	52
Female	48
Ethnic group %	
Tswana	57
Afrikaner	39
English	4
Occupational Status %	
Employed	9
Unemployed	91
Consultation %	
Alone	57
Accompanied	43
PTA (0.5Hz – 4kHz)	
Better ear (SD)	49,6 dBHL (9,1)
Worse ear (SD)	56,1 dBHL (8)

Key: M = mean, SD = standard deviation, PTA = Pure Tone Average

Table 1 shows the characteristics of the sample under study. Demographic information was obtained from the hospital files and verified with the participants.

3.1.1. Ethnic Profile

As depicted in Table 1, most of the participants were from the Tswana ethnic group, with the least being English, indicating the main population group in this community as being Black African.

3.1.2 Occupational Status

As depicted in Table 1, all 23 participants, except for two, were unemployed. This result is not surprising considering the average age (67,8) of the majority of the participants, described as retired or not economically active. However, the researcher found eight participants (30,4%), who varied in age from 28 to 64 years old were in the adult stage of

being employable, but only a 40-year-old and 64-year-old male participant (9%) were employed at the time of the data collection. Though these two participants were employed, their journeys of seeking help were not different from the other participants. None of the participants in the study were self-employed or working students.

3.1.3 Consultation with the Healthcare Provider

Over half of the participants (57%) had sought help and consulted audiology services alone while the rest (43%*)* had been accompanied by family members to their appointments. Spouses and children joined their kin for these visits. Observations from the data analysis showed that participants that were older in age, from 70 years to 89 years of age (47,8%, *N* = 23*)* had been accompanied to the consultation whereas those less than 70 years of age, only two (16,6%) had consulted with someone. This is apart from an 89-year-old male participant that came alone to seek help from the audiologist. The findings on the type of visits are consistent with an older age cohort in this study and the probability of these participants needing support for their daily needs. With reference to gender, it was found that more males (69,2%) than females (30,8%) had come alone. The researcher posits that this difference may be due to the severity of the loss or the availability of social support for both genders.

3.1.4 Audiological Profile

In terms of audiometric results, all participants were diagnosed with a hearing impairment as was required by the inclusion criteria. The degree of the hearing impairment ranged from 23,75dBHL to 91,25dBHL in the better ear, calculated as a four-frequency pure tone average (4FPTA). The mean of the better ear was 49,6dBHL (SD±9,1) indicating a moderate impairment (WHO, 2021). Due to the sample size being mostly older adults (73,9%; *N = 23)*, the researcher considered the audiological profile in relation to age-related hearing impairment. This type of impairment, described as a progressive, symmetrical,

bilateral sensori-neural hearing loss, was found in only six participants (Wang & Puel, 2020). Meanwhile, of the remaining 11 participants above the age of 60 years, it is suggested that their hearing impairment may have been influenced by comorbidities or family history hence the asymmetry. These participants reported the onset of hearing difficulties from childhood to a few years before accessing the audiologist. In addition, diagnostic audiology assessments indicated a combination of sensori-neural and mixed hearing impairment bilaterally because of middle ear pathology from childhood.

Participants below the age of 60 years (26,1%*)* presented with varied causes, including unknown causes, childhood middle ear pathologies, and/or cancer-related causes. Childhood middle ear pathologies were reported by three participants (13%).

3.2 SUB-AIM 1: Pattern of presentation of symptoms in relation to cultural practices and beliefs

3.2.1 Pattern of presentation of symptoms according to first contact

Table 2

Participants' First Contact in Seeking Help (N = 23)

First contact in seeking help	Number of participants
Public Healthcare Clinic	6
Private Doctor	4
Family and Friends	3
ENT Specialist	2
Audiologist	2
Hearing Centre	2
Public Hospital Endocrine Specialist	1
Private Healthcare Worker	1
Traditional Health Provider	1
Chemist	1

Table 2 demonstrates the first contact and the frequency with which that contact was consulted at the beginning of their help-seeking journeys. Results from the table are expanded on below.

Participants' patterns of presentation, in response to being asked from whom they first sought help, were between formal and informal social networks. The majority of participants (82,6%) responded that they had first sought help from Western medical healthcare professionals whereas few participants (17,4%) initially sought help from family, friends, and colleagues. As depicted in Table 2, the most commonly reported formal networks were the PHC as well as private healthcare doctors, with allied healthcare workers being the least points of help-seeking. The PHC is the first entry point into the healthcare system hence the higher number of participants contacting this service. Yet, it is interesting that audiologists were the least to be consulted from these formal networks, with ENT specialists not appearing in the most consulted contacts either. Participants who sought help at the PHC would likely have been helped by a nurse, because ear and hearing care specialists are commonly found in hospitals. Nevertheless, even those participants who sought help in the private health sector, results also indicated, that audiologists and ENT specialists were seldom the first point of contact. Participant 15 stated:

"I went to the clinic.' (Participant 15)

Participant 24 reported the following about his journey:

"I only started seeking help in the previous week (pauses) I was at the clinic:" (Participant 22)

Participant 20 stated:

"So, I went to the clinic..." *(Participant 20)*

Those who did not use public healthcare clinics reported the following:

"We first went to the doctor." (Participant 2)

Participant 10's daughter responded in this way:

"She went to the GP first…then after the GP she then went straight to the specialist doctor." (Participant 10)

One participant who was able to access audiology services immediately said,

"We came straight here (referring to the Audiologist)." (Participant 19)

The PHC, as the route for seeking help in the public health sector indicated what was available for participants in this context. Similarly, private doctors were first in line for those consulting in the private health sector.

Part of the pattern of presentation also involved participants seeking help from their social support networks. The number of participants was notably few (17,3%*)* in comparison to those who sought help with healthcare professionals Participant 16 described his help-seeking in this way

"I found help when I used a traditional remedy from a colleague who was a traditional medicine provider." (Participant 16)

Participant 9 stated:

"The lady that stayed with me…' (Participant 9)

Participant 23, referred to her neighbour who was also her friend as the one whom she first asked for help by stating that:

"She referred me; they will do it at (hospital name) soon." (Participant 23)

Evidently, participants' first sources of help were a variety of providers where relief was sought for their hearing difficulties.

3.2.2 Type of help received from first contact

Table 3

Type of Help Received (N = 23)

First contact	Type of help received	Total %
PHC	Basic ear assessment & referral to hospital	26,1
Private Doctor	Basic ear assessment & referral to hospital	17,4
Family or Friends	Support and recommend referral route	13,1
Audiologist	Diagnostic audiology assessment	13,1
ENT Specialist	Ear Specialist assessment	8,7
Hearing Centre	Diagnostic audiology assessment	8,7
Public Hospital Endocrine Specialist	Referral to ideal caregiver	4,3
Private Healthcare worker	Audiology Assessment	4,3
Traditional health provider	Traditional herbal medicine	4,3
Chemist	Cerumen management	4,3

Table 3 describes the form of help that participants received when they presented to their first contact. Those participants who interacted with medical specialists, gave explanations of procedures typically from their understanding.

As depicted in Table 3, most participants received basic ear assessment followed by either a direct referral to the nearest hospital, prescription of medication or no intervention. The type of help received by the participants was equal to the scope of practice of the healthcare workers. This seemed insufficient as most healthcare workers performed only a visual inspection of the ear, followed by onward referral for further investigation at a hospital. Only one participant received cerumen management while another participant was referred to the ideal health provider by a healthcare worker not involved in ear and hearing care. It is interesting that only a few participants (21,7%) received the appropriate diagnostic

audiology assessment of their ear and hearing difficulties with even less participants (8,7%) being helped by an ENT specialist. Participants reflected their experiences by stating the following:

> *"He looked at them, with a tool, he put in a light then he said one ear has a hole."*
>
> *"Then he wrote a letter and referred me here." (Participant 22)*

Participant 6 was helped by a medical doctor and reported that:

> *"He just prescribed eardrops. He just looked in…" (Participant 6)*

Participant 2, disappointed with the help received from the doctor, described her consultation in the following way:

> *"When I go to the doctor, the doctor tells me that I must find help. The doctor tells me that he only treats the body, not the ears. The ears, eyes are not the things that he treats..." (Participant 2)*

Meanwhile, Participant 4 sought help at the chemist and responded in this way:

> *"That chemist... only just syringed it. He put something in the ear, and he syringed the ear." (Participant 4)*

In response to asking the endocrine specialist for help with her ear complaints, Participant 7 stated that:

> *"So, he wrote a referral letter for me, then he told me that because my treatment is complete here at the endocrine clinic, I must go to a specific doctor. Then he wrote a letter for me to come to Potchefstroom because they also check the ears here." (Participant 7)*

Participants received more help from medical doctors, nurses and an oncologist as opposed to audiologists and ENT specialists who specialise in hearing health.

However, those who consulted audiologists and ENT specialists were managed differently to the participants who received help from non-audiology healthcare professionals. Participant 20's daughter-in-law said:

"They checked his ears and gave us the results of the hearing." (Participant 20)

Participant 1 sought help from a hearing centre and reported that:

"They checked me out and they said to me like we did here. (Pauses), and he said, well your right ear is a little bit worse than your left ear." (Participant 1)

Participant 21 stated the following from her visit to the ENT Specialist:

"He tested the ears and referred me to the Audiologist." (Participant 21)

Whereas Participant 18, clearly not satisfied with the management of his hearing difficulties but still being able to consult a specialist at the onset of his help-seeking journey, reported the following:

"He gave me treatment for the infection not for the hearing, then he gave me feedback only about the ears." (Participant 18)

In comparison, the four participants (17,4%) who used informal social networks to seek help were either given alternative medicine for their hearing complaints, support by family or directed to a healthcare professional for consultation to resolve their hearing difficulties. This is what participant 16 stated:

"He made a mixture of Vicks in a particular cloth and gave to me to use, from there the symptoms stopped." (Participant 16)

Participant 9, who had confided in his immediate social support said the following:

> *"… and then she said we must all go together but I was scared. I said but I can still hear." (Participant 9)*

Participant 8 received specific referral details as he said:

> *"It is a lady; I think she works at (hospital name). We are in the same church. She told me that (name of Hospital) can help me, go to (doctor's name), he works with (hospital name). They will show you the way to help you." (Participant 8)*

Family and friends provided support by directing participants towards the relevant healthcare professionals. In addition, they were also available to accompany participants to the healthcare professionals.

Only one participant reported using traditional medicine for his hearing difficulties. For participant 16, the use of traditional medicine improved his symptoms such that he did not continue seeking help.

3.2.3 Influence of cultural practices and beliefs in seeking help

From describing their pattern of presentation, each participant was asked to explain the cultural practices or beliefs that influenced their seeking help from the social networks documented above. The responses from most of the participants (82,6%) pointed towards a belief in the Western medical model to cure illness. Notably, this influence was found in all the ethnic groups as they expressed the value of healthcare professionals over traditional professionals to resolve their hearing complaints. Although some participants appeared surprised at the question, they nevertheless felt strongly about their beliefs by saying:

> *"You go to the doctor. Even with your beliefs, you must go see the doctor, we refer to you because you guys went to school." (Participant 17)*

Participant 2's daughter reported that:

> *"No, we went to the doctor because we thought that he would have some knowledge." "For us, we think that the doctor has the knowledge, or the knowledge would be from the doctor." (Participant 2).*

Participant 22, expressed that he did not trust traditional healers but rather stated:

> *"I believe that I want to be healed, feel better, cured." "It is you, the doctors, that will cure me. Traditional healers will only take advantage of your money." (Participant 22)*

Participant 10 reported in this way:

> *"When I am sick, I go to the doctor." (Participant 10)*

These participants, though varying in age and socio-economic position, were influenced, and motivated to seek help for their ear and hearing difficulties due to experiencing and viewing their bodily ailments from a biomedical. However, participants' responses may also have been influenced by the hospital context by providing answers that are deemed socially appropriate. In addition, being interviewed by a health practitioner and the stigma associated with traditional medicine may have prevented participants from openly declaring their influences. Comments by Participants 17 and 23 confirmed this view:

> *"Even with your beliefs, you go to the doctor." (Participant 17)*

> *"Ja, I believe, I have faith (referring to religious faith). …but you know some days you need people in places to help you. Doctors in places to help you." (Participant 23)*

Meanwhile, 17,4% of the participants reported that they were influenced by either their indigenous cultural practices or their immediate social networks. Participant 16 for example, a 58-year-old male, reported the following,

> *"We are people of the soil, those Africans that believe in African remedies, that is why I used the remedy that was given to me." (Participant 16)*

Participant 16 felt strongly about being an African and the associated use of indigenous medicine as a remedy for his body complaints. He explained that he did not hesitate at being given this remedy as it was the norm and formed part of his socio-cultural context. It is interesting that only one participant reported an "alternative" traditional practice as influencing his help-seeking particularly at the beginning of his journey while no other participant in the sample reported being influenced by faith healers or any other traditional or religious practices.

Participants (13%) that had sought help from family and friends, had themselves assumed that they had made first contact with a healthcare professional but in fact they had first sought help from non-healthcare networks. This difference was observed as participants were reviewing their responses during the interviews. Surprisingly, the number of participants (13%) that were influenced by their immediate social support was more than those (4%) from traditional practices. Participant 23 reflected on her help-seeking by stating that;

> *"OK, I can start with that, because I've had a hearing problem for quite several years now and I've been asking my neighbour because her mother used to be here." (Participant 23)*

Participant 23 had confided in her neighbour repeatedly about her hearing impairment believing she would be able to help her.

To further illustrate this point, Participant 8 had reported that he sought help by asking a lady from his church, where he could find help and said the following:

> *"It is a lady, where does she work (Pauses), I think she works at (Hospital name). She told me that (name of Hospital) can help me." (Participant 8)*

Evidently, some of these support systems had previous experiences with resolving their hearing difficulties hence these participants had confided in them. However, one participant defended his beliefs even though he used his social network for help, by stating that:

> *"...but I use medical doctors, that is where my faith is and then also prayer (pauses) those two things." (Participant 8)*

He also stated:

> *"I go with the belief that I am going to pray to God to ask where should I start. Yes, to help me and to help the doctors because if you don't pray to God to help my doctors, sometimes things won't work out." (Participant 8)*

Participant 8 had sought help from his social network yet when asked what influenced him, he referred to his religious beliefs. It is possible that he minimised his social support as an important cultural influence.

Nevertheless, data analysis showed that another participant was also influenced by their religious beliefs. According to the participant and her daughter, when solutions to their hearing difficulties were beyond their abilities to manage, the daughter explained that:

> *"She realised that because the doctor was asking for a lot of money, the solution is to surrender everything to God." "So, she said according to her faith, it is rather better to surrender everything to God". (Participant 10)*

This is comparable to Participant 16 who was influenced by traditional beliefs and then sought help from Western medical healthcare.

Meanwhile, three participants (13%) who were influenced by a Western medical model of healthcare also reported being influenced by the limitations from the hearing impairment. This is reflected in the comment made by Participant 1 below:

> *"I just feel that you know at this point in my life, I want to hear my kids; I want to hear my grandkids (pauses) talk to me, my 2 grandkids are 8 and 10 years old. I can't hear what they are saying." (Participant 1)*

Participant 22, the oldest participant in the sample, stated:

> *"I was influenced by the fact that people are laughing at me. I cannot hear even when they are talking, they become irritable with me at home." (Participant 22)*

Both Participant 1 and 22 had hearing thresholds that ranged from severe to profound bilaterally which is consistent with the self-reported hearing difficulties that participants were experiencing. However, Participant 15, whose thresholds were below the sample average reported that:

> *"The thing that influenced me was that I realised that I was becoming a problem for people." (Participant 15)*

Even though Participant 15 presented with a mild hearing impairment, the impact on her life and those around her also influenced her help-seeking.

3.3 SUB-AIM 2: Process from onset of symptoms to accessing audiology services

The process that participants took from the onset of symptoms to accessing audiology services was generally composed of two journeys. As a pattern towards accessing audiology services, participants were identified to have had short or long journeys. From the onset of

symptoms, the process of seeking help and finding audiology services for most of the participants (74%) was long, with the rest of the participants (26%) having experienced a short journey to seeking help as they were able to reach the audiologist by self-referral or shortly after one referral.

3.3.1 Short Journeys

Table 4

Participants' Short Journeys of Help-seeking (*N = 23)*

Participant	Short journeys	
Participant 5	Public Hospital Audiologist	
Participant 19	Public Hospital Audiologist	
Participant 12	Private Healthcare worker	→ Public Hospital Audiologist
Participant 21	Public Hospital ENT Specialist	→ Public Hospital Audiologist
Participant 22	Public Healthcare Clinic	→ Public Hospital Audiologist
Participant 23	Neighbour	→ Public Hospital Audiologist

Table 4 shows the short journeys as described by some of the participants in their help-seeking process. As indicated, only a few participants were able to reach audiology services immediately.

As depicted in Table 4, most participants within the short-journey cohort (26%) were able to promptly access audiology services from the onset of their journeys. Participants used healthcare and non-healthcare networks to reach the audiologist while the healthcare networks were mostly involved in the direct referral to audiology. Though the type of healthcare workers involved were not all described, an ENT specialist, possibly working closely with the audiologist, typically enabled the process of seeking help to be short. Surprisingly, participants who accessed the audiologist immediately, said the following:

> *"My father was here, about 8 years ago, and I've told her, maybe we must come here and maybe we can just test." (Participant 4)*

Participant 19's daughter-in-law reported:

"My father-in-law has come to the Audiologist before." (Participant 19)

The ease of access to the audiologist by the participants through first-hand knowledge of the services made the process shorter. It also helped participants when healthcare workers directly referred them to the audiologist from the public healthcare clinic as Participant 22 stated:

"I was at the clinic. I saw the doctor, and that doctor then phoned here at (name of hospital) to come..." (Participant 22)

Participant 22 was able to access audiology services sooner rather than later through the actions of a healthcare professional. It is possible that participants' journeys could have been longer without the assistance and knowledge of the healthcare professionals. Similar conclusions can also be drawn regarding those who used non-healthcare networks like Participant 23 who reported:

"As I said, I went to my neighbour for help." (Participant 23)

Of the four participants that were directly referred by another individual, only one participant used the private healthcare worker at the beginning of the process of seeking help. It is interesting to note this, as the majority of participants, regardless of their ethnic background, used public healthcare services. The researcher posits that Participant 12 used private healthcare services because of an existing relationship they had with the medical doctor.

3.3.2 Long journeys

Table 5

Participants' Long Journeys of Help-seeking (N = 23)

Participant	Long journeys-
Participant 2	Private Doctor → Family friend (HCW) → Public Hospital Audiologist
Participant 7	Public Hospital Endocrine Specialist → Public Hospital ENT Specialist → Public Hospital Audiologist
Participant 9	Friend → Family (HCW) → Public Hospital Audiologist
Participant 11	Hearing Centre → OTC → Friend → Public Hospital Audiologist
Participant 13	Public Healthcare Clinic → Public Healthcare Clinic → Public Hospital ENT Specialist → Public Hospital Audiologist
Participant 14	Public Healthcare Clinic → Public Hospital ENT Specialist → Public Hospital Audiologist
Participant 15	Public Healthcare Clinic → Public Healthcare Clinic → Public Hospital ENT Specialist → Public Hospital Audiologist
Participant 17	Employer HCW → Public Hospital ENT Specialist → Public Hospital Audiologist
Participant 1	Hearing Centre → Private Audiologist → Public Tertiary Hospital → Public Hospital Audiologist (2)
Participant 3	Public Healthcare Clinic → Public Hospital ENT Specialist → Family friend (HCW) → Public Hospital Audiologist
Participant 4	Chemist → Private Doctor → Acquaintance/Colleague → Public Hospital Audiologist
Participant 16	Traditional Medicine → Public Healthcare Clinic → Public Hospital ENT Specialist → Public Healthcare Audiologist
Participant 6	Private Doctor → Public Audiologist → Public Doctor → Public Hospital ENT Specialist → Public Hospital Audiologist
Participant 8	Friend (HCW) → Private ENT Specialist → Private Audiologist → Private ENT → Public Hospital ENT Specialist → Public Hospital Audiologist
Participant 10	Private Doctor → Private ENT Specialist → (Family) Healthcare worker in hospital → Public Hospital Audiologist
Participant 18	Public Hospital ENT Specialist → Private Doctor → Public Hospital ENT Specialist → Public Hospital Audiologist
Participant 20	Public Healthcare Clinic → Public Hospital ENT Specialist → Public Healthcare Clinic → Public Hospital ENT Specialist → Public Healthcare Clinic → Public Hospital ENT Specialist → COVID-19 vaccination site → Public Hospital Audiologist

Key: HCW = Healthcare workers, OTC = Over-the-counter

Table 5 depicts the long process of seeking help from the onset of symptoms until participants accessed audiology services. Participants mapped their individual journeys independently or with the help of family members.

In the long journeys, as shown in Table 5, 17 participants (74%*)* interacted with a variety of healthcare workers from the private as well as the public health sector. While one (5,8%) participant sought help from seven different people, three participants (17,6%) interacted with two people before accessing audiology services. Informal social networks were also part of the process of these long journeys as participants sought to resolve their hearing difficulties. Thus, participants had unique journeys as they made their way through the healthcare system. Some participants began their journeys at the lowest level of healthcare such as PHC (*n = 6)*, private doctor (*n* = 5) and chemists (*n = 2*) while some sought help with audiologists (*n = 2*) and specialists (*n = 1*). However, in between, the process was long because participants went from one healthcare professional to another seemingly without a solution. A family member had this to say:

> *"She went to the chemist, and they only syringed it. He syringed the ear, but that was not it (Pauses) It was really a hearing struggle." (Participant 4)*

Participant 19 bemoaned the management of his hearing by saying:

> *"The doctor gave me medication to treat the infection but not for the hearing." (Participant 18)*

Participant 20 reflected on his long journey with the following words:

> *"Ya, that was for the third time that I went to the clinic (pauses), the nurse gave me a referral letter but the third time I went there, the doctor (at the clinic) was there, and he was able to help me." (Participant 20)*

Participant 2 commented by saying:

> *"Isn't it that at (doctor's name), he said that he treats only the body, so find someone elsewhere." (Participant 2)*

As participants started their journeys, their ear and hearing complaints were not resolved therefore they continued seeking help. However, some participants returned to the same healthcare worker that they had unsuccessfully used earlier in their journeys. This is apparent with participants who sought help from the public healthcare clinics. Participant 13 reported:

> *"I went to the clinic two or three times." (Participant 13)*

> *"Yes, last year again, I kept going to the clinic and telling them that I cannot hear very well." (Participant 15)*

However, this was also observed with three participants that had consulted ENT specialists. Their journeys were long because they consulted the specialist repeatedly while seeking to resolve their hearing difficulties. The consultations in between were mostly to the private healthcare professionals. Participant 8 explained his journey in the following way:

> *"I quickly went to (specialist's name). He also checked me thoroughly, then he referred me to the private audiologist. Then she referred me back to (specialist's name). So, (specialist's name) realised that the money she was asking for is very high - over 27 or 24 thousand. So, I did not have that money., what can I do? So, he said he would refer me to the hospital (public ENT specialist), then the hospital will refer me to the audiology." (Participant 8).*

Participant 18, who was not happy with the management of his ears by the specialist, in between his consultations with the specialist stated:

"I went to a private doctor. I was looking for help (Pauses) but an assault at the taxi rank made me go back to the specialist." (Participant 18)

Accordingly, solutions to illnesses were to be found in the health facilities and its healthcare workers. However, as documented above, healthcare workers did not always contribute to the long journeys. One male participant, acknowledging that he found help after a long time, used the healthcare system to his advantage by repeatedly going to the clinic with the intention of being referred to the hospital. Participant 20 said:

"The reason is I wanted to go to the hospital. So, that is why, at the clinic, I go with the intention, not even with the expectation of help, but I go intending to ask for a referral letter." (Participant 20)

Personal preferences appeared to also contribute to participants' long pathways of seeking help.

From the repeated journeys to healthcare workers, to not finding help from healthcare workers, participants journeys were also long as they additionally sought help from the informal networks in their social contexts. Most of these informal social networks were healthcare workers (29,4%, n = 17) whom participants knew personally while a few were friends or acquaintances (11,7%, n = 17). This is reflected in the following participant's comment:

"(Name of doctor) said that he treats only the body, so we must find someone elsewhere. Then we asked Ous (name of friend), where can we go for the ear doctor? She said here, she even works at (name of hospital)." (Participant 2)

While Participant 3 said:

> *"I went to the (ENT specialist name) but 'til today I haven't found help. That is why I asked my younger sibling to find help for me here at (name of hospital)." (Participant 3)*

Participant 11's wife was frustrated with the cost of healthcare until a friend helped them in this way:

> *"We couldn't afford going to audiologists and so then a friend of ours. This lady, we stay in the same complex. She told us about you. She said try them." (Participant 11)*

Participant 4's daughter was eventually helped by her colleague:

> *"…my boss brought his dad here about 4-5 years ago. That is how I knew to come here." (Participant 4)*

It was after having been through more than two healthcare professionals, with unresolved hearing complaints that these informal networks were consulted by participants. Whether participants were alone or accompanied by their children, as most were older adults, these informal networks came after participants had sought help from healthcare workers in the medical facilities.

Despite seeking help from informal networks after seeing healthcare workers, two participants (11,2%) consulted with friends at the beginning of their journeys before reaching healthcare professionals. Participant 8 said the following:

> *"Someone told me about (name of place). It is a lady. I think she works at (name of hospital). We are in the same church. This lady told me that (name of ENT specialist) is the one who works with ears, speech and so on…" (Participant 8)*

Participant 9 lived with a friend who had a hearing impairment:

"I told the lady that stayed with me. She had a hearing problem and then she said we must all go together." (Participant 9)

Both participants were directed towards appropriate help but still had long journeys to reaching the audiologist. Access to audiology services could have been shorter but was also further delayed as Participant 9 reported:

"...but I was scared. I said but I can still hear." (Participant 9)

When Participant 9 was ready to seek help, it appeared from his response documented above that he knew where to go but he nevertheless sought help from a family member who was a healthcare worker in the hospital before accessing the services he needed.

In contrast, six of the participants (35,2%) who were helped by family and friends, had immediately accessed audiologists from these social networks. Participants that did not have these informal social networks went through a combination of healthcare professionals in the private and public health sector seeking help before they reached the audiologist.

With regards to seeking help from the private health sector, participants' journeys were complex. Participants (41%, $n = 17$) saw various healthcare professionals before reaching the audiologist. Whereas in the public health sector, a PHC consult was followed by a referral to the ENT; in the private sector, a private doctor, was followed by either a private ENT specialist or a private audiologist or a family or friend and even sometimes a combination of these networks before reaching the public audiologist. In addition, participants from all the ethnic groups, appeared to have a preference towards private healthcare rather than using public healthcare.

However, not all participants sought help from private healthcare professionals because of preference of care. Participant 18 was seeking a second opinion as he explained:

"I went to the doctor because I wanted to know more. I felt the doctor (specialist) wasn't helping me." (Participant 18).

This 40-year-old working male participant nevertheless returned to the same specialist who eventually referred him to the audiologist.

Data results also indicated that ENT specialists acted as gatekeepers. For most participants (52,9%, *n* = 17), the specialist was the link for reaching the audiologist while for some (17,6%, *n = 17)* the specialist reportedly did not refer participants on to audiology services. Participant 6, who was accompanied by her husband detailed her journey:

"He (referred to husband) actually started to go to the doctor and then my ear was paining very bad and then he said to me…ya why don't you go see the doctor? and then I went directly to her (ENT specialist). She then said I must come here." (Participant 6)

Participant 13 stated:

"The specialist checked my ears and then he referred me to you." (Participant 13)

However, Participant 3 stated:

"They sent me to the hospital to (name of ENT Specialist) but I find no help." (Participant 3)

"I went to the hospital repeatedly; but I found help after a long time. (Pauses). I saw the specialist for almost seven months and instead of my ear being better, it became worse." (Participant 20)

As the ENT specialists were found to be at the end of the process of seeking help for most participants in the long journeys, this was contrary to the short journeys where a participant first sought help with the specialist. Participants reached the specialist after seeking help

from a combination of other healthcare professionals and informal networks. Participant 15 stated:

> *"Yes, last year again, I kept going to the clinic and telling them that I have a hearing problem, then they gave me a referral letter to go to the hospital. I saw the doctor until he referred me here." (Participant 15)*

Participant 13 added,

> *"The specialist checked my ears and referred me to you." (Participant 13)*

Participant 14 was accompanied by his son reported that:

> *"The process was easy. There were no hassles. We went to the clinic and the clinic referred us to the hospital. Once we saw the doctor, he then gave us a letter and an appointment to come to you." (Participant 14)*

The researcher considers if participants realised how accessible the specialist was considering their long journeys.

With regards to the specialist, five participants (29,4%) did not interact with the specialist in the process of seeking help. Participant 1, a male participant who was in a tertiary hospital for another medical condition stated:

> *"...because I had prostate cancer. Then while I was there, the doctor said to me, I wanna take you to the audio. The doctors said they cannot talk to me. Then they took me up to the audio division." (Participant 1)*

A healthcare worker, who was not working in ear and hearing care, referred Participant 1 to the audiologist. In addition, this participant was helped by two audiologists, while other participants were helped by mostly private healthcare workers, friends, families, and over-the-counter consultations at the least. Participant 11's wife reported:

"We struggled. We couldn't afford going to the audiologist and (pauses) but then our friend, this lady told us about you." (Participant 11)

Perhaps participants were seeking help from specific healthcare professionals only or that participants did not know where to go. As Participant 11 admitted:

"Well, we didn't know about it. Oh, I didn't know there was a possibility that we can come here." (Participant 11)

Nevertheless, more steps were added to participants' journey as they sought to resolve their hearing difficulties.

Data analysis indicated that participants eventually accessed audiologists, as the appropriate healthcare provider, at the end of their journeys. However, two participants had sought help from audiologists at the onset of their journeys.

Participant 1 said:

"When I stayed in Bangkok. Now, Bangkok is a very good place, and we stayed in a hotel there (pauses) and the other corner I saw a hearing centre. I wasn't even going to go there, by accident I see this hearing centre and then I went there, and they said free hearing test." (Participant 1)

While Participant 11 confirmed with her husband by saying:

"(name of hearing centre) isn't it? That is the first place you went to for your ears, right?" (Participant 11's wife)

This pattern of seeking help should have resolved their hearing impairment sooner but participants continued seeking help. Participant 1 described the outcome of a second hearing test by saying:

"... and she said "oh, not so good, you better get hearing aids" or whatever. But then I obviously, uhm, decided to cancel my medical aid because my income was like (hesitates) I just lived; I just basically exist." (Participant 1)

Participant 11 stated:

"Well, we couldn't afford going to the (audiologist's name) and whoever because - they are just too expensive (pauses) and so we wait." (Participant 11)

3.4 SUB-AIM 3: Barriers and facilitators towards hearing help-seeking behaviour adopted

3.4.1 Barriers

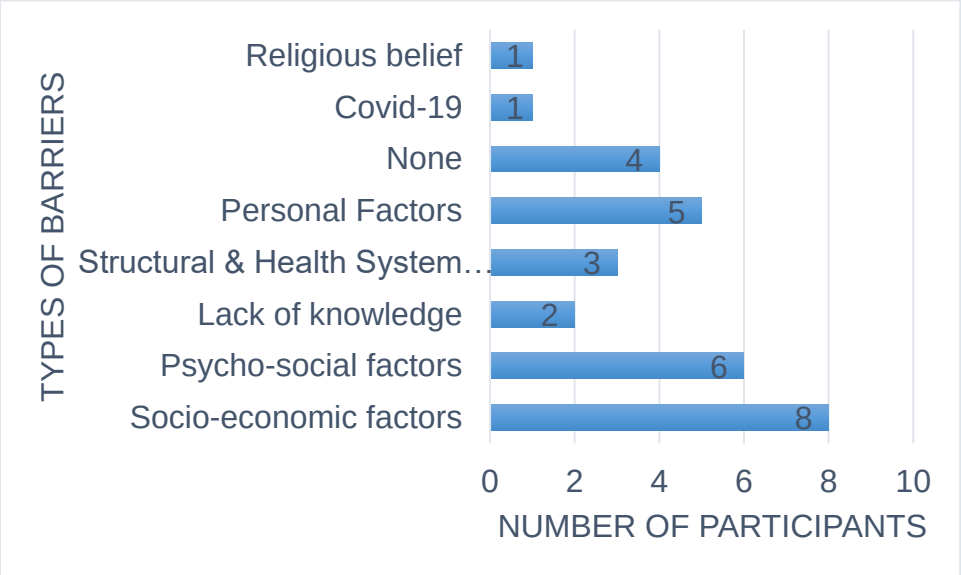


Figure 1. *Participants' Barriers towards Hearing Help-seeking (N = 23)*

As is evident above, Figure 1 shows a variety of factors that acted as barriers in participants' hearing help-seeking behaviours. These factors were identified using a deductive thematic approach and they are all discussed individually below.

3.4.1.1 Socio-economic factors. Figure 1 shows that the greatest barrier among participants was that of socio-economic factors (34,7%). Participants described mostly a lack

of finances and health insurance as a great limiting factor towards accessing help. Participant 11's wife stated:

"The only thing was finance! (Pauses). It was just the money." (Participant 11)

Participant 12's daughter expressed her inability to help her father by reflecting in the following way:

"If you don't have money, it is difficult. Your hands are cut off." (Participant 12)

Participant 4 said:

"...because you know it's very expensive…and that's why we (pauses), idle because the medical aid is not helping and she's a pensioner. You know (pauses), that's why." (Participant 4)

Participant 10's daughter, who worked in the hospital as a nurse reported:

"As I had mentioned that the things that stopped us (pauses) it was the money part of it." (Participant 10)

Participants lamented the cost of healthcare with what they could afford and access for their health complaints. However, participants were referring to the cost of private healthcare not public healthcare.

One must consider if this barrier was more notable for older adults as they aged and with no possibility of employment to pay for these services. However, one participant, though old in age, reported that:

"Money was not the barrier; I was simply very happy." (Participant 24)

Though for this participant finances were not the barrier, most participants were prevented from moving forward in help-seeking because of this factor.

3.4.1.2 Psycho-social factors. Psycho-social factors (26%) accounted for the second highest barrier towards hearing help-seeking Six participants described attitudes towards the hearing impairment, healthcare workers, as well as hearing aids as contributing to the delay in their journey. From the transcribed interviews, despite the effect of the hearing impairment on communication, participants minimised or denied the hearing difficulties that they had by reporting the following:

Participant 19 denied the problem while her daughter had acknowledged it.

> *"She stopped me herself. She was stubborn. It was hard to admit the hearing loss for her." (Participant 19)*

While Participant 2 and her daughter minimised the hearing impairment:

> *"I think just like me…she took it lightly." (Participant 2)*

Participants' families had either a positive or a negative attitude towards the hearing impairment which influenced participants' decisions towards seeking help. Participant 13 explained it in this way:

> *"I was monitoring the ears to see if they were getting worse or not." (Participant 13)*

Participant 4's daughter said:

> *"I didn't think it was that bad (pauses), it's not necessary already that time." (Participant 4)*

However, this was followed by a sense of guilt as families considered the hearing impairment and their parents:

> *"...but I decided, no, I must make it easier for my mom." (Participant 4)*

A related psycho-social factor was that of stigma. Not only did participants have a negative attitude towards the hearing difficulties but the same was observed towards hearing aids. Participant 9 said,

> *"...my brother also had one, but it was also big, and I said I don't want those things. Really, you know, (pauses)... it, it's not me because I, (hesitates), I can't see myself in those." (Participant 9)*

An attitude towards healthcare workers was also observed to be a stumbling block in help-seeking for hearing difficulties. Participant 6 reported the following,

> *"Ya, you know I'm not a person who likes to go to the doctor. I just don't like it. So, I don't trust them actually unless I know that doctor very well." (Participant 6)*

A negative experience with healthcare workers, contributed to this attitude. The researcher posits that the negative experience was a serious barrier for Participant 6 in their decision-making. Coincidentally, this is the same participant that believed that God would heal her.

3.4.1.3 Personal factors. Five participants (21,7%) reported personal factors inhibiting the process of seeking help. This included family responsibilities to dynamics related to age, which prevented participants from seeking help sooner. Participant three said:

> *"My only prevention was (pauses)my mother. She was in and out/going to and from (referring to hospital admission due to ill health) with her and her situation became (hesitates)" (Participant 3)*

Participant 16 did not elaborate on his personal factors but merely stated that:

> *"I stay alone and there were family issues that prevented me." (Participant 16)*

Participants were required to prioritise the needs of others before their own. This resulted in their own needs not being met timeously. Meanwhile, barriers that were from when

participants were younger in age were reported. Participant 17 acknowledged his responsibility in not being able to help his parents help him:

> *"I was the barrier not my parents. If I had said something to them, I would have been helped." (Participant 17)*

Participant 21 reflected on her decision-making:

> *"When you are young, you play with your time. You must immediately seek help." (Participant 21)*

Participants took responsibility for unresolved hearing difficulties despite being dependent on parents at the time.

3.4.1.4 Structural and health system factors. As indicated in Figure 1 (depicted above on page 88), healthcare workers were highlighted by participants (13%) as a barrier towards accessing help. Participants experienced a lack of information and care related to their presenting difficulties. This prevented them from continuing in their journeys.

Participant 18, who had sought help from an ENT specialist at the hospital reported:

> *"The doctors do not give you the full information. The sick person tells the doctor, but the doctor must also help." (Participant 18)*

Participant 21 stated:

> *"...because of my previous experience when I was younger, I didn't know I could find help. I thought maybe they can't help me." (Participant 21)*

Healthcare professionals from the public healthcare clinic to the hospital did not seemingly help in easing the burden of ear and hearing complaints. Nevertheless, despite being perceived to have been failed by the healthcare system, some participants also contributed to

the barrier of unresolved hearing difficulties such as Participant 21 who stated that she 'played with her time' when she was younger.

3.4.1.5 Lack of knowledge. From participants' experiences of healthcare, a lack of knowledge about ear and hearing prevention and cure prevented participants from seeking help. Though few (8,7%), not knowing where to go for help was limiting for the two participants as they felt they could have resolved their hearing difficulties sooner. Participant 2's daughter stated that:

> *"It was a lack of knowledge that if a sickness starts, quickly go to the doctor, search, and find out…you know. So, I think that the barriers are the lack of knowledge." (Participant 2)*

This lack of knowledge was not only observed with the two participants but also with healthcare workers. Participant 2 stated:

> *"When I go to the doctor, the doctor tells me that I must go and find someone (pauses), the doctor tells me that he only treats the body not the ears." (Participant 2)*

Healthcare workers added an extra burden on those with hearing complaints to find their own solution to their ill health. Nevertheless, not only did participants face barriers from healthcare workers like participant 18 but their own personal lack of knowledge of audiology services delayed their journey of seeking help. Participant 18 lamented not knowing about audiology services for him to seek help sooner. A secondary injury to his ear resulted in a referral to the audiologist as he repeatedly said:

> *"It was a lack of knowledge." (Participant 18)*

3.4.1.6 COVID-19. Considering the COVID-19 pandemic, one participant, a 64-year-old male, reported that COVID-19 was a barrier towards seeking help. Participants 8 was

about to seek help when the South African government declared a level five lockdown stipulating that everyone stay home. As a result of the impact of the hearing impairment on daily activities, the participant reportedly decided to move forward in his journey just at the beginning of the pandemic.

"It was Covid (pause) and then the need for money." (Participant 8)

Even though the effects of COVID-19 were experienced by everyone, only one participant reported on its effects.

3.4.1.7 Religious beliefs. As only one participant reported COVID-19 as a barrier, Participant 6 was the only adult that reported that she always believed that God would heal her. This was her reply in response to the barrier in seeking help although the participant admitted to being reluctant to seek medical help due to a negative attitude towards healthcare workers.

3.4.1.8 No barriers at all. Finally, an interesting aspect emerged from the data in that a few participants (17.3%) reported that they did not experience any barriers in their journey towards hearing help-seeking. From accessing health services to knowledge of the audiologist, participants felt they were able to move forward without any hindrances in their journeys. Participant 5's daughter said the following:

"Aarg no, I think because my mom was visiting my brother now and I didn't notice it. He noticed it and when he told me, I thought maybe I must bring her. So, there's nothing." (Participant 5)

Participant 14, who was accompanied by his son stated:

"There were no challenges. Everything was easily accessible." (Participant 14)

"I don't recall having any barriers. It's just that…ai, I don't know. I would be lying." (Participant 15)

Considering the benefit of seeking audiology services and resolving their hearing difficulties, these participants did not perceive any barriers. As Participant 22 insisted:

"…that is not a barrier, in fact I was actually very happy (happy to be referred for help)." (Participant 22).

It is interesting that participants who had been accompanied by family members also reported no barriers.

3.4.2 Facilitators

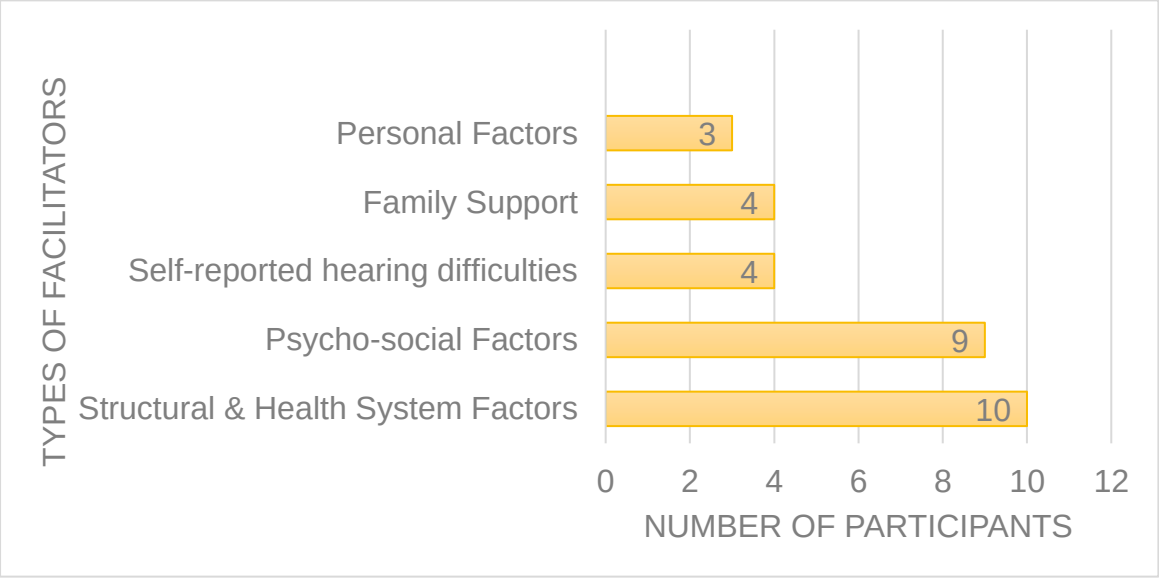


Figure 2. *Participants' Facilitators towards Hearing Help-seeking (N = 23)*

Figure 2 above depicts facilitators in the participants' environment that were deductively identified when participants were asked what influenced their help-seeking. These five factors will be discussed below.

3.4.2.1 Structural and health system factors. As depicted in Figure 2, the majority of participants (43,4%) reported structural and health system factors as the main facilitator

towards seeking help for their hearing difficulties. The availability and support of healthcare workers, knowing healthcare workers in the community and the ease of access to health services were reasons that moved participants forward in their journey. Participant 1 said the following:

> *"The doctors, (pauses) the doctors there. (pauses) They said, you have to look after your hearing, (hesitates) have to look after your hearing because you don't hear what we're saying." (Participant 1)*

Participant 2, an 89-year-old female participant, accompanied by her daughter stated:

> *"I think the help was Ous (HCW name) and to come here to (Hospital name). 'I think the help was that Ous (HCW name) referring us here." (Participant 2)*

Participant 15 explained that:

"The things that made it easier for me to find help was the clinic only and the hospital." (Participant 15)

Participant 14 added that:

> *"It's the healthcare workers. They work very well, I applaud them." (Participant 14)*

Evidently, participants were overwhelmingly pleased with the help that they received from the healthcare professionals - directly or indirectly. Participant 1 reflected on the help he received at the hospital by saying,

> *"They actually made, me believe that I have to give my hearing a chance. I could have left it there… like that.*"

Even when participants were accessing the hospital services for other reasons, the availability and help of healthcare workers influenced them to pursue interventions despite having

already sought help. This is seen in Participant 1's comment above. Similarly, Participant 20, who was evidently still looking for a solution for his hearing difficulties despite his long journey, stated:

> *"To come to (hospital name) is because of I received a pamphlet at the vaccination site. Oh! there is an (pauses) let me try somewhere maybe they can see something different." (Participant 20)*

One wonders if these participants had different expectations of help from public healthcare workers hence their positive responses. Nevertheless, Participant 21 was mindful of the challenges in the public healthcare sector and reasoned the delay in getting an appointment by justifying the waiting period.

> *"As soon as we got the appointment it was easier for us." "...because I know their clinic is busy, you just need to be patient. The state only asks us to be patient. We pay so little." (Participant 21)*

Participants were able to access the health services they required without being burdened about its affordability.

> *"It's wonderful to get to (pauses) to know that you can get help for it without going to pay that kind of money." "It's so easy to find help." (Participant 23)*

3.4.2.2 Psycho-social factors. Psycho-social factors followed as the second highest facilitator (39,1%) towards resolving ear and hearing complaints. This included an attitude towards the hearing impairment, the hearing aid itself and participants' sources of motivation and related self-efficacy. Participant 12's daughter-in-law stated

> *"It is frustrating for him and my mom." (Participant 12)*

Participant 2's daughter highlighted her mother's feelings by saying:

"I think it was the frustration from her side. She was frustrated with herself and even upset with people. Being upset or irritable and realising that this is not working." (Participant 2)

Participant 3 commented in the following way:

"The other thing that helped me to find help is that I enjoy working with people. So sometimes when they talk, and I don't hear them (pause) I become embarrassed and the fact that I cannot hear (hesitates) it is embarrassing." (Participant 3)

Attitudes towards the hearing impairment were experienced mostly during interactions with others. These feelings were not only as a result of the hearing impairment, but also due to additional health problems in older age. This is observed in a comment by a participant who said:

"Yes, and then she gets upset and irritable with herself, that what does it matter, the eyes are also failing, it's the age and now the ears. She really gets frustrated." (Participant 2)

Despite participants' attitudes, data analysis indicated that family members were also influenced by their own feelings as they experienced participants' hearing difficulties:

"But then, it is only now that I realise that but this, this is a serious problem, you know, and then, for me to realise that it is a serious problem, it was affecting me. Especially between us (pause) you will find that when I talk to her, I increase my voice, and then it is not ok." (Participant 2)

What was notable in the data analysis was that a negative attitude towards hearing aids became a positive influence later for one participant. Pursuing help was now a possibility for this participant. He stated:

"…and now the fact they say it's smaller things (referring to the hearing aids), it will be bearable for me. I can grow my hair a little bit longer, things like that, so I can hide it. So, they don't see it." (Participant 9)

While participants were positively influenced in their attitude towards the hearing impairment, it is interesting that source of motivation also helped to move four of the participants (17,3%) towards resolving their hearing difficulties.

Participant 7 stated:

"It is to ask for yourself, to initiate asking for help (pauses) to ask for help from the doctors." (Participant 7)

Participant 16, who had initially sought help from traditional health providers said:

"I am an ambitious person. So, I said to myself this is not working for my life. It is rather a stumbling block." (Participant 16)

Participant 22, an 89-year-old male reported:

"I simply thought to myself like, the doctor was telling me to go. I simply said to myself, ya, this is a great help for me." (Participant 22)

3.4.2.3 Self-reported hearing difficulties. While some participants' reasons for seeking help were mainly influenced by their behavioural attitudes, four participants (17,3%) described the experience of the hearing difficulties upon the quality of their everyday lives as a catalyst in their journeys. Three participants reported a difficulty in communicating, with one participant reporting auditory signs of decreasing hearing as a reason for seeking help. Participant 19 had this to say:

"It's, talking to somebody and I don't understand what they say or don't hear what they say. That's the main thing for me to say…well I need some help." (Participant 9)

Participant 13 complained of activity limitations by reporting that:

> *"It's the news, I can't hear well when listening to the TV or when I'm with people. I cannot hear what they are saying." (Participant 13)*

Participant 6, reported auditory symptoms by stating the following:

> *"...but then this little zing thing, is irritating me. and then I thought it never used to be there. There must be something wrong and that's when I went. I started with the doctors." (Participant 6)*

3.4.2.4 Family support. Family support was described by four participants (17,3%) as facilitating their journey of seeking help. Families either encouraged participants to find help or they sought help for them. It was also noted that support was mostly from female members of families and they in addition accompanied participants to reach help. Participant 4's daughter felt that it was her responsibility as she stated:

> *"I made the appointment. I brought her here. We booked her in, and you just helped us now." (Participant 4)*

Participant 3, who had a high self-efficacy yet felt embarrassed by her hearing difficulties was supported by her family to find help.

> *"Then also, my younger siblings kept on asking me, asking me (about her hearing). She also said she will do what my mother intended to do, (pauses) I want to find help for you for your ears." (Participant 3)*

Participant 5 stated:

> *"I didn't (pauses) like I said, I didn't think two times, where I must take her. I know where I must take her, (Pauses) because I know where to come." (Participant 5)*

3.4.2.5 Personal factors. A positive relationship between personal factors and help-seeking was also found with three participants (13%). Though few, social support, age, and a traumatic event enabled participants to move forward in their help-seeking journey. While two participants were indirectly influenced to seek help, Participant 12 was 82 years of age when he decided to seek help. Participant 12's daughter explained his condition:

> *"He's old and sick." (Participant 12)*

However, it was also frustration, as reported by the family, that influenced Participant 12 to seek help. It is interesting that although the sample consisted mostly of older adults, age was only reported by one participant. Meanwhile, Participants 11 and 18 were only influenced by personal reasons.

Participant 11's wife stated:

> *"She told us and that was also about a year ago that we just didn't do anything about it." "…and then (friend's name) came and she said…come with me." (Participant 11)*

Participant 18, who had consulted an ENT specialist explained that:

> *"An incident helped me to get to the Audiologist. Had it not been for the assault at the taxi rank…I really don't know." (Participant 18)*

Despite having consulted an ENT specialist before, this employed male participant sustained an assault to his head which resulted in being referred to audiology via the same medical specialist that he had consulted before. Consequently, it was this specialist that the participant reported as being a barrier.

4. DISCUSSION

Help-seeking for adults with hearing impairment has been defined as more similar than different in the experiences of participants from different countries. In addition, those with hearing difficulties reportedly make sense of this process from the context of their daily lives (Laplante-Levesque et al., 2012). According to Carson (2005), self-assessment based on activity limitations imposed by the hearing impairment influences decisions in all contexts towards hearing help-seeking behaviour. However, Zhao and colleagues (2015) described that geographic locations within differing countries can have different ways of understanding situations related to hearing help-seeking. Hence, research in the field of hearing help-seeking has been limited to provide an understanding of the decisions made towards resolving hearing difficulties in different environments.

In the context of the current study, the researcher investigated the help-seeking behaviour patterns of adults with hearing impairment in a peri-urban community of a multi-cultural and multi-lingual South Africa. Specifically, descriptions of patterns of presentation of symptoms in relation to cultural practices and beliefs were investigated. This was followed by definitions of the process of accessing audiology services from the onset of symptoms for all participants; then factors in the environment that acted as barriers or facilitators towards the hearing help-seeking behaviour that was adopted were examined. Findings in this study, even with a small sample size, have contributed to understanding patterns of help-seeking from the participants' perspective in a LMIC context.

4.1 Demographic Information

Twenty-three participants were included in this study representing the current demographic profile of South Africa and more specifically the North West province where the study was conducted. According to Statistics South Africa (2016), the 2016 intercensal

community survey for each province, showed that the population group distribution in the North West was Black 91,6%, Coloured 1,6%, Indian/Asian 0,4% and White 6,4%. Though the study sample was small, it nevertheless represented the profile of the population groups in the country making the study relevant contextually in its findings. In comparison to the current research in this field, to the knowledge of the researcher, this profiling has not been included in relation to study participants. Researchers that have investigated help-seeking in their settings have mainly focused on the behaviour patterns of individuals with hearing impairment (Carson, 2005; Duijvestijn et al., 2003; Laplante-Levesque et al., 2012). In a multi-lingual country, like South Africa, it is important to consider this factor as population groups are closely related to their cultures, which subsequently influences their behaviour (Flood & Rohloff, 2018; Ramma & Sebothoma, 2017). The strength in investigating help-seeking behaviour in this current study, is that the individual's social context including their ethnicity was considered.

As ethnicity is closely related to language, it is interesting that only three ethnic groups were identified despite South Africa having 11 official languages (South African Government; SAHO, 2021). However, the current study's findings were reflective of the demographics in the health provider catchment area as indicated by Statistics South Africa (2022) as well as the diversity of the country, in view of the age and gender distribution. Since South Africa is multi-lingual, all participants were able to express themselves adequately for the purposes of the study.

This study's sample also demonstrated the complexities of the South African context in terms of access to healthcare according to socio-economic position, which ultimately impacted on help-seeking practices which Coovadia et al., (2009) and Khoza-Shangase, (2019) have discussed in their research studies. In South Africa, health outcomes favour those with a higher socio-economic position, which is the minority, whereas the majority

have adverse health outcomes not only because of their socio-economic position but also because of the influence of language and culture (Ataguba et al., 2015; Flood & Rohloff, 2018). These three factors influenced many participants in this study, in their pattern of seeking help from the public healthcare system.

Specifically, part of the socio-economic characteristics of most of the participants was their occupational status. All participants except for two were unemployed. In addition, four participants (17,3%) who were within the working age population were neither employed nor self-employed. This is consistent with the high unemployment rate that is currently at 32,6% as reported by Statistics South Africa (2021). This finding, however, must be interpreted with caution as most of the participants (73,9%) were largely not economically active due to their age. The South African government considers old age from 60 years, where older adults are in the retirement stage of their lives if they were working and or may receive an older person's social grant from the state (South African Government, 2022). Despite being unemployed, patients' help-seeking patterns were not similar as participants initially sought help from different providers. Participants may have had income or earnings from other sources that enabled them to seek help from a variety of health providers. The researcher suspects that participants may not have openly disclosed their sources of income to the researcher who was also a healthcare worker in the hospital. Yet participants were also not asked if they received social security income which possibly influenced from whom they sought help.

In relation to their socio-economic position, a large proportion of all the participants from all the ethnic groups accessed the public healthcare system at some point for most of their hearing health needs as reflected in the results. The researcher posits that occupational status is the most salient reason for the use of the public sector by most of the participants. Coovadia and colleagues (2009) reported that an uneven distribution of resources across

provinces also influences health inequalities that affects selection of healthcare by those who need it. A study on healthcare use in a different province indicated that those who used the private healthcare sector were wealthy, medically-insured and from the White ethnic group (Abaerei et al., 2017). This is in direct contrast to the findings of this current study where participants were mostly unemployed, without a medical aid and from a combination of ethnic groups in the sample. This possibly reflects on the imbalances even within one country and provides more reason for the relevance of this study.

With regards to the age distribution in the study, the proportion of those above the age of 64 (65,2%) was consistent with published findings from the World Health Organisation (2021) regarding an increasing world population of people over the age of 60 years. Similarly, the limited studies on hearing help-seeking have mostly investigated this phenomenon in older adults (Carson, 2005; Duijvestijn et al., 2003; Meyer et al., 2014; Saunders et al., 2012) who were able to seek audiology care easily after onset of symptoms. However, these studies were conducted in HICs where healthcare systems and socio-economic factors are different in comparison to South Africa's developing context. To support the dominant demographics in this study, Hoeven and colleagues' (2012) study on the differences in healthcare seeking behaviour between rural and urban communities, found that in the North West province, the urban population was older than the rural population. In comparison, in another more urban province, a younger population was reported by Abaerei et al. (2017). Although, this current study was based in a peri-urban community, Hoeven and colleagues' study (2012) helps to explain the older cohort and the related employment findings.

Furthermore, participants who were older were also found to have consulted an audiologist with a family member. This finding is consistent with previous studies describing social support as an important aspect in hearing health-seeking (Carson, 2005; Clements,

2015; Meyer & Hickson, 2012). Family members and other close social networks were reported as having a positive or a negative effect upon the individual with a hearing impairment. This meant that they could be externally motivating or discouraging in the pursuit for help. However, these findings demonstrate social support from the perspective of HICs. In contrast, a study on help-seeking with a different chronic condition – Hepatitis C, in a low-income country (Pakistan), showed that social support was related to cultural beliefs (Pirani et al., 2015). In this study, women needed to seek permission from the male figure in the home to visit healthcare services (Pirani et al. 2015). Similarly, Elobaid et al (2016) reported that in the United Arab Emirates, men are the main decision-makers in the family, therefore having the power in a typically traditional and patriarchal society to influence behaviour patterns. This shows a gap in contextually understanding participants' help-seeking patterns.

In relation to the audiology consultation, the sample of participants in this current study who sought help were found to present on average with moderate hearing thresholds. Laplante-Levesque et al. (2012) similarly reported that help-seekers had a mild to moderate hearing impairment. This contrasts with Knudsen and colleagues' (2010) study who found that help-seekers were those with the highest degree of hearing impairment – greater than 56dB. However, the self-reported hearing difficulties could explain the association between seeking help and the higher thresholds but participants in this current study also presented with hearing difficulties that impacted their daily functions. This is supported by Ramma & Sebothoma (2017) who found a strong association between self-perception of hearing impairment and help-seeking behaviours. The researcher posits that participants in Knudsen et al.'s (2010) study may have delayed seeking help knowing that healthcare services were readily available whereas participants in the current study sought help at the beginning of the ear and hearing complaints from various healthcare professionals. Another possible

explanation could be that 17 participants from the sample (73,9%) presented with an asymmetrical hearing loss, according to Knudsen et al. (2010) individuals with an asymmetrical hearing loss were more likely to seek help than those with a symmetrical loss. However, the study sample was too small to draw any conclusions on this factor. In addition, studies in this area are limited to support the influence of hearing sensitivity on hearing help-seeking (Meyer & Hickson, 2012).

4.2 Pattern of presentation of symptoms in relation to cultural practices or beliefs

The first key finding of this current study revealed that many participants (82,6%) preferred the formal, Western medical healthcare providers as their first contact for resolving their hearing difficulties. This was despite the diverse country context, multiple health services, challenges in access and equity in healthcare, socio-economic differences (Khoza-Shangase, 2020; Musinguzi et al., 2018; van der Hoeven et al., 2012), and different participants' patterns of presentation of symptoms in relation to cultural practices and beliefs. A belief and an understanding of hearing impairment from a biomedical causation requiring the same solution was strikingly indicated. This is consistent with the studies conducted in South Africa (Pronyk et al., 2001; Moodley et al., 2016) where similar results were found in which participants first sought help from medical healthcare providers rather than non-healthcare providers such as traditional practitioners. These were studies of participants that had non-auditory chronic conditions in two different geographic locations. However, Sorketti et al. (2013) compared help-seeking in HI and LAMI countries and reported traditional healers as the predominant first contact for participants in developing countries. Although comparing HI and LAMI countries sheds light on the realities of different contexts in terms of help-seeking, the Sorketti and colleagues' (2013) study may have been too generalised in its comparison of LAMI countries. Nevertheless, the finding in this current study appears to suggest that participants with hearing difficulties understood their illness

from their own contextual reality. Therefore, more studies are needed to understand this phenomenon from different contexts.

With regards to the contextual realities of a multi-cultural environment, this study revealed that only 4,3% of participants sought help from traditional practitioners or those who use traditional medicine. This equated to one participant who used African herbal medicine prescribed to him for his ear complaints at the beginning of his help-seeking journey. This finding is consistent with van der Hoeven et al.'s (2012) who found that only a third of their study population in the same province visited informal networks. In addition, most participants from both rural and urban communities, when seeking help for a non-auditory chronic condition, did not visit traditional practitioners but those who did, reported that it was primarily for social problems (van der Hoeven et al., 2012). This is despite de Andrade and Ross (2005) revealing that traditional practitioners were involved and had been consulted in the treatment of a variety of ear and hearing difficulties. Furthermore, participants from their study cited that help was sought with traditional healers for mainly cultural reasons. This is consistent with the participant's explanation of the reasons for seeking traditional medicine for help. The difference in explaining the reasons for consultation highlight the cultural variations that exist in this context, which need to be considered when investigating behaviour patterns in help-seeking.

Research in hearing help-seeking has not reported this finding due to the dearth in contextually relevant studies in this field. For instance, Laplante-levesque et al., (2012) acknowledged the limitation in not investigating cultural differences in their four-country research paper. However, the finding in this current study and the related limited number of participants seeking help according to their cultural practices may be as a result of what Coovadia et al. (2009); Mackian et al. (2004) and Naik et al. (2012) have cited as urbanisation, attribution of illness and evolving socio-cultural and experiential factors in this

community. Participants' may have covertly attributed their hearing difficulties to cultural reasons but were not willing to openly share this in a medical setting. Nevertheless, this implies that culture and the social context cannot be separated in the lived experiences of those with hearing difficulties. In addition, in a culturally diverse country like South Africa, Audiologists cannot ignore the impact and influence of these cultural practices and beliefs as they provide an insight into the help-seeking behaviours of their patients (Pillay & Serooe, 2019).

Despite only one participant expressing his preferences and lived experiences by using cultural beliefs to resolve his ear complaints, interestingly, three participants considered their beliefs on the help-seeking journey. One would wonder the reason behind not intentionally seeking help with religious healers at the beginning of their journey or reporting this initially to the researcher. It can be considered that the participant did not want to appear as neglecting their spiritual beliefs over dependence on Western medical model of healthcare alone, especially when questions were posed by a health practitioner. However, Cornally and McCarthy (2011); Scott and Walter (2010) have reported that individual preferences dictate whether to seek help, and if so with which helper. Although participants did not report these findings as part of a pattern of presentation on the journey at the beginning of their help-seeking process, it is evident that decision-making was not simple nor linear, but rather it revealed the context within which the participants found themselves during their journeys which influenced their individual journeys.

Another pattern that emerged from the context of the current study was that in making decisions at the onset of symptoms, a few participants (13%) presented first to their family and friends for help. These were social networks that participants felt would support them in finding solutions for their ear and hearing difficulties. Culturally, such a pattern in presenting to family and friends has been found in other communities (Mojaverian et al., 2012; Zhao et

al., 2015). According to Mojaverian and colleagues (2012) the dominant socio-cultural model of social relationships in Asian contexts made participants prefer to present themselves to the social support around them than professional support when faced with ill-health. Again, Zhao and colleagues (2015) discussed cross cultural help-seeking in other non-auditory chronic conditions, because there were no studies of this phenomenon in hearing-impaired adults. A pattern of seeking help from family and friends meant that the society or the individual values the importance of the group over the needs of the individual. This dimension of communal support identified as collectivism reflects the cultural beliefs and the subsequent attitude towards seeking help (Zhao et al., 2015). Reportedly, those influenced by collectivism are less likely to seek help externally, attributing their health issues to internal causes (Zhao et al., 2015). Having said that, this may explain the limited number of participants that sought help from family and friends as it infers that participants lived in a more individualistic context. Nevertheless, this is a noteworthy finding in a culturally diverse country, where individualism and collectivism appear to be valued equally. Considering this, the reliance on social support can also be ascribed to three factors, namely emotional support, participants' lack of knowledge regarding where to seek help and a comparing and contrasting of symptoms to verify the need for help (Carson, 2005; Moodley et al., 2016). Participants sought help from family and friends because they did not know where or with whom to consult some needed emotional support from their families as they struggled to acknowledge their hearing impairment. Dimensions in help-seeking indicate that there is not only one way that participants make decisions related to their ill health, which again, reveals the complexity inherent in investigating help-seeking (Cornally & McCarthy, 2011). According to Pillay and Serooe (2019), this indicates that a holistic model of care is important to ensure all facets of the patient's life are included in the healthcare process. Therefore, in depth studying of hearing help-seeking behaviour patterns is required to

understand the spiritual, cultural, and social support in view of the findings by Zhao and colleagues (2015).

The findings on the pattern of presentation are noteworthy as they indicate that there is an interplay of factors to consider in adults with hearing impairment when presenting to help providers within their environments (Olenja, 2003). Specifically, studies on hearing help-seeking need to reflect the dynamics of each geographic location not only in terms of availability and access to hearing services but also in relation to cultural practices and beliefs. A combination of patient factors, contextual factors, and the social networks together produce a pattern for seeking help (Meyer & Hickson, 2012; Oberoi et al, 2016). Audiologists need to consider these factors within preventive audiology by being more responsive to their social context and be population focused in their interventions (Kathard et al., 2012; Oberoi et al., 2016).

4.3 The process from onset of symptoms to accessing audiology services

The second key finding revealed that participants reached audiology services after seeking help from multiple providers. The researcher mapped the pathways as described by Mkize and Uys (2004) through these providers and found short and long pathways as participants navigated their social contexts in search for an ideal caregiver. Unfortunately, comparable findings have not been reported in research studies on hearing help-seeking in other countries different to South Africa (Carson, 2005; Duijvestijin et al., 2003; Laplante-Levesque et al, 2012). Findings from these HICs have mostly indicated short processes to the ideal caregiver which Laplante-Levesque and colleagues (2012) rightfully attribute this to the predominant culture and the healthcare system of those countries. In comparison, studies on other chronic non-auditory medical conditions such as breast cancer, rheumatoid arthritis and tuberculosis have reported a dynamic process for seeking help (Moodley et al., 2016; Pati &

et al., 2019; Pronyk et al., 2001). These study results were from countries with pluralistic healthcare systems and multicultural influences like South Africa.

4.3.1 Short journeys

All six participants (26%) on short journeys had easy access to the audiologist by either self-referral or via a subsequent referral from another provider. This pattern of short journeys was found to be in line with findings from studies conducted in HICs that participants reached audiologists directly or after one referral from a healthcare practitioner (Carson, 2005; Duijvestijn et al., 2003). Furthermore, two participants accessed audiology services directly from onset of symptoms. This is consistent with hearing help-seeking behaviour research from developed contexts, as adults with hearing impairment sought help directly from audiologists (Carson, 2005, Laplante-Levesque et al., 2012). However, there is a difference in terms of the number of participants that sought these services. While in developed contexts most participants sought help from these ideal healthcare workers, other research studies on non-auditory chronic medical conditions show a different picture in terms of ideal healthcare providers. According to Mkize and Uys (2004) and Pati et al. (2019) studies on mental illness and rheumatoid arthritis reported few participants directly seeking help from specialists or ideal healthcare providers. This is then consistent with findings from this current study as only two participants were able to access from the audiologist at the beginning of their help-seeking process. It can be argued that Mkize and Uys (2004) as well as Pati and colleagues' (2019) findings are comparable to the current study because of the setting in which the research was conducted. The former was conducted in South Africa and the latter in India. According to the World Bank (2021), India shares the same socio-economic position as South Africa. However, the researcher posits that this similarity helps to understand the journeys of participants in LAMI countries and fills the gap in knowledge on understanding illness behaviour within context.

In addition, these short journeys reflected the nature of health services and the social context of participants. Participants were able to access the audiologist because a healthcare professional or a neighbour had direct knowledge of these services, hence the immediate referral. This demonstrates the benefit of healthcare professionals who were knowledgeable about the services of audiologists in order that participants may be able resolve their hearing difficulties sooner rather than later. Mkize and Uys (2004) stated that social support, location of provider of care and severity of symptoms were some of the reasons for the short journeys which is supported by the study's findings. In contrast, Laplante-Levesque et al.'s (2012) research on hearing help-seeking from the perspectives of adults with hearing impairment in four developed countries, indicated that it was the health service delivery model that resulted in the short journeys. This again, demonstrates the influence of the contextual environment in decisions related to seeking help. Nevertheless, if participants believed in a bio-medical causation to cure their illness, then medical healthcare should be easily accessible for all individuals with hearing impairment regardless of their living conditions. Most importantly, healthcare services should also be similarly available irrespective of ethnic background or financial position.

Despite this study having a small sample, it is evident that a short process from the onset of symptoms to accessing audiology services was not common. In addition, the process was different for each participant. In a country with inequality and an uneven distribution of resources, the social aspects of where you live, grow, work and age influence health outcomes (Mulwafu et al., 2017; WHO, 2020). This implies that these factors cannot be separated from the help-seeking behaviour of participants in their contexts. Unfortunately, participants were not asked about what services they could afford, which could have shed light on the specific journeys. In addition, though delay in seeking help was not measured, the time of onset of symptoms to finding help could possibly have influenced from whom

participants sought help. The fact that only a few participants were able to access the ear and hearing services shortly also reveals the status of hearing health in South Africa. More research is required to understand these short journeys with the current public and private healthcare service delivery model.

4.3.2 Long journeys

Findings from the data analysis also revealed that the majority of the participants (74%) had long journeys in reaching the ideal healthcare provider. These participants reached audiology services after interacting with multiple healthcare workers including non-medical social networks. The process of help-seeking was ongoing and complex as participants tried to find solutions to their ear complaints. Remarkably, even though participants were from the same community their long journeys to access audiology services were not similar. Several other researchers (Moodley et al 2016; Musinguzi et al, 2018; Pati et al., 2019; Pirani et al., 2015) reported on this common pattern of multiple providers used by participants to seek help, even when participants were from the same community. For instance, Pati and colleagues (2019) described female rheumatoid arthritis patients in Odisha, India, seeking help from a combination of untrained, trained and specialist providers. However, these findings were from studies on non-auditory chronic medical conditions. In contrast, qualitative research in hearing help-seeking has not reported similar findings (Carson, 2005; Duijvestijn et al., 2003; Knudsen et al., 2010; Laplante-Levesque et al., 2012). The lack of findings can be ascribed to researchers only conducting studies in healthcare systems and socio-cultural contexts that are homogenous and therefore different to the current study's context. As limited as the hearing help-seeking research is, this phenomenon has only been investigated in HICs with a western medical viewpoint where ear and hearing care professionals are easily available and accessible. In contrast, research on other chronic medical diseases such as hypertension, and Hepatitis C has been conducted in developing

contexts like Uganda, India, and Pakistan (Musinguzi et al., 2018; Pirani et al., 2015; Pronyk et al., 2001). Therefore, findings from the current study are then validated within similar environments and provide a greater understanding of the contextual factors around help-seeking behaviour.

4.3.2.1 Public and private healthcare use. Interestingly, from all the multiple providers used in this context, nine participants (57,8%*)* sought help from public healthcare clinics followed by private doctors in their choice of care for hearing impairment. This is consistent with South African-based studies in different communities (Western Cape and Limpopo) by Moodley et al. (2016) and Pronyk et al. (2001) where participants presented to primary healthcare services at the onset of their symptoms. In contrast, though Laplante-Levesque and colleagues (2012) described a broad range of experiences from individuals with hearing impairment from four different countries (Australia, Denmark, United Kingdom, United States), they nevertheless reported participants typically sought help from the general medical practitioner. In addition, study participants perceived that this was the entry towards audiology services. Furthermore, it is notable in this current study that participants sought help from the public healthcare clinic were mostly from the Tswana ethnic group. Public healthcare clinic services in South Africa are free for all and therefore accessible, affordable, and acceptable (van der Hoeven et al., 2012) yet participants from the Afrikaner ethnic group did not use this avenue to seek help. This is despite participants being unemployed and of pensionable age. Though there is freedom of choice in terms of where one can seek help, this finding points to the segregation of the community and the healthcare system inequalities found in this country which are both influenced by socio-economic factors (Coovadia et al., 2009). Unfortunately, these current findings on selection and choice of multiple healthcare providers cannot be compared to the current research on hearing help-seeking due to a lack of contextual investigations. Nevertheless, the unequal distribution of resources observed in

these findings results in this difference in pathways to care and implies that seekers do not access the same type of healthcare (Coovadia et al., 2009). Moodley and colleagues (2016) explained that the type of healthcare services accessed by patients is influenced by perceptions of care, finances, and other structural factors. It is possible that the difference in the path to seeking care for both groups was influenced by perceptions of care in the public versus private healthcare sector however this also suggests that medical conditions such as hearing impairment are not resolved equally in these long journeys. More attention is required on addressing these inequalities at all levels to prevent severe consequences of hearing impairment.

In defence of the participants that did not use the public healthcare clinic, Pati and colleagues (2019) explained that with many health problems, help-seekers do not avail themselves to public healthcare services but rather prefer self-medication, traditional, and private practitioners. This could explain the pattern observed in this current study, where participants had sought help from private doctors, chemists, traditional healers as opposed to the public healthcare clinics throughout their journeys before accessing audiology services. Similarly, Musinguzi and colleagues (2018) found that hypertensive participants self-treated with herbal medicine, consulted pharmacies and other providers at lower-level healthcare services. They also described that these were participants with mild symptoms as opposed to those with severe symptoms who sought help with specialists. It is reasonable then to understand the type of consults and the long process in this study, as ear and hearing symptoms were possibly mild in the initial stages of seeking help: hence the type of providers participants visited. Unfortunately, as symptoms were not resolving participants went from one provider to the next, and when they were not satisfied with their previous steps, they continued to seek help from the low-level services, to resolve the discomfort. These findings

confirms that different patterns do exist in different contexts regarding hearing help-seeking hence more research is required in this field of preventive audiology.

4.3.2.2 Multiple visits to the healthcare provider. In the current study, part of the pattern of help-seeking behaviour was that participants had additional consultations with the same healthcare services at the public healthcare clinic. This finding is consistent with a study conducted by Moodley et al. (2016) where female breast cancer participants visited the same healthcare providers more than once seeking a solution. Research studies by Pirani et al. (2015) on Hepatitis C as well as Pronyk et al. (2001) on Tuberculosis also found that participants had a pattern of visiting a provider more than once. Reasons for this behaviour pattern was attributed to inappropriate investigations, misdiagnosis, or a lack of referral to the next ideal healthcare provider (Moodley et al., 2016; Pirani et al., 2015, Pronyk et al., 2001). In this study, reasons for the multiple visits were attributed to poor referral and a lack of availability of hearing care specialists. It is also possible that healthcare workers were still monitoring the effectiveness of the ear management that they had prescribed hence the repeated visits. Nevertheless, this resulted in long processes to accessing audiology services as participants considered other providers in their context. In addition, the researcher posits that participants possibly returned to the same healthcare providers because of psycho-social factors such as a change in attitude towards the hearing impairment (Carson, 2005). Participants in this current study were notably older in age with no financial means to seek a quick solution hence some followed up with the same healthcare workers. Similar findings related to multiple healthcare visits to the same provider have not been reported from studies on hearing help-seeking (Duijvestijn et al.,2003; Laplante-Levesque et al., 2012; Saunders et al., 2012). Therefore, their findings on repeated visits to the same health provider is an important result as it provides a better understanding of help-seeking in context, particularly

the structure of the healthcare system and its provision of overall quality of care (Muzinguzi et al., 2018).

4.3.2.3 Referrals from private to public healthcare sector. Another contextual aspect of these long journeys was the pattern of help-seeking between private and public healthcare. Interestingly, some participants began their journeys in the private healthcare sector followed by referrals to the public healthcare sector, specifically the public hospital. This combination of private followed by public visits was also reported by Moodley et al. (2016) and Pati et al. (2019). These authors found that most participants from their studies in the Western Cape, South Africa, and India, respectively, began their journeys in the private sector before being referred to and ending in the public hospital. In addition, they reported that once participants sought help at these private facilities, they were quickly referred for appropriate assessment and management to higher level services. This is comparable with the current study as participants were also referred to the public hospital, after interacting with private healthcare workers, where they accessed ear and hearing care providers. In contrast, a study by Pronyk et al. (2001) on tuberculosis patients in Limpopo, South Africa found a greater number of participants presenting to public hospitals than private practitioners. The difference between these findings can be attributed to regional dynamics which is possible in multi-cultural contexts where there is an ongoing unequal distribution of resources, including socio-economic and health disparities (Coovadia et al., 2009). For example, Limpopo is described as rural whereas Western Cape is more urban (Pronyk et al., 2001). This is related to the deprivation index of each area in which a more rural area will have a high index because of its poor social and material conditions, whereas an urban area will have a low index because of access to economic, social, and related resources (May & Gray, 2008; McIntyre, 2002). Nevertheless, this indicates that help-seeking for any medical condition is not linear nor predictable even within one country (Mackian et al., 2004). The

contextual realities in any environment need to be considered as they influence where help is sought. Unfortunately, hearing help-seeking research is currently limited to HICs and has not reflected similar findings. Even Laplante-Levesque and colleagues (2012), who jointly investigated help-seeking in countries with public and private healthcare service delivery models did not report on this factor. Nevertheless, the findings in this current study point to a need to expand hearing help-seeking research in all environments to understand this phenomenon in contexts where there are also pluralistic healthcare systems (Pati et al., 2019).

To further explain this private to public sector pathway, Moodley and colleagues (2016) found that the reasons for this pattern in their study was the influence of overall quality of care and the structural environment such as the ease of access and convenience of prompt doctor services in the private sector. Participants sought help from the private sector for these reasons however they were then referred, or they sought help at the public hospital. This may well be the reason for the differences in consultations in this current study as well, but participants' reasons for the different pathways were not explored. The researcher posits that participants had a bias towards the care received from private healthcare professionals, but lifestyle factors (retired; unemployed; cost of care) prevented them from continuing with the same professionals. In addition, participants may have thought that their symptoms and presenting difficulties were mild hence they used private healthcare workers. All these reasons have a place within the current study's setting as participants live in a country with a quadruple burden of disease, multiple options of care and resource constraints on multiple levels (Coovadia et al., 2009; Pillay-van Wyk et al., 2016; van der Hoeven et al., 2012). In addition, the social determinants of health combined with contextual factors have an influence on help-seeking behaviour patterns. Therefore, plans by the South African government to introduce a national health insurance for all citizens (NHI Bill, 2020) may address these disparities and reduce long journeys in seeking care for ill health.

4.3.2.4 Informal social networks. Within these long journeys, family and friends were also part of the long process to accessing audiology services. Some of the family and friends were also healthcare professionals working in the hospital. In this case, participants had confided in these social networks after their journeys to healthcare practitioners did not have desired outcomes. Such patterns have been reported by Moodley and colleagues (2016) who described that an employee played a role in helping a participant in their study seek care for their medical condition. Disclosure to close social networks was an important trigger to seeking healthcare (Moodley et al., 2016). Friends and family who had either consulted an audiologist or who worked in the hospital and therefore had knowledge of these services, reliably helped participants on their journeys, adding to the concept of collectivism (Zhao et al., 2015). It is possible that participants' journeys could have been longer had they not confided in those close networks who helped to shorten the process by directing them towards ear and hearing professionals. Yet, in investigations on hearing help-seeking, a different pattern was reported wherein family and friends acted more as an emotional support than a referral link towards a healthcare provider (Carson, 2005; Knudsen et al., 2010; Saunders et al., 2012). This is the difference that exists between LAMI and HICs. Word of mouth and knowledge of services such as audiology plays an important role in help-seeking by connecting adults with hearing impairment to the ideal healthcare provider. This finding is typical in multi-cultural environments where more value is placed on collectivism amongst communities implying that help-seeking is part of a community's identity and must therefore be understood from a cultural perspective (Mackian et al., 2004; Mojaverian et al., 2012; Zhao et al., 2015). Despite the journeys being long, the influence of the social context cannot be ignored in the person's life.

4.3.2.5 ENT specialists as gatekeepers. Another common pattern in these long journeys was participants' pathways involving ENT specialists. For almost of the

participants in the long journeys (47,8%), ENT specialists were commonly also part of the help-seeking process towards the ideal healthcare provider. In some journeys, few participants sought help from the specialist at the early onset of symptoms, while in others it was a combination of interactions with private and public ENT specialists, and for most help was sought from the specialist towards the end of their journeys. This is because specialists are regarded as secondary or tertiary level healthcare workers. Interestingly, similar to family and friends, most participants ($n = 9$) accessed audiology services via a direct referral from the specialist. This pattern is consistent with Laplante-Levesque et al.'s (2012) hearing help-seeking research where ENT specialists, acted as gatekeepers before individuals with hearing impairment could access hearing services. This is the only study among the limited research available on this phenomenon that showed this pattern. Nonetheless, journeys in the above authors' study were short, typically from developed contexts where access, affordability and availability are guaranteed. Findings from research studies on other chronic medical conditions reported that participants reached specialists after subsequent pathways and through a combination of healthcare providers similar to the current study (Mkize & Uys, 2004; Pati et al., 2019). Consequently, participants' journeys were long and complex, as for example, only eight of 113 women with rheumatoid arthritis in Pati and colleagues' (2019) study were able to access a rheumatologist at first contact. In this current study only two participants were able to access the specialist at first contact. The above two authors support the finding in this current study about the process of help-seeking for adults with hearing impairment. Though ENT specialists were frequently involved in the process, it was after long journeys that participants reached them. Evidently, the pattern found in this study is consistent with available research on other diseases regarding access to specialists or ideal providers (Mkize & Uys, 2004; Pati et al., 2019). Once participants reached specialists, they received the required intervention for their hearing difficulties. Therefore, the advantage of

the participants in the current study was that contact with an ENT specialist helped adults with hearing impairment to resolve their ear complaints sooner because they were then referred to the audiologist. This is possibly a common pattern for those seeking help for their hearing difficulties in LAMI countries, but more research needs to be conducted to confirm or disapprove these results. There are not enough studies in hearing help-seeking research to support this pattern.

These long journeys have confirmed that help-seeking behaviour is not a static event, but an ongoing process influenced by patient factors, the socio-cultural environment, and the healthcare resources available to participants in their contexts (van der Hoeven et al., 2012; Mkize and Uys, 2004; Muzinguzi et al., 2018). This continued seeking of help with healthcare professionals also shows a strong belief in Western medical healthcare. The fact that most participants had long journeys than short indicates that in some contexts, especially where there are multiple providers of health combined with an evolving mix of cultural beliefs, participants' pathways towards accessing audiology services will not be simple and direct (Abaerei et al., 2017; Pronyk et al., 2001). In view of the context that hearing healthcare workers find themselves in, it is important that they are aware of the complex journeys that adults with hearing impairment take when seeking help and include these in their management. Promotion of hearing healthcare from the primary level of healthcare will also shorten these long journeys.

4.4 Barriers and Facilitators towards hearing help-seeking behaviour adopted

4.4.1 Barriers

4.4.1.1 Socio-economic factors. An important finding in examining barriers in participants' environments indicated socio-economic factors as the major limiting factor for the participants (34,78%) in seeking help for their hearing difficulties. This limitation

included finances and access to medical insurance which correlated with participants reported occupational status. This finding is consistent with van der Hoeven et al.'s (2012) South African study where they reported that those with a lower income had less money to spend on good healthcare and therefore waited longer to consult a healthcare provider. It could be argued from van der Hoeven et al.'s study (2012) as to the definition of good healthcare as well as the reasons behind participants' financial barriers when access to audiology and other healthcare services are charged at minimal or at no cost in the public healthcare sector (Ramma & Sebothoma, 2017). However, the lack of finances has been linked to poorer health outcomes which is related to a community with a high deprivation index (Cabrera-Barona et al., 2017; Kashem et al., 2019). Therefore, van der Hoeven and colleagues' (2012) study is helpful in demonstrating the effects of the environment on help-seekers which this current study confirms. Within this barrier, it was also observed that it was a combination of participants from mostly the Afrikaner (21,73%) and minimally the Tswana (13,04%) ethnic group that expressed this barrier. This dynamic is interesting in view of the socio-demographics and the distribution of resources in this country (Coovadia et al., 2009). Coovadia and colleagues (2009) reported that resources are not distributed equally and that historically access to finances was discriminately segregated (Coovadia et al., 2009). However, this current study's results depict a picture where these assumptions of socioeconomics cannot be made based on just history. Research in hearing help-seeking needs to be conducted in all contexts as similar findings have not been reported nor investigated as authors gathered data from only one environment (high-income developed contexts) or conducted literature reviews on the subject (Carson, 2005; Dujivestijn et al., 2003; Laplante-Levesque et al., 2012; Saunders et al., 2012).

According to Knudsen et al.'s (2010) literature review at the time, no data existed on socio-economic variables and help-seeking. This is apart from one study that reported cost as

a barrier towards seeking help, although the authors did not specify the number of participants in their findings (Laplante-Levesque et al., 2012). In some countries, the healthcare system is structured very differently to South Africa which makes it unlikely that it would have been the majority of adults with financial difficulties as their socio-economic position does not influence access to healthcare. Qualitative, descriptive research on hearing help-seeking with participant interviews from Carson (2005) within the Canadian context did not yield results suggesting environmental factors related to costs and finances as a barrier to help-seeking behaviours adopted. In contrast, a study on help-seeking patterns on participants with a mental illness conducted in South Africa revealed that cost was a factor in not being able to seek help, but this also was related to transport costs (Anderson et al., 2013). The current study's participants did not all elaborate on the reasons for money being a barrier, but most of the participants (75%) had initially sought help from private practitioners where cost of services was possibly more than they could afford; hence they did not pursue further help from private practitioners. When one considers that health outcomes in South Africa are not only influenced by healthcare but also by aspects such as one's income status and where one lives, works, and is educated (Ataguba et al., 2015), this study's findings are in line with these reported facts. These results demonstrate that the above aspects produce a pattern by which adults with hearing impairment make decisions to seek help (Oberoi et al., 2016). Hearing healthcare workers must be aware and acknowledge these patterns and include these into preventative audiology services.

4.4.1.2 Psychosocial factors. Another observed pattern from the current study was the impact of psychosocial factors on participants' (26,08%) decisions to seek help for their hearing complaints. In general, participants had a stigma and an attitude towards their hearing impairment by either denying or minimising the severity of the hearing impairment and the subsequent hearing difficulties. Laplante-Levesque et al. (2012) describes this as a

low self-perception of the degree of the hearing disability. Some participants were not ready to seek help indicating a possible denial while some had a fear of the technology altering their self-perception. Families were also affected emotionally by the loss of hearing and the subsequent difficulties brought to the home. These findings are in line with much of the research in the field of hearing help-seeking with the major factor influencing help-seeking reportedly being psychosocial factors (Clements, 2015; Laplante-Levesque et al., 2012; Meyer & Hickson, 2012; Saunders et al., 2012, Southall et al., 2010; Wallhagen, 2009). Through literature reviews and participant interviews from HICs, these authors stated that the most salient reason given as a hindrance for hearing help-seeking was stigma. This inhibited adults with hearing impairment and their hearing families from moving forward in their journeys. Nonetheless, it is interesting that in a different context, participants would have similar experiences in relation to emotional factors. In contrast, research in the South African context on other non-auditory chronic diseases reported contradictory results. A study by Anderson and colleagues (2013) in the Eastern Cape, South Africa found that barriers to help-seeking for depression comprised a combination of structural, knowledge and psycho-social factors; meanwhile van der Hoeven et al. (2012) in the North West, South Africa reported mostly on socio-economic conditions followed by attitude towards the illness to explain the hindrances to help-seeking. The researcher suggests that the difference in these findings may be attributed to the environmental contexts in terms of rural versus a more urban area and the provision of healthcare services in those areas (Coovadia et al., 2009; van der Hoeven et al., 2012). As documented by Abaerei et al. (2017), South Africa has large disparities in healthcare even among provinces and therefore it is also probable that healthcare needs are not met equally in all contexts. This implies that hearing help-seeking results cannot be generalised to the whole population, but that these results confirm the

diversity of a context and how a multiplicity of factors can influence help-seeking behaviours (Clements, 2015).

Zhao and colleagues (2015) considered the impact of multiple factors including culture in influencing hearing help-seeking behaviour. In their four-country investigation (China, India, Sweden, and United Kingdom), they acknowledged the enormous differences that exist in audiological services and the impact on patients' journeys. One key finding from their study was in relation to HICs and the major role that psychological factors play as opposed to access and affordability in LMIC countries. This may explain the reason most participants in this current study reported socio-economic as opposed to psychological factors as the major barrier in their help-seeking journey.

4.4.1.3 Personal factors. Findings from the current study also revealed that contextually, personal factors contributed towards delaying participants on their journeys. This included personal matters such as one participant whose mother was chronically sick and was therefore prioritised in seeking medical attention. Other participants mentioned family dynamics such as being a child and depending on adults as well as internal family issues that stopped participants from seeking help. Research into hearing help-seeking has investigated personal factors in as far as age, gender, and level of education (Knudsen et al., 2010) whereas some researchers have investigated how personal factors can be a positive influence on the help-seeking journey (Carson, 2005; Ramma & Sebothoma, 2017). In as far as the WHO ICF Framework is concerned, the health organisation has put forth that because of the variability among cultures, other factors besides age and gender must be considered in understanding illness behaviour (ASHA, 2021). One research study that helps us understand the impact of personal factors is a study by Pirani et al. (2015) who found that a patriarchal system in the population of Pakistan caused a barrier for women to seek help for their illness. Moodley and colleagues (2016) reported that one participant in their Western Cape, South

African study reported a competing priority of work commitment delaying her in seeking care. These are personal factors as they point to the cultural context and the dynamics of people's lives, the surrounding community and its influence on the seeker and the help-seeking process. The current study's findings are therefore pertinent because they reflect the context and have the potential to influence practice.

4.4.1.4 Structural and health system factors. Another pattern reported by participants that reflects the disparities in the healthcare system is structural or health system factors (Musinguzi et al., 2018). This finding confirms South African published research that reports that access to healthcare and satisfaction by its users was related to conditions of inequality economically (Abaerei et al., 2017; Ataguba et al., 2015; Skordis-Worrall et al., 2011). In this current study, three participants felt that healthcare workers' abilities, behaviours and overall quality of care was a barrier in their help-seeking behaviour. According to the participants, who were all unemployed except for one, medical help was short-coming to resolve their hearing difficulties according to their expectations as they described not being helped sufficiently. Previous experiences and feelings of being underserved by healthcare professionals were the main explanation for this barrier. The researcher reasons that participants expressed this view considering the delay in reaching audiology services as ideal healthcare providers. Nonetheless, this finding on health system factors is consistent with only one research paper in hearing help-seeking research, where Meyer and Hickson (2012) used the ICF Framework to describe contextual factors. In their literature review, they discovered that participants were hindered in their help-seeking journey due to poor management of their hearing difficulties by professionals. These professionals were mostly GP's and ENT specialists which, interestingly, was the same for the current study participants. Though this is the only study that supports the current study's findings, their reasons are not similar because the authors indicated that most reviews

ascribed this type of barrier to healthcare professionals stigmatising hearing impairment. In contrast, an explorative study conducted by Khoza-Shangase (2019) in South Africa, on factors influencing service delivery on children with hearing impairment, reported that caregivers felt appropriate healthcare service unavailability and the knowledge and skills of healthcare providers were a barrier in early intervention services. Khoza-Shangase's (2019) findings support the participants' perspective in the current study. An additional study by Anderson et al. (2013) in a different setting in South Africa, found that participants with depression reported being unsure that they would get proper treatment or that treatment would help them. Even though the number of participants is minimal in this study as well as in Anderson et al.'s study (2013), the findings are notable when considering the context and the living conditions of adults with hearing impairment. This implies that it is not only patient factors that influence help-seeking behaviour but also provider factors that contribute towards barriers in patients' journeys (Oberoi et al., 2016). Decisions-makers in the health ministry need to take into consideration the distribution of resources for quality healthcare and for strengthening health systems for all patients.

4.4.1.5 Lack of knowledge. As the results indicate, an additional limited number of participants reported a lack of knowledge of audiology services (8,6%), COVID-19 (4,3%) and religious beliefs (4,3%) as barriers in their help-seeking journeys. This finding is consistent with Anderson et al.'s (2013) research who reported that 30,1% of their participants had a lack of knowledge about where to go for a chronic disease (mental health). Their study also found that, most commonly, disease prognosis was not anticipated which the current study found with some participants. This is also in line with Moodley and colleagues (2016) who reported poor knowledge and prognosis of breast cancer as a barrier in their study hence participants sought help only when symptoms worsened. To the researcher's knowledge, similar findings have not been reported in hearing help-seeking research. The

emphasis and importance of creating awareness within preventative audiology about hearing health for the whole population cannot be overestimated.

4.4.1.6. COVID-19 and religious beliefs. Interestingly, the least reported barrier from participants was related to cultural beliefs and the current global health crisis. COVID-19 and religious beliefs were indicated by two participants as a hurdle in their help-seeking journeys. Along with the rest of the global community, the South Africa government implemented a Level 5 lockdown, which required individuals to remain in their places of residence for the stipulated time to curb the spread of the disease. Essential services like healthcare were exempt from this regulation and therefore no restrictions were placed on access and delivery of healthcare services. However, the response and the impact of COVID-19 upon individuals requiring these services cannot be underestimated as the public avoided healthcare facilities due to hesitancy and fear of contracting the virus (ASSAF, 2020; Siedner et al., 2020). In contrast, participants in Anderson et al.'s (2013) study highlighted chronic medical conditions as an influencing factor in seeking help. The COVID-19 pandemic, though not a chronic medical condition but still serious and a burden universally, resulted in one adult not being able to seek help in moving him forward in his hearing help-seeking journey. This must be considered in view of the current social and health limitations in a country like South Africa. Any social condition in one's environment can contribute to delay in help-seeking behaviours (Coovadia et al., 2009; van der Hoeven et al., 2012). This is more critical when we consider the inequities produced by the social determinants of health in the country (ASSAF, 2020). The researcher does not know how many more participants could have reported similar results because of the study's limited sample. It is also possible that because of the setting of the interview, participants in this study were more focused on reporting barriers related to their hearing difficulties rather than the Coronavirus disease. As far as the researcher is aware, hearing help-seeking research has not seemingly investigated

the impact of chronic diseases and even COVID-19 on help-seeking behaviours. This implies an inherent complexity in help-seeking behaviour patterns and the importance of considering contextual factors on illness behaviour, whether local, national, or global, and more importantly, for hearing health practice.

The complexity of hearing help-seeking was also demonstrated by one participant reporting that she believed that God would heal her. This indicates religious practices influencing participant's behaviour towards resolving their ill health and is consistent with Pirani et al. (2015) who reported that patterns of help-seeking behaviour are strongly related to the individuals' cultural practices. Pirani and colleagues' findings are from participants in Karachi, Pakistan who were diagnosed with Hepatitis C. Though the disease presents itself differently to hearing impairment, this finding supports Cauce and colleagues (2002) who state that people emerge from cultural contexts, and these have an impact on decision making (Naik et al., 2012). Hence, the current study's finding is noteworthy in a culturally diverse context and lends support to the statement by Cauce et al. (2002). Unfortunately, Zhao et al. (2015) found no studies on the influences of culture on hearing help-seeking while Hickson & Scarinci (2007) also reported a lack of research in this area. Therefore, there is a need to investigate the cultural factors that influence help-seeking behaviour patterns.

4.4.1.7 No barriers at all. Numerous studies have reflected on the differences in healthcare services in this country as well as the persisting quadruple burden of disease (HIV/AIDS and Tuberculosis; cerebrovascular disease, maternal and child mortality and interpersonal violence and injuries) (Coovadia et al., 2009; Khoza-Shangase, 2020; Mayosi et al., 2009; Pillay-van Wyk et al., 2016). When we consider this together with the diverse socio-economic conditions of adults in this country and the inequalities that exist, it is interesting to note that some participants (17,3%) reported no barriers in their help-seeking journey. Participants' personal characteristics did not point to the possible reasons for this

finding. In addition, participants had different journeys to accessing the audiologist. This is a unique outcome from the study despite the negative consequences of hearing difficulties together with the inherent socio-economic and health inequalities (Strawbridge et al., 2000). Perhaps, participants thought of physical barriers, which they did not experience in their journeys as some were accompanied by their next of kin, hence their responses. This points to a need to further investigate patterns of help-seeking and find out reasons for participants' delay in seeking help which may explain the journeys with no barriers highlighted.

4.4.2 Facilitators

4.4.2.1. Structural and health system factors. From the study's third key objective, the researcher also sought to examine the facilitators that influenced hearing help-seeking behaviour patterns. This was important to investigate in order to understand, in context, the behaviour patterns towards actualising ideal healthcare provision. Remarkably, 43,4% participants reported structural and health system factors as the primary influence on their journeys. Specifically, participants highlighted the care and concern from healthcare personnel, their first-hand knowledge of audiology services, the access, availability, and affordability of these services as promoting their help-seeking. This was from primary health clinic to hospital services, with healthcare workers whose scope of practice was not related to ear and hearing care. This common pattern among the majority of the participants is consistent with statements by Carson (2005) who reported that physicians could act as gatekeepers thereby influencing hearing help-seeking. Knudsen et al. (2010) also reported a positive association between help-seeking and source of motivation. However, the source of motivation mostly reported in literature is family and friends which is consistent with HICs; Mackian (2003) stated that help-seeking in these countries was viewed from the participant as a decisive agent. Hence, none of the hearing help-seeking literature has investigated these health system factors as a pattern of facilitating help for the individual with a hearing

impairment, as Knudsen and colleagues (2010) previously acknowledged this gap in research from their literature review on this subject. Nevertheless, this is an interesting finding as some participants also reported, in contrast, healthcare providers being a barrier in their help-seeking journey. A study by Musinguzi et al. (2018) on factors that influence hypertension in Uganda is the only study that explored and reported on healthcare providers and their influence on help-seeking behaviours. This study was contextually relevant in its findings as it supported the current study's results. In a country with overall limited resources in the healthcare sector, coupled with a poor perception of public healthcare services, an unequal healthcare provider-to-patient ratio, and a focus on life-threatening diseases (Abaerei et al., 2017; Khoza-Shangase et al., 2017; Khoza-Shangase, 2020), this positive finding is important as it provides insight about patterns that influence help-seeking from the environment through participants' lived experiences. Healthcare providers must take cognisance of the important role they play in the healthcare system and in patients' help-seeking behaviours. The researcher also acknowledges the sense of agency in her field of work which should result in empathy and being intentional towards patients' needs.

4.4.2.2. Psycho-social factors. Psycho-social factors were reported secondly by eight participants (34,7%) as facilitating their help-seeking journey. Interestingly, the same factor ranked second as a barrier towards help-seeking. In this study, participants' ongoing hearing difficulties caused frustration and embarrassment in their daily lives which spurred them on towards seeking help. Evidence from Southall et al.'s (2010) qualitative research on 10 adults with acquired hearing loss supports this finding of emotional strain upon adults with hearing impairment. Other influencing factors were hearing aid image and self-efficacy which helped move participants forward in their journeys. This is consistent with much of the literature on hearing help-seeking, as researchers in this field reported psycho-social factors playing a prominent role in facilitating help (Carson, 2005; Duijvestijn et al., 2003;

Knudsen et al., 2010; Laplante-Levesque et al., 2012; Meyer & Hickson, 2012; Southall et al., 2010). However, some researchers (Duijvestijn et al., 2003; Knudsen et al., 2010) reported that hearing aid image and technology were not strong factors in influencing hearing help-seeking. This can be argued because in the current study, participant nine initially saw the hearing aids as a barrier due to their size but then reported later that the miniaturised hearing aids influenced him to take steps towards seeking help. One wonders if any of the other participants had a similar attitude towards hearing aids. Perhaps, participants did not share the same attitude as the psycho-social issues were more serious than the hearing aids.

It should be noted that though the current findings are supported by most of the research on this phenomenon, the results differ in that in HICs, psycho-social factors play a primary role in hearing-related behaviours. In a LAMI country, the social context and the healthcare capacity distinctly influence help-seeking (Zhao et al., 2015). This is supported by Zhao et al. (2015) who explored the cultural influences on hearing help-seeking in four countries and concluded that psycho-social factors contribute to a greater amount for certain population groups and societies than others. This is especially so when those countries are not confronted by socio-economic and health system challenges. These current results provide a better understanding of the association between environmental and emotional factors in adults with hearing impairment. Persons with hearing difficulties are emotional beings but are nevertheless influenced by their contexts. This implies that hearing care providers must understand the process that seekers go through in their journeys and include it in their management.

4.4.2.3 Self-reported hearing difficulties. Another pattern influencing help-seeking behaviours was self-reported hearing difficulties. Experiencing activity limitations, participating restrictions and the gradual progression of the disease was a deciding factor towards seeking help for five participants (21,7%) (Carson, 2005). This is in line with

current hearing help-seeking research that reported degree of hearing complaints as a catalyst in the sequence of events to resolve loss of functioning (Duijvestijn et al., 2003; Knudsen et al., 2010; Meyer & Hickson, 2012). A systematic literature review by Knudsen and colleagues (2010) found self-reported hearing difficulties as being the only robust predictor of this behaviour among 24 other factors in their results. This means that adults with hearing impairment use their daily life experiences when making sense of their hearing impairment and eventually deciding to take action to help themselves (Laplante-Levesque et al., 2012). In a similar context (South Africa) as this current study, Ramma and Sebothoma (2017) reported a strong association between self-reported hearing difficulties and a higher likelihood of seeking help, which is consistent with results from HIC contexts. Current studies on hearing help-seeking have not found anything to the contrary. The difference in the findings is in the fact that self-reported difficulties were not the major facilitating factor among participants in this current study. As reported, most participants were influenced largely by structural and health system factors. Despite differing results from Ramma and Sebothoma (2017) in terms of the primary association, current results indicate the importance of contextual influences on adults with hearing impairment. Though adults appear to experience the effects of their hearing difficulties similarly, hearing help-seeking can only be understood from the individual's perspective because it is not homogenous across all contexts (Laplante-Levesque et al., 2012; Olenja, 2003). In addition, facilitating factors may not be similar or equally important across all settings. This therefore requires clinicians to consider everyone uniquely and consider the environment from which individuals come from to understand their help-seeking behaviour patterns.

4.4.2.4. Family support. While participants were influenced by the impact of the hearing impairment upon their lives, family (*n = 4)* and personal factors (*n =3*) were reported as facilitators in the journey towards seeking help. Participants did not hesitate regarding

pointing out that family members assisted them and therefore, a positive attitude by families supported their decision (Meyer & Hickson, 2012). Families were practical in their support as they found audiology services and made appointments for the participants. In addition, families accompanied participants to these appointments. For some of the participants, both family and personal factors combined to influence their journeys. Having noted that, this finding on family influence is consistent with current hearing help-seeking research that individuals who had sought help from their next of kin received more social support effectively moving their journey forward (Carson, 2005; Duijvestijn et al., 2003; Knudsen et al., 2010). In contrast, Clements (2015), Southall et al. (2010) and Wallhagen (2010) reported family support as a negative influence on individuals' help-seeking behaviours for their hearing impairment. Furthermore, Saunders et al. (2012) accounted for family support as one of the nine primary factors to negatively influence help-seeking. Yet this current study did not find any participants experiencing support from their families as a barrier. These results from literature are interesting as they were in HICs, even though some of the researchers conducted literature reviews instead of qualitative descriptive investigations. To further support the current study's findings, Anderson et al. (2013) explored help-seeking among adults with depression in the Eastern Cape, South Africa and found that those with social support were more likely to seek help. The researcher posits that contextual factors such as family involvement strongly influences how hearing-impaired adults resolve their hearing difficulties in their process of contrasting and comparing their symptoms (Carson, 2005). More research in this area is required in all contexts as it will assist clinicians in understanding the motivating factors behind individuals coming into their consultations. In addition, it will also inform hearing health policy towards appropriately targeting preventive audiology services.

4.4.2.5 Personal factors. Another contextual pattern indicated from the researcher's study was related to personal factors. One could argue that personal and family factors can be viewed as similar, but the researcher found that the type of personal factors reported by participants were very distinct from the family factors, hence this differentiation. Generally, participants described age-related aspects, acquaintances, and personal circumstances as influencing participants' behaviour to seek help. In line with the findings about age, Meyer and Hickson (2012) reported that the older the adult with hearing impairment, the more likely they are to seek help. Yet, different results have been reported by Knudsen et al (2010), Wallhagen (2010) and Ramma and Sebothoma (2017). Reasons for these contrasting results can vary from social context influences, psycho-social factors, and possible demands on individuals' lives at the time. Nevertheless, this personal aspect needs further investigation including the reasons it is a barrier for some participants and a facilitator for others.

In addition to age, persons in the immediate environment acted as facilitators towards seeking help. This is a direct contrast from how the current literature describes these support systems. Carson (2005) describes an iterative process of 'coping', as adults with hearing impairment use their friends and colleagues as a self-assessment of their hearing difficulties followed by help-seeking behaviour. This process continues until these individuals are ready to seek help. In the current study, support systems acted as a network to point participants to audiology services as they had previously contacted or consulted with them. Participants had acknowledged their hearing difficulties but did not know healthcare providers that would be able to assist them. This lack of knowledge was related to their socio-economic conditions as participants had previously sought help with private healthcare practitioners and could not further afford the cost of this type of healthcare. There is no evidence in the current hearing help-seeking research on this finding, but because this current study sought to investigate this phenomenon from a multi-cultural and multi-lingual context, these findings are relevant in

that they shed light on how adults with hearing impairment manage their illness from different contexts. This finding has implications for hearing healthcare access and availability in the South African context and the effects of delaying management of hearing impairment.

Interestingly, one male participant reported that a traumatic event in his life influenced his journey towards seeking help. Although his journey consisted of consulting with an ENT specialist, it was this incident that the participant felt had facilitated being referred to audiology services. This traumatic incident must be interpreted with the reported high incidence of interpersonal violence and injury that forms part of the quadruple burden of disease in the country (Coovadia et al., 2009; Pillay-van Wyk et al., 2016). This fact in combination with the participant's dependence on the healthcare provider and reduced socio-economic conditions, are important to consider in understanding the influence of the context on illness behaviour patterns. Nevertheless, such contextual factors have not been considered or investigated in the available hearing help-seeking research. In contrast, Hickson and Scarinci (2007) have described the hearing-impaired partner's self-reported hearing difficulties and hearing aids as some environmental factors that influenced participants' journeys.

From the literature, most noteworthy is the primary influence of personal factors such as age, self-perceived hearing difficulties and family support (Hickson & Scarinci, 2007; Meyer & Hickson, 2012). This reported finding is not consistent with the current study's findings as only a few participants reported on the influence of personal factors as opposed to structural factors from the majority of the participants. It is also interesting that despite the older adult cohort, only one participant reported age as a factor. Perhaps, participants did not want to refer to their age because of the social stigma related to older age. The researcher acknowledges that the current study's sample was limited yet results on personal factors as

indicated above reveal South Africa's current context and helps us understand behaviour patterns of adults seeking help for their hearing impairment, from the onset of symptoms until they reach audiology services.

5. CONCLUSION

5.1 Overview of the current study

The current study investigated the help-seeking behaviour patterns of adults with hearing impairment in a peri-urban community in South Africa. The study sought to describe the pattern of presentation of symptoms in relation to cultural practices or beliefs. This study defined the process of accessing audiology services from the onset of symptoms and then examined the contextual barriers and facilitators towards the help-seeking behaviour that was adopted.

Findings from the current study have indicated that the majority of participants viewed their illness from a Western biomedical viewpoint in explaining their help-seeking behaviour patterns and for resolving their hearing difficulties. In so doing, participants from this peri-urban community, who were mostly older adults, presented themselves to healthcare professionals at various levels of healthcare in both the private and the public health sector. Participants believed in healthcare professionals, hence they sought help from them, and therefore the influence of culture was deemed minimal in the participants' patterns of help-seeking for hearing impairment. This study also showed that participants' ethnic background, which is closely related to language and culture in the South African context, did not influence their pattern of presentation in relation to cultural practices or beliefs. Though some participants expressed believing in religious faith or traditional medicine, a pattern of valuing medical over traditional providers was indicated in their responses. This implies that even in multi-cultural and multi-lingual contexts, the help-seeking behaviour patterns of individuals with hearing impairment cannot be assumed. Adults living with hearing difficulties make decisions according to their needs.

In this study, though most participants used healthcare professionals, the use of social networks revealed the importance of the involvement of the community in participants' help-seeking behaviours. More than emotional support, the pattern of presentation indicated a communal support of sharing information and being helped by those who had prior knowledge of audiology services. This is expected from such a context as South Africa, where a culture of collectivism still exists despite the permeating influence of an individualistic way of life.

It is important to note that only one participant described their pattern of presentation according to his traditional beliefs. This is interesting in a country rich and diverse in culture. However, this does not indicate that the majority of participants do not subscribe to the use of more traditional means to cure their illnesses, but rather that it is possible that this participant was willing to share his help-seeking behaviour in an environment that does not always accommodate his beliefs. The sample for this current study was also small hence a larger sample could have yielded different results in this aspect.

The study also revealed that the process of accessing audiology services was complex. Only a few older adults were able to access audiologists immediately from the onset of symptoms which resulted in short journeys, while the majority of participants moved from one provider to another seeking help. Participants did not also commonly use the same process to seek help despite using the public or the private healthcare sector in this community. Their journeys, whether short or long, were a combination of formal and informal networks influenced by a variety of factors. Seemingly, in this process of reaching the audiologist, participants sought help through what was accessible to them at the time – whether it was a family practitioner, or someone who knew an ear and hearing care specialist. However, when the hearing difficulties did not resolve, participants continued seeking help from other sources. This then contributed to the pattern of long journeys**.**

In both the private and the public healthcare sector, healthcare providers contributed to participants' long journeys by not directly referring participants to audiologists. Even though there is a referral pathway for accessing higher levels of service in the public healthcare sector, which is where audiologists would be found, it was common to find that participants did not always use this pathway routinely or successfully. In addition, those participants who sought help from private healthcare workers also went from one provider to another before seeking help from the public healthcare sector. At the end of the process, participants' journeys reached audiology services mostly through referrals from ENT specialists. These long journeys imply that healthcare service providers were either not knowledgeable about management of ear and hearing difficulties or about accessing audiology services. The current study also revealed that some healthcare professionals acted as gatekeepers while some participants also sought solutions that were not effective in resolving their hearing difficulties. Therefore, a combination of factors contributed towards participants' journeys. However, the healthcare system needs to be reviewed to define the process and the reasons in which adults with hearing impairment will be referred to ear and hearing services to prevent lengthy processes.

While a combination of providers was sought as the nature of the illness persisted, usage of healthcare was distinct between those who sought help from the public healthcare and from the private healthcare. Participants from the Tswana ethnic group mainly consulted with public health services, while some also sought help from private practitioners. Meanwhile, participants from the Afrikaner ethnic group sought help mainly from private healthcare services. As a result of the socio-economic position of participants, they all ultimately accessed and used the services of a public healthcare audiologist. Universal healthcare through the National Health Insurance (NHI Bill, 2020) has a major role to play

for adults with hearing impairment to receive equal health services timeously. This will also contribute to reducing the long-term consequences of this sensory impairment.

Results from this study indicated that socio-economic factors acted as a barrier towards hearing help-seeking behaviour adopted. Most participants lamented reduced access to finances in resolving their hearing difficulties. This is supposedly referring to the more cost-bound private healthcare that participants preferred in lieu of public healthcare which is available and affordable for all South Africans. For this study, it was interesting that socio-economic factors influenced participants more than psycho-social factors. This pattern is relevant and consistent within a developing context under which South Africa finds itself as well as being described by the World Bank (2021) as part of the LAMI countries. More importantly, this reveals that help-seeking behaviour was influenced by the participants' lived experiences. While finances were the biggest obstacle to help-seeking behaviour, it is interesting that a few participants reported no difficulties in their help-seeking. Despite the known challenges in the healthcare system, the material and social deprivation in resources and the long process to accessing audiologists, participants did not have any barriers from the onset of symptoms. These participants described being able to access audiology services because of prior knowledge, a faster process than expected in the healthcare system and a determination to resolve their hearing difficulties.

In the declaration of COVID-19 as a pandemic in 2020 (WHO, 2020), this study showed that the viral infection influenced access to health services. Limitations even in movement in the effort to contain the virus prevented timeous help-seeking. Nevertheless, participants' contextual environment was more influential as a barrier even though COVID-19 was a global disease.

The setting of this study also revealed that structural and health system factors facilitated help-seeking behaviour. Though disparities in health service provision exist, it is interesting that participants acknowledged health facilities and healthcare providers as enabling the process to resolve their hearing difficulties. Services were available and accessible and healthcare professionals in the community assisted older adults towards the ideal healthcare provider. As compared to barriers, psycho-social factors followed structural and health system factors in influencing participants in their help-seeking. The emotional impact of the hearing impairment on older adults influenced their quality of life towards seeking help. Though adults with hearing impairment experience the consequences of the hearing difficulties upon their lives similarly (Olusanya et al., 2014), the difference is that participants in a South African community reported the healthcare system as a major contributor in moving participants forward in their journey.

A few participants reported family and personal factors as facilitating their journeys towards seeking help. Family support for the older adult with a hearing impairment can be negative or positive however for participants in this study, families found the help needed or encouraged participants to resolve the hearing difficulties.

5.2 Implications and impact of the study

There is a dearth of research in hearing help-seeking behaviour from different settings, regions and locations that describes the experiences of adults with a hearing impairment from their contextual realities. This study sought to investigate this behaviour from a multi-cultural and multi-lingual context of a developing country by describing the pattern of presentation according to participants' cultural traditions and belief systems, defining their journeys from onset of symptoms to accessing audiology services and examining the barriers and facilitators from the environment.

The anticipated findings were that within a diverse country like South Africa, help-seeking behaviour would reflect the realities of the context. Participants' behaviours would be influenced by the social environment particularly as culture plays an important role in African contexts. The process of reaching the audiologist would be complex when considering the individual, their socio-demographics, the socio-economic dynamics, and South Africa's healthcare system. It was expected that help-seeking journeys would consist of public and private consultations because of the dynamics mentioned above however what was unexpected was the long journeys that most participants used to access ear and hearing care. When considering the challenges in the South African healthcare system, it was surprising that participants highlighted health system factors as a facilitator in their help-seeking journey. In addition, family and friends were helpful in linking participants directly to an audiologist. Without these social networks participants may have possibly still have been continuing to seek help. The researcher also noted that despite public sector healthcare being available and affordable for all adults with hearing impairment, seeking care was still influenced by finances.

Therefore, results of the study have shown that patterns of help seeking behaviour for adults with hearing impairment are associated with the individuals' environment. In addition, seeking help is not a linear process which requires clinicians to understand the journeys of those who eventually reach audiology services. This will guide clinical practice to be more contextually relevant for audiologists to better serve their patients. Health-seeking behaviours must be known and understood by healthcare providers.

This study also confirms that living in a highly deprived area in combination with unfavourable social determinants of health has poorer health outcomes for those who are ill. Self-reported hearing difficulties are not the only factor to influence the behaviour patterns of patients as reported in high-income studies. The disadvantages related to the local

community, or the nation affect the individual and the services they require for their ear and hearing needs. However, these disadvantages reveal where the gaps are for improving inequalities at a social and health level. More importantly, hearing health policy within the South African context must provide for equitable access to audiology services for all healthcare users in preventing severe consequences of hearing impairment. The South African Government's plan to implement universal healthcare should include the availability of preventative audiology services.

5.3 Strengths of the study

This study has shed light on the importance of investigating individual behaviours towards help-seeking from a socio-cultural viewpoint.

The health-seeking behaviours of those with hearing impairment in a diverse country that is rich in culture and language are determined by the immediate context and the social environment. Hence, participants were recruited using maximum variation sampling purposively to obtain a varied sample to reflect their individual experiences. In addition, according to clear criteria, the researcher was able to select individuals from an audiology department where adults with hearing impairment would most likely come. This was feasible when considering the purpose of and the amount of time for the study.

This study revealed that participants' decisions and journeys in attending to their hearing difficulties are influenced by a variety of factors within and outside of their control. In addition, participants' experiences in resolving hearing impairment are not analogous as shown in the current literature. The availability of resources, the socio-cultural aspects of a community, and the general healthcare system contribute to the decisions made by adults in their health-seeking behaviour with this sensory impairment.

The study revealed the status of hearing health and hearing care in South Africa. Access to audiology services is limited as previously documented showing that South Africans seek to resolve their hearing difficulties with what is accessible to them at that moment according to their socio-economic status.

5.4 Limitations of the study

- The participant sample size was relatively small in relation to the intended goal of 30 participants. The fact that data collection was over a period of more than 2 months shows the possibility that more participants could have been included in the study if time was permitting.

- Notwithstanding attempts to have participants with a variety of ages from 18 years and above, the study was limited in that most participants were above the age of 60 years which reduced the heterogeneity of the study. The inclusion criteria also selected only participants for initial audiology consultations which means that these participants had already started the process of seeking help. This prevented investigating this phenomenon from those who had not yet sought help, which could have provided interesting insights.

- The method of collecting data using interviews only limited the information gathered from participants to independent experiences. A focus group could have contributed to the already rich information acquired from the participants about hearing help-seeking.

- The researcher interviewed the participants herself whilst being employed where the data was collected. Interview bias could have been present which possibly limited interviewing independently without any impartiality. Participants may have also given favourable results because of the setting of the interview.

- Collection of data from one community limited the experiences to individuals in that environment. Inclusion of adults from another community or even province could have yielded a broader understanding of this phenomenon.

5.5 Recommendations

There is a need to investigate hearing help-seeking behaviour by focusing on the contextual experiences of help-seekers from different environments. This will provide a broad view of this subject from the individual's perspective as they interact with their social networks, from their families to the healthcare system. In other words, illness behaviour can be better understood from the individual's environment. In addition, patient's lived experiences may be culturally, linguistically, patriarchally and even socially determined. Hence, it is essential that research studies are conducted in a variety of settings with a diversity of influences. Researchers will also have to include pluralistic healthcare systems in their investigations.

With regards to preventative audiology within the South African context, it is important that health systems are strengthened from the primary health care level so that adults with hearing impairment can access audiology services from the onset of symptoms. Healthcare workers at primary level services as well as private healthcare providers should be empowered with the knowledge and skills related to ear and hearing care to reduce repeated visits to these facilities, thereby causing unnecessary delays and adverse effects of the hearing impairment. A common referral pathway, that directs all health providers regarding referrals to the audiologist or the ENT specialist, will prevent non-audiology professionals independently deciding the course of action for adults with hearing impairment in cases where there is uncertainty. This will provide the patient with timely professional management of the disease and prevent the long journeys that help-seekers often experience

towards resolving their hearing difficulties. Consequently, when hearing help-seekers receive the appropriate assessment and management of their hearing complaints from healthcare workers, it will result in a reduction in the negative consequences of hearing difficulties.

As far as health services are concerned, equal and equitable health services for all adults can only be achieved through the introduction of universal healthcare. Universal healthcare will ensure availability of ear and hearing care so those seeking help, regardless of their socio-economic position, social support, and limited communal and regional resources, receive similar access to audiology services whilst considering their individual needs. Some of the participants in this study were not satisfied with the healthcare service that they used which indicates that the type and quality of services available should be fair and comparable for all help-seekers. In addition, promotion, and awareness of hearing healthcare to the public will benefit everyone, including social networks like friends and families who are often involved in this help-seeking process. This will subsequently influence journeys to the ideal healthcare provider.

In clinical practice, it is recommended that audiologists consider the journeys of their patients when managing hearing impairment. Case history taking during assessments should include an evaluation of the process that adults have taken to reach the audiologist. In this way, audiologists will be able to understand the help-seeking behaviours of patients beyond their own contexts and experiences and therefore be able to place the patient at the centre of the consultation. This will then lead to the provision of an appropriate treatment plan that is based on the help-seeker's lifestyle and their socio-cultural background. Audiologists who consider the participants' context, even if they consulted traditional health practitioners, will be more effective in their consultations for hearing assessment and for hearing aid uptake.

Adults with hearing impairment seek to cure their hearing difficulties but those involved in healthcare and the healthcare system should seek to prevent worse health outcomes by considering patients' help-seeking behaviour.

5.6 Further research

This qualitative descriptive research study was undertaken for the purposes of investigating help-seeking behaviour in relation to the experiences of adults with hearing impairment. Results indicated that decisions to seek help are based on a variety of factors influenced by beliefs, the context and the individual's social network. To discover the possible merit of these findings further research needs to be conducted with a larger sample from a diversity of cultures, languages, and population groups. Opportunities for research with a larger sample will contribute to the current findings by providing a greater understanding of this phenomenon within a multi-cultural and multi-lingual country. From this small sample, it is unknown how influential cultural practices and belief systems are for adults with hearing impairment in a diverse community. Therefore, conducting studies in urban and rural communities as part of a larger sample, using non-medical settings may provide researchers with better insights. Findings in these studies might provide in-depth information on the cultural influences in urban populations compared to rural populations, leading to better provision of health services tailored for each location.

With regards to data collection procedures, using open-ended questions for interviewing older adults provided the researcher with rich perspectives towards understanding hearing help-seeking behaviour patterns. Although the recruitment of older adults was not the intention of the researcher, research conducted in different locations with the same age group of adults can provide a broader understanding of this phenomenon compared to the current one-sided literature findings from HICs. As part of the data

collection procedures, future research can include journal writing of participants' experiences at home without the pressure of being interviewed. This has the possibility to yield more information related to help-seeking behaviours. In addition, as highlighted, focus groups can also be used to provide deeper insights from this subject.

The family as a social network could also be included in future research endeavours, as in-depth interviewing of the family circle can support the experiences of help-seekers by providing useful information as it affects third parties. Investigations could also focus on how third parties influence the help-seeking journey in less individualistic yet more collective, communally orientated cultures. Furthermore, younger populations such as children or persons with hearing loss due to other aetiologies can also be considered as part of research studies to gain insights into how children as compared to adults seek help. This can contribute to the current lack of knowledge on hearing help-seeking.

Finally, with the current division of healthcare between private and public healthcare sector, research can be conducted into the help-seeking pathways of individuals with hearing difficulties in both sectors to see if their experiences are different.

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APPENDICES

APPENDIX A

Interview Guide

Title: In pursuit of preventive audiology: Help-seeking behaviour patterns of adults with hearing impairment in a peri-urban community in South Africa

Biographical information

Participant code: _____

Gender: Male or Female

DoB: _____

Ethnicity: _____

Degree of Hearing loss: _____

Occupation: Unemployed/ Employed/Self-employed:

Student: Yes or No.

Participant: alone or accompanied by significant other

I would like you to tell me about your journey of seeking help for your hearing difficulties.

1. Tell me about the time when you started noticing that there was a problem you're your ear/hearing.
2. Who did you first seek help from?

A: Doctor

B: Traditional Healer/Sangoma/Inyanga

C: Herbalist

D: Pastor/Imam/Priest

E: Ancestors

F: Family

G: Other

A) probe for pattern of presentation-first consulter.

3. What did they say/do?

4. From the response above, what was the reason for going to the ____? Some people will go to _____. How is this related to what you believe about how you treat any sickness in your body? What do you believe about what you do when you are sick?

5. Describe the journey that you took or followed from the very first sign/s that made you see that there was a problem (first symptom/s) to the audiologist/reaching this hospital?

   A) Probe for pathway or process taken.

   B) How did they actually seek help? How was the process (facilitators and barriers)?

6. What do you think were some of the barriers to you getting help for your hearing difficulties? Barriers to seeking help for your hearing difficulties. (what were the things that blocked you/prevented you/stopped you from getting help?)

   A) Probe description in the journey, before reaching the audiologist.

B) Any barrier according to the patient including context specific barriers.

7. What do you think were some of the things that made it easier for you to get help for your hearing difficulties? Facilitators to seeking help for your hearing difficulties. (what were the things that helped you from getting the help?)

   A) Probe description in the journey, before reaching the audiologist.

   B) Any facilitator according to the patient including context specific barriers.

APPENDIX A - Setswana

Interview Guide

Title: In pursuit of preventive audiology: Help-seeking behaviour patterns of adults with hearing impairment in a peri-urban community in South Africa

Biographical information

Participant code: _____

Gender: Male or Female

DoB: _____

Ethnicity: _____

Degree of Hearing loss: _____

Occupation: Unemployed/ Employed/Self-employed:

Student: Yes or No.

Participant: alone or accompanied by significant other

Ke batla gore o mpolelele ka leeto la gago la go tsamaya o batla thuso kamathata a ditsebe tsa gago.

1 Mpolelele ka nako eo fa o ne o simolola go ipona gore o na le mathata a ditsebe/go sa utlwe?

2 O ile wa batla thuso sa ntlha go mang?

A: Ngaka yaSegowa

Umthombo Building – 1st Floor, Room U132, Braamfontein East Campus , Private Bag 3, WITS 2050
T +27 11 717 4577 | E sppa.SHCD@wits.ac.za | www.wits.ac.za/shcd/speech-pathology-and-audiology/

B: Ngaka yaSetswana or setso/Sangoma/ Ngaka

C: Moalafi/ Diapemere/ Boraditlhare

D: Moruti/MoImam/MoPriesta

E: Bagologolwane

F: Lelapa

G: Ba Bangwe

A) Batlisisa mabapi lepattern ya tlhagiso kago mothusi wa ntlha?

3 Ba rileng?

4 Gotswa mo karabong e e fa godimo~~,~~ *ka tumelo ya gago, wena, sa ntlha o e le waya* _____. *O nka mpolelela gore seo se amana yang le setso sa hao, kapa tumelo ya hao, mabapi le ho phekola go kula mo mmeleng wa gago?*

5 Tlhalosa leeto le o le tsamaileng gotsa o le latetsing go tloga ko matshwaong sa ntlha fela fa tsimologong ga o akanya gore go na le bothata (ditshupo tsantlha) go ja ka go bona audiologist/gotsa go fihla bookelong?

A) Batlisisa ka tsela gotsa thulaganyo e tserweng.

B) Ba batlhe thuso jang? Thulaganyo e tserweng e ne e le jang?

6 O akanya gore ke dikgoreletsi dife tse di ne tsa go thibela go bona thuso mabapi le mathata a ditsebe tsa gago? (dintho tse emisitseng gotsa tsethibeletsing go fitlhela thuso).

A) Batlisisa tlhaloso mabapi le leeto, pele go fitlha go audiologist?

B) Dikgoreletsi dingwe go ya ka molwetsi le go akaretsa kgang ya fa a philang teng.

7 O akanya gore ke dilo dife tse dirileng gore o kgone go fitlhelela thuso ya mathata a ditsebe tsa gago? (Dintlha tsethusitseng gofitlhela thuso).

A) Batlisisa tlhaloso ma bapi le leeto, pele go fitlha go audiologist?

B) Ditsamaiso dingwe go ya ka molwetsi le go akaretsa kgang ya fa philang teng.

APPENDIX B Ethics Clearance Certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Miss Thobekile Kutloano Mtimkulu

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M201003

NAME: (Principal Investigator)	Miss Thobekile Kutloano Mtimkulu
DEPARTMENT:	Human and Community Development Witrand Hospital Potchefstroom, Northwest
PROJECT TITLE:	In Pursuit of Preventive Audiology: Help-Seeking Behaviour Patterns of Adults with Hearing Impairment in a Peri-Urban Community in South Africa
DATE CONSIDERED:	30/10/2020
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Prof Katijah Khoza-Shangase
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	08/03/2021

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the Third Floor, Faculty of Health Sciences, Phillip Tobias Building, 29 Princess of Wales Terrace, Parktown, 2193, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions.Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report.** The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in **October** and will therefore be due in the month of **October** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

Date 10/03/21

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX C Request for permission to conduct study

To

The Acting Chief Executive Officer

Witrand Hospital

Mrs ME Mpolokeng

08 December 2020

Good day,

My name is Kutloano Mtimkulu and I am doing a Master of Arts' Degree in Audiology at the University of Witwatersrand, Johannesburg. In fulfilment of my degree, I am conducting a study titled: **In Pursuit of Preventive Audiology: Help-Seeking Behaviour Patterns of Adults with Hearing Impairment in a Peri-Urban Community in South Africa.**

My study seeks to understand the behaviour patterns of those with hearing difficulties by investigating the pathways to seeking help as well as the needs, barriers and demands, to help in contributing towards supplying better ear and hearing health in South Africa. This study is relevant to the area of audiology because there is limited published research in this area of hearing help-seeking, particularly in low-and-middle income countries such as South Africa. The study results may contribute towards a better understanding of hearing health in a diverse and multicultural context and may also improve healthcare management of those with hearing impairment, while contributing towards efforts around prevention of hearing loss.

Umthombo Building – 1st Floor, Room U132, Braamfontein East Campus , Private Bag 3, WITS 2050
T +27 11 717 4577 | E sppa.SHCD@wits.ac.za | www.wits.ac.za/shcd/speech-pathology-and-audiology/

I, therefore, would like to request for permission to conduct my study in the Audiology Department of the hospital. This will involve interviewing a minimum of 15 adults consulting with the audiologist, where they will be answering a few questions in relation to their hearing and hearing difficulties. This interview will take on average 45 minutes, with written informed consent from the willing participants and permission sought for recording the responses correctly and accurately for data analysis later. Interruption to their main purpose in coming to the hospital will be kept minimal.

Should permission be granted to conduct the study, all patient information shared with me will not be available to others, no individuals' names or personal details will be stated in the study or in the discussion thereof. The information will be kept in a locked cupboard in a locked office or stored electronically in a secure environment.

Participation will be voluntary, and no one will be forced to take part in this study. If patients choose to not participate, they will not be affected in any way whatsoever. There will also be no personal costs to participation in the study and participants will not receive any direct benefits from participation nor are there any disadvantages or penalties should you choose to not participate. Any information they provide will not be used against them when consulting with the Audiologist regarding their hearing complaints.

Consenting patients will not be disadvantaged in any way before, during and after their time in the hospital and in their consulting with the Audiologist.

If any of the participants experience any distress or discomfort at any point during this process, the interview will be stopped or re-started at another time. Should they need support or counselling, that will be made available to them.

Ethical approval has been applied for from the University of Witwatersrand Human Research Ethics Committee (Medical) to conduct this study. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Medical), telephone +27011 717-1252/2700, email Mr Rhulani Mkansi Rhulani. Mkansi@wits.ac.za

Administrative officer:

Ms. Z Ndlovu 011 7172700/123-4 zanele.ndlovu@wits.ac.za

If you have any questions, please do not hesitate to contact me on 0822987706.

Sincerely,

_____

Miss Kutloano Mtimkulu

MA (Audiology) Student

Department of Audiology

University of the Witwatersrand

Cell: 0822987706-

Email: kuthimti@yahoo.com

_____

Prof K. Khoza-Shangase

Research Supervisor

Department of Audiology

University of the Witwatersrand

Tel: 011 717 4565

Email: Katijah.Khoza-Shangase@wits.ac.za

Mrs L. Petrocchi- Bartal

Research Co-Supervisor

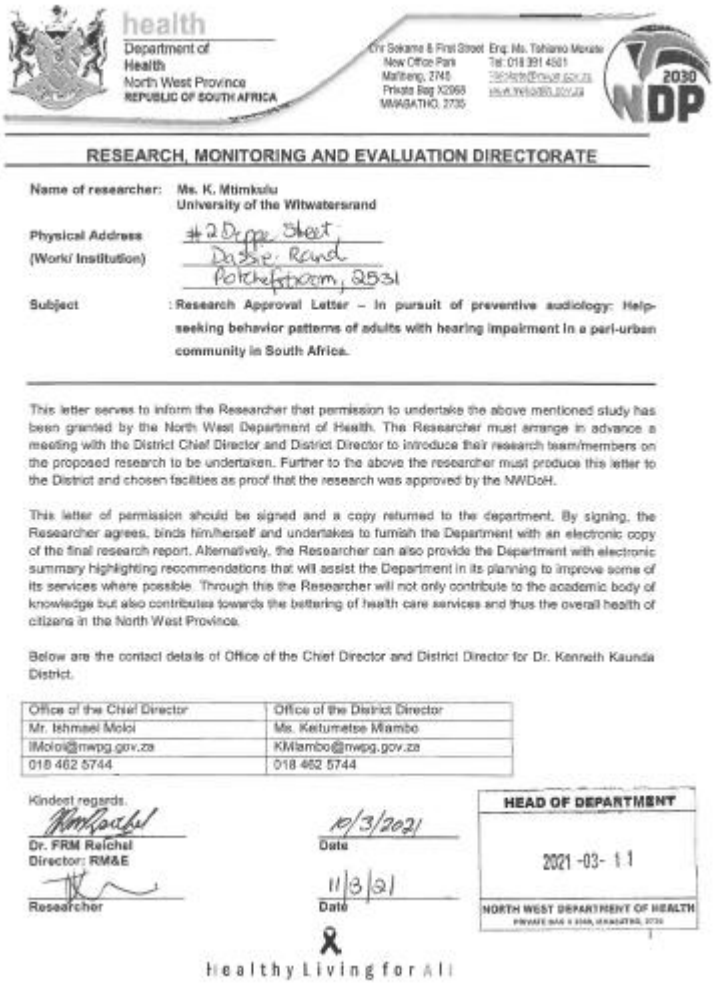
Department of Audiology

University of the Witwatersrand

Tel: 011 717 4568

Email: Luisa.Petrocchi-Bartal@wits.ac.za

APPENDIX D Approval from the North West Department of Health



health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

Cnr Sekame & First Street
New Office Park
Mahikeng, 2745
Private Bag X2068
MMABATHO, 2735

Enq: Ms. Tshiamo Monate
Tel: 018 391 4561

2030 NDP

RESEARCH, MONITORING AND EVALUATION DIRECTORATE

Name of researcher: **Ms. K. Mtimkulu**
University of the Witwatersrand

Physical Address (Work/ Institution) #2 Dropmore Street
Dr Sive Road
Potchefstroom, 2531

Subject : **Research Approval Letter – In pursuit of preventive audiology: Help-seeking behavior patterns of adults with hearing impairment in a peri-urban community in South Africa.**

This letter serves to inform the Researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The Researcher must arrange in advance a meeting with the District Chief Director and District Director to introduce their research team/members on the proposed research to be undertaken. Further to the above the researcher must produce this letter to the District and chosen facilities as proof that the research was approved by the NWDoH.

This letter of permission should be signed and a copy returned to the department. By signing, the Researcher agrees, binds him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively, the Researcher can also provide the Department with electronic summary highlighting recommendations that will assist the Department in its planning to improve some of its services where possible. Through this the Researcher will not only contribute to the academic body of knowledge but also contributes towards the bettering of health care services and thus the overall health of citizens in the North West Province.

Below are the contact details of Office of the Chief Director and District Director for Dr. Kenneth Kaunda District.

Office of the Chief Director	Office of the District Director
Mr. Ishmael Moloi	Ms. Keitumetse Mlambo
IMoloi@nwpg.gov.za	KMlambo@nwpg.gov.za
018 462 5744	018 462 5744

Kindest regards.

Dr. FRM Reichel
Director: RM&E

10/3/2021
Date

Researcher

11/3/21
Date

HEAD OF DEPARTMENT
2021 -03- 11
NORTH WEST DEPARTMENT OF HEALTH

Healthy Living for All

APPENDIX E: Participant Information Sheet

Date:

Good day,

My name is Kutloano Mtimkulu and I am doing a Master of Arts' Degree in Audiology at the University of Witwatersrand, Johannesburg. In fulfilment of my degree I am conducting a study titled: **In Pursuit of Preventive Audiology: Help-Seeking Behaviour Patterns of Adults with Hearing Impairment in a Peri-Urban Community in South Africa.**

My study seeks to understand the behaviour patterns of those with hearing difficulties by investigating the pathways to seeking help as well as the needs, barriers and demands, to help in contributing towards supplying better ear and hearing health in South Africa. This study is relevant to the area of audiology because there is limited published research in this area of hearing help-seeking, particularly in low-and-middle income countries such as South Africa. The study results may contribute towards a better understanding of hearing health in a diverse and multicultural context and may also improve healthcare management of those with hearing impairment, while contributing towards efforts around prevention of hearing loss.

As part of my study, I would like to invite you to take part in an interview where you will be answering a few questions in relation to your hearing and hearing difficulties. This interview will take an average of 45 minutes. With your permission, I would also like to record the interview in order to be able to write down all your answers correctly and accurately.

Should you decide to participate in the study, all information you share with me will not be available to others, no individuals' names or personal details will be stated in the study or in the discussion thereof. The information will be kept in a locked cupboard in a locked office or stored electronically in a secure environment. Participation is voluntary and you are not being forced to take part in this study. The choice of whether to participate or not, is yours alone. If you choose to not participate, you will not be affected in any way whatsoever. If you agree to participate, you may stop participating in the research at any time and tell me that you don't want to continue.

There will be no personal costs to you if you participate in the study and you will not receive any direct benefits from participation nor are there any disadvantages or penalties should you choose to not participate. Any information you provide will not be used against you when consulting with the Audiologist regarding your hearing complaints.

If you experience any distress or discomfort at any point during this process, the interview will be stopped or re-started at another time. Should you need support or counselling, that will be made available to you at the hospital. In this regard, the researcher will contact the psychologist and personally submit a referral letter on behalf of the participant for provision of services.

If you have any questions during or afterwards about this research, feel free to contact me or my supervisors on the details listed below. The results of this study will be written as published articles and/or a dissertation. It may be accessed through the University of the Witwatersrand library website. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Medical), telephone +27011 717-1252/2700, email Mr Rhulani Mkansi

Rhulani.Mkansi@wits.ac.za

Administrative officer:

Ms. Z Ndlovu 011 7172700/1234 zanele.ndlovu@wits.ac.za

If you have any questions, please do not hesitate to contact me on 0822987706.

Sincerely,

Miss Kutloano Mtimkulu

MA (Audiology) Student

Department of Audiology

University of the Witwatersrand

Cell: 0822987706

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Prof K. Khoza-Shangase

Research Supervisor

Department of Audiology

University of the Witwatersrand

Tel: 011 717 4565

Email: Katijah.Khoza-Shangase@wits.ac.za

Mrs L. Petrocchi- Bartal

Research Co-Supervisor

Department of Audiology

University of the Witwatersrand

Tel: 011 717 4568

Email: Luisa.Petrocchi-Bartal@wits.ac.za

Dr C. Penny

Chairperson: Human Research Ethical Committee (Medical)

University of the Witwatersrand

Tel: 011 717 2700

Appendix C: Participant Consent Form

I, _____ agree to participate in this research study.

The research has been explained to me and I understand what my participation involves.

I have read / understand the information letter and understand what is required of me.

I agree to being recorded and I understand that participation is voluntary, and should I want to withdraw at any time during the interview I may do so without any negative consequences.

I understand that my participation will remain anonymous, and no personal details will be used in the gathering of information for this study.

Signed: _____

Date: _____

APPENDIX F Pilot Study Questionnaire

Interview Guide

Title: In pursuit of preventive audiology: Help-seeking behaviour patterns of adults with hearing impairment in a peri-urban community in South Africa

Biographical information

Participant code: _____

Gender: Male or Female

DoB: _____

Ethnicity: _____

Degree of Hearing loss: _____

Occupation: Unemployed/ Employed/Self-employed:

Student: Yes or No.

Participant: alone or accompanied by significant other

I would like you to tell me about your journey of seeking help for your hearing difficulties.

1. Tell me about the time when you started noticing that there was a problem with your ear/hearing.
2. Who did you first seek help from?

   A: Doctor

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B: Traditional Healer/Sangoma/Inyanga

C: Herbalist

D: Pastor/Imam/Priest

E: Ancestors

F: Family

G: Other

Probe for pattern of presentation-first consulter.

3. What did they say/do?

4. From the response above, how is this related to your cultural values or belief system? What are or were the cultural influences towards resolving your hearing difficulties?

5. Describe the journey that you took or followed from the very first sign/s that made you see that there was a problem (first symptom/s) to the audiologist/reaching this hospital?

A) Probe for pathway or process taken.

B) How did they actually seek help? How was the process (facilitators and barriers)?

6. What do you think were some of the barriers to you getting help for your hearing difficulties? Barriers to seeking help for your hearing difficulties. (what were the things that blocked you/prevented you/stopped you from getting help?)

A) Probe description in the journey, before reaching the audiologist.

B)Any barrier according to the patient including context specific barriers.

7. What do you think were some of the things that made it easier for you to get help for your hearing difficulties? Facilitators to seeking help for your hearing difficulties. (what were the things that helped you from getting the help?)

   A) Probe description in the journey, before reaching the audiologist.

   B) Any facilitator according to the patient including context specific barriers.