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UNDERSTANDING THE HEALTHCARE-SEEKING DECISIONS AMONG RURAL HOUSEHOLDS IN SARGODHA DIVISION, PAKISTAN

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ABSTRACT

The rural healthcare-seeking is an iterative household process shaped by illness interpretation, distance, cost, family influence, provider availability, and previous care experiences. This qualitative study focuses upon the rural communities across Sargodha Division, Punjab, Pakistan, comprising the districts of Sargodha, Khushab, Mianwali, and Bhakkar. The 2026 study is designed around 35 adults who have participated in household healthcare decision during previous 12 months. Constructivist grounded theory guides purposive and theoretical sampling, semi-structured interviewing, constant comparison, memo writing & category development. Five research questions study how households recognize illness, negotiate financial, geographical constraints, use family and community networks, move between formal and informal providers, revise future choices through trust and prior experience. Analysis is organized around healthcare-seeking pathway of recognizing, negotiating, mobilizing, selecting, and reassessing. The study aims to extend patient-centered access theory that how barriers combine serially within rural households rather than operating as isolated constraints. Findings can inform transport, referral, outreach, trust-building strategies for rural health services in Punjab.

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INTRODUCTION

The access to healthcare in rural areas goes beyond just having a clinic or a hospital nearby. First, families have to be able to identify signs, assess the need for urgency, find an acceptable provider, organize transport, raise funds, get help from family & determine whether they prefer professional services over informal services. In this way, the patient-centered model of access takes into account

five dimensions of health service (approachability, acceptability, availability and accommodation, affordability, and appropriateness) and corresponding abilities (to perceive, to seek, to reach, to pay for, and to engage in care). They are particularly applicable in rural areas of Pakistan where such barriers are often combined into one healthcare event. Care-seeking for healthcare is relational and experience-based. The concept of healthcare-seeking behaviour generally encompasses the actions taken by individuals, households in response to perceived illness. The research from rural Pakistan climaxes that household decision-making, financial dependency, limitations of mobility, awareness of danger signs, and perceptions of service quality play an important role in whether healthcare is sought.

Studies from rural areas of Sindh and southern Punjab have revealed that issues related to family hierarchy, transportation, costs, cultural explanations of disease, and transitions from biomedicine and alternative healing are critical in deciding on health services (Qureshi, Sheikh, Khowaja, Zaidi, Vidler, Bhutta & Dadelszen, 2016; Habib, Jamal, Zaidi, Siddiqui, Khan & Versfeld, 2021; Ahmed, Malik, Zia, Akbar, Li, Shahid & Tang, 2023). The research carried out in the Sargodha District has emphasized concerns around perceived low quality of care at public antenatal facilities (Tasneem & Ozdal, 2023). Still, what is lacking is a process-oriented study of healthcare-seeking behavior in rural part of Sargodha Division in Pakistan. Previous Pakistani literature has highlighted factors such as distance, transport, decision-making power at home, lack of awareness, lack of money, and dissatisfaction with the quality of services but most of this information has been disease-specific, maternity-related, and found in different provinces and districts of Pakistan (Qureshi et al., 2016; Ahmed et al., 2023).

Even where information comes from Sargodha itself, it has been based on the quantitative analysis of service quality rather than qualitative tracking of journey from identifying symptoms to seeking medical help and later decision-making influenced by healthcare encounter (Tasneem & Ozdal, 2023). Thus, the issue is not that there is simply 'poor access' for rural communities. The individual may know where facilities are, but they cannot go there until transport, money are arranged; they be able to get to a health service, but will refrain from going back because of lack of communication, drug shortages, long queues, and lack of trust; and they may go to the local informal provider first due to perception that the condition is not severe among their family members. Qualitative studies from Pakistan illustrate that such constraints often come together with role of family, availability of services, and perceptions of quality (Qureshi et al., 2016; Habib et al., 2021; Ahmed et al., 2023). This study tackles problem through providing a better understanding of when and why healthcare journey changes.

Research Objectives

- ✓ To explore that how rural households recognize as well as interpret health problems before seeking the care.
- ✓ To identify how financial, geographical, social, cultural & institutional factors shape healthcare-seeking decisions.
- ✓ To examine the influence of family and community networks on treatment timing as well as provider choice.

- ✓ To understand that how households negotiate between formal, informal, as well as traditional sources of the care.
- ✓ To develop grounded explanatory model of how previous healthcare experiences & trust shape future healthcare-seeking.

Research Questions

RQ1: How do rural households recognize and interpret health problems before deciding to seek professional healthcare?
RQ2: How do financial, geographical, social, cultural & institutional conditions shape healthcare-seeking decisions in rural communities?
RQ3: How do family members and community networks influence when, where, as well as from whom the healthcare is sought?
RQ4: How do rural households negotiate between the formal healthcare services and informal or traditional sources of the care?
RQ5: How do previous healthcare experiences shape trust, future provider choice, and subsequent healthcare-seeking behaviour?

LITERATURE REVIEW

The patient-centered access framework proposed by Levesque and Harris and Russell (2013) acts as the main sensitizing concepts for research. Access is perceived within this framework as a process that is result of interaction between health services characteristics and the capabilities of patients. Approachability on the side of services relates to identification of their existence and accessibility in terms of information. Acceptability is associated with the social and cultural fit. Availability and accommodation involve spatial and organizational ability to access services. Affordability involves economic capability while appropriateness relates to match & quality of received care. The above-mentioned characteristics relate to people's ability to perceive the need, access care, get to services, afford services and engage in care respectively. Cu, Meister, Lefebvre and Ridde (2021) shows that this framework is widely used, helpful in organizing barriers and facilitators in different settings. In the present study, the framework serves as a sensitizing structure and not as a prespecified coding template. Therefore, this is because grounded theory aims at building theories using data through constant comparison.

In using the prespecified model as the sole coding template, we undermine the grounded-theory approach. On the contrary, dimensions of access provide a basis for formulating the initial research questions with room left for other possible categories, like family negotiation, informal counseling, severity of perceived illness, previous treatment experience, male/female dominance in decision-making or trust, which might transcend access dimensions. This approach is compatible with the methodological principle that grounded theory should not amount to mechanized coding or word counting (Suddaby, 2006). The research employs a constructivist approach in which meanings of healthcare-seeking behaviors are seen as socially constructed by experiences of the respondents. This approach is appropriate for rural healthcare since treatment decisions are made within a household or community context. The resulting theory will be centered on process, i.e., what comes first, what transforms the process, what strategies are used and how do they change subsequent

processes. Therefore, empirical evidence from Pakistan indicates that health care access in rural areas is multifaceted.

According to Qureshi et al. (2016), in rural Sindh, factors like transportation, cost, accompaniment, family decision-making & perceived quality determined maternal health care-seeking behavior. Habib et al. (2021) also highlighted restricted financial autonomy, lengthy travel time, mobility issues, and lack of female health workers as some of barriers faced by women living in rural settings. In the rural southern Punjab, Ahmed et al. (2023) indicated that isolation, poverty, illiteracy, and cultural understanding of illnesses influenced the decisions of individuals regarding health care utilization. All of the above-mentioned factors clearly suggest that geographic, economic, social, and cultural contexts should be analyzed together. The second theme involves issues of provider experience, household influence, and trust. Households in rural areas depend on their relatives and local social networks to raise funds, get transportation and receive information regarding providers' performance. It has been found that spouses, mothers-in-law, and other relatives can exert their effect on when and where women seek treatment, whereas respectfulness in interactions, quality of services, access to them, and past experience determine the future utilization (Qureshi et al., 2016; Habib et al., 2021).

Evaluations of public antenatal services by women in the Sargodha District provide evidence that the perceived quality affects further use of health care (Tasneem & Ozdal, 2023). This information supports the study of trust as an acquired characteristic as opposed to a personality trait. In this connection, qualitative process-oriented analysis is thus well-suited for use in the current research. With the grounded theory approach, data gathering, coding, constant comparison, memos, and theoretical sampling can evolve simultaneously in such a way that the categories become more refined throughout the research process. In rural communities, the process can begin with home-based remedies, advice from the family members, traditional or informal practitioners, pharmacies, dispensers, or unlicensed practitioners before a qualified doctor or hospital is consulted. Grounded theory proves especially helpful if the aim is to examine the mechanisms behind transitions rather than describing barriers, that is, how households move from home-based care to outside care, how the types of providers change, or from trust to distrust. Moreover, according to the methodology, grounded theory cannot be equated to mere coding or counting using the software (Suddaby, 2006; Ohta & Sano, 2023).

Initial Sensitizing Framework

Figure 1 illustrates first sensitizing framework developed for seeking rural healthcare in Sargodha. This framework includes elements of healthcare access centered on patients along with household negotiations, selection of providers, and feedback from the previous experiences. Rural households may have access to the basic health units, rural health centers and informal providers, but the mere presence of facility does not necessarily guarantee its effective utilization. Regional evidence from Sargodha Division shows substantial private-sector utilization and concerns regarding satisfaction with public primary healthcare facilities. In this linking, this framework is useful for conducting the interviews without precluding the grounded categories that may exist in elucidated framework in particular context.

RESEARCH METHODOLOGY

This study examines healthcare access among rural residents in 2026 using qualitative constructivist grounded theory design. Thus, it is guided by an interpretivist/constructivist research philosophy because the study seeks to understand how rural residents interpret their experiences of illness, the healthcare choices, household expectations, and previous interactions with healthcare providers. The study follows a predominantly inductive and process-oriented approach. Existing healthcare access theories are used only as sensitizing concepts to inform the interview guide, while coding and category development remain open to meanings, experiences, and relationships that emerge from participants' accounts. The target population consists of adult rural residents of Sargodha Division, Punjab, Pakistan. The Sargodha Division comprises the districts of Sargodha, Khushab, Mianwali, and Bhakkar, giving the study scope for variation in distance from healthcare services, household condition, and past experience with healthcare providers. The study involves 35 individuals who have either personally made, or helped make, a healthcare decision for the household within the past twelve months.

The purposeful sampling is employed initially in order to ensure variation in terms of gender, age, household condition, district, distance from healthcare services and experience with the healthcare providers (Ahmad et al., 2021; Sohail et al., 2020). In the course of analysis, theoretical sampling will be used in order to further develop the emerging concepts. Thus, in-depth and semi-structured interviews taking about 35–60 minutes will be employed in data collection (Ahmad et al., 2021; Mutereko et al., 2021; Sohail et al., 2020; Sohail, Ahmad, & Khan, 2021; Sohail, Hussain, & Riaz, 2021). In this drive, every interview starts with the most recent illness or healthcare experience of participant and proceeds to explore issues such as symptoms recognition, seeking of care, treatment, cost, transport, family influence, acceptability of the healthcare providers, employment of informal sources, and influence of past experience on trust and future health seeking behavior. Interviews will be conducted in the participants' preferred language, that is, Urdu, Punjabi, or Saraiki where necessary. Data collection and analysis take place concurrently in accordance with grounded theory principles.

Early transcripts are examined using line-by-line or incident-by-incident coding. Focused coding is then used to identify more significant and analytically useful categories. Constant comparison is applied throughout analysis to examine similarities and differences across participants, districts, demographic groups, types of healthcare providers, and stages of the healthcare-seeking process. Memo writing is used to document emerging explanations, category properties, contradictory cases, relationships among categories, and decisions about the theoretical sampling. Sampling continues until main categories are sufficiently developed & additional interviews contribute progressively fewer new conceptual insights (Guest, Namey & Chen, 2020; Hagaman & Wutich, 2017; Hennink, Kaiser & Marconi, 2017). NVivo 11 is used to manage the qualitative data and support analytical process (Ahmad et al., 2021; Sohail, Ahmad, & Khan, 2021; Sohail, Hussain, & Riaz, 2021). Thus, interview transcripts, field notes, and analytical memos are organized within the NVivo project and linked to relevant participant characteristics. The coding queries assist in retrieving and comparing data across cases.

Word-frequency queries, color tree maps, and cluster analysis are used only as supplementary visual and diagnostic tools. Although such outputs might reveal certain patterns that need to be explored qualitatively, they do not influence development of grounded theory categories because the frequency or similarity of textual content does not always imply the conceptual significance of the categories. The trustworthiness of the study is increased by such measures as providing an audit trail, writing reflective memos, identifying deviant cases, making coding decisions transparently, and reviewing coded data with peers. Ethical approval is obtained from the relevant institutional ethics committee before participant recruitment begins. The participants' names are replaced with identification codes in the transcripts and final report. The potentially identifying combinations of information, village, occupation, family role, or illness experience, are generalized where necessary because individuals may be more easily recognized in small rural communities. Audio recordings, transcripts, field notes and NVivo 11 project are stored securely and are accessible only to authorized research team.

RESULTS OF STUDY

Table 1 Demographic Profile of Participants

Characteristic	Category	n	%
Gender	Male	17	48.6
	Female	18	51.4
Age	20-30	6	17.1
	31-40	9	25.7
	41-50	10	28.6
	51+	10	28.6
Education	No formal/primary	12	34.3
	Secondary	14	40.0
	College+	9	25.7
Distance to usual facility	<5 km	11	31.4
	5-15 km	14	40.0
	>15 km	10	28.6
Recent provider used	Public facility	14	40.0
	Private provider	10	28.6
	Informal/traditional first	11	31.4

The demographics table is kept to illustrate the desired reporting framework for a heterogeneous grounded theory sample. When the analysis is done, the participant demographics should be stated briefly and then used for the case comparisons rather than being taken as an indication of statistical representativeness.

NVivo-Assisted Exploratory Analysis

Word-Frequency Analysis

NVivo 11-word frequency query is illustrated below as an initial approach to understanding the corpus. Some notable words are care, cost, distance, doctor, family, trust, transport, medicine, clinic, waiting, provider, and treatment. Frequency of words may help us understand repeated usage of

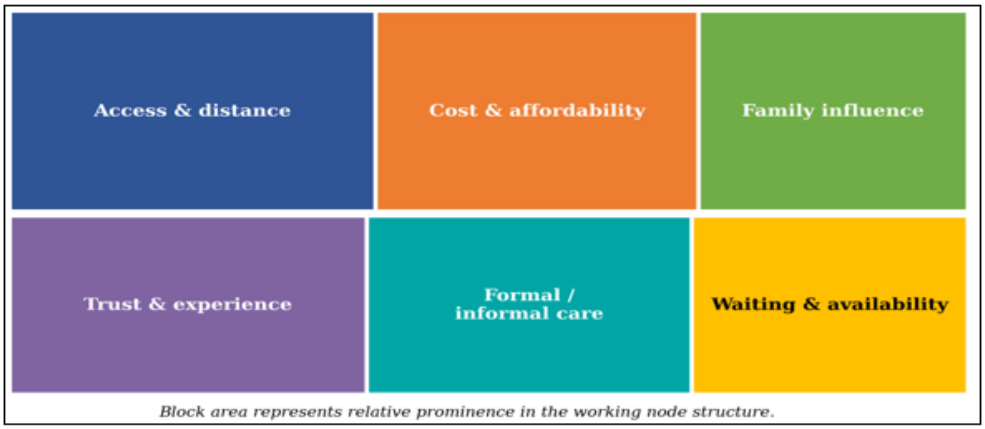
language as well as some helpful text fragments; however, common words do not imply themes in any case. In fact, the interpretation of the concept 'trust' will thus largely depend upon whether the respondents talk about individual practitioners, organizations, medicines, state services, or family/ communities' advice.

Figure 1 NVivo 11 Word-Frequency Query Display

Treemap Analysis

NVivo 11 Tree Map offers a concise visual representation of the prominence of the main codes used in analysis. Access/distance, cost/affordability, family, trust/experience, shift from formal care to informal care, and waiting/service availability are prominent codes within analysis framework. Still, the usefulness of tree map lies in the comparative aspect. It helps to identify the areas which require further examination through transcripts but interpretation should be kept within the codes, cases, and memos.

Figure 2 NVivo 11 Colour Tree Map of Major Coded Areas.

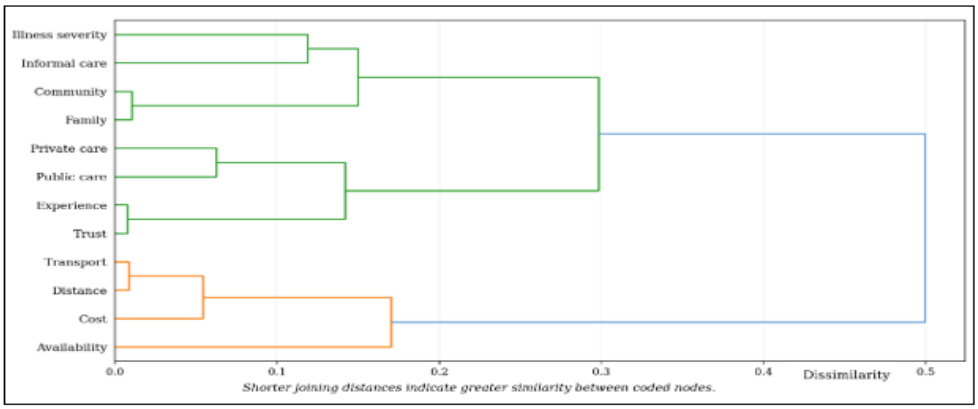


Cluster Analysis

NVivo 11 clustering is applied to reveal similarities between the thematic nodes of the codes. The dendrogram create clusters of nodes that have common concepts like cost-distance-transportation,

family–community influences, trust–experience and type of provider choice. The shorter the joining distance, the higher the similarity between the nodes in the coding scheme. In this linking, the clustering is an exploratory tool and requires text comparison not interpretation of the statistically significant types.

Figure 3 NVivo 11 Cluster Analysis of Thematic–Node Similarity



Grounded-Theory/Thematic Findings

The findings have been organized under five linked themes that directly correspond to the research questions. Each theme must eventually be buttressed with several excerpts, examples & analytical notes. The present categorization scheme has been kept since it integrates the interpretation of illness, resource mobilization, social navigation, provider relocation and trust within single quest for the healthcare.

Theme 1: Recognizing Illness & Negotiating Seriousness

The participants' initial choice would often be based on whether the symptom warranted the need for formal care. The illness categorization depended on the intensity of the symptom, its length, past experience, and guidance from their families. When the symptoms were not so serious, participants preferred taking care of them themselves or through some local means; however, when there was any kind of a sudden decline, serious pain, inability to work, or risk to life, formal care was sought. "At first, I thought it was the same weakness I had before, so we waited and used medicine already at home. When I could not stand properly the next morning, my husband said we should go to the clinic." (R04, female, 38). "We do not go for every fever because travel costs money. I watch whether the person is eating and working. If the condition changes or stays for two days, then I become worried." (R11, male, 52). When the pain became stronger at night, the family agreed that it was no longer something to manage at home." (R19, female, 29). "The decision starts with whether we think it is dangerous. Sometimes we are wrong, since what looks small in beginning becomes serious later." (R31, male, 44).

Theme 2: Distance, Transport & Affordability as Combined Constraint

The distance was never mentioned alone, but rather together with cost. Cost came in many forms – transport cost, loss of work hours, uncertainty on how to go back home after the visit, and also fear

of extra medical costs on diagnosis and treatment. What comes out clearly here is the resource mobilization category. "The clinic fee itself is not always the biggest issue. First, I must arrange the motorcycle, then pay for fuel, and if they send us to the town hospital the whole cost changes." (R02, male, 47). "I knew where to go, but knowing the place is different could take me because there was no transport at that time." (R08, female, 34). "When cash is short, we first buy something from the nearby shop or local dispenser. Going to hospital means transport, tests and medicine, so the family discusses whether we can manage it." (R23, female, 56). "A long distance also means losing a day of work. For a poor household, the cost is not only the fare; it is the income you lose while waiting." (R35, male, 61).

Theme 3: Family & Community Networks as Healthcare Navigators

However, family and community acted as enablers as well as barriers. Transportation and financial assistance came from family, providers were suggested, symptoms were identified, and treatment at home was suggested prior to visiting doctors. Community recommendations were instrumental when the participants did not have enough information about the quality of health care provided by health care providers. "My sister had been treated by doctor before, so I trusted her suggestion more than an advertisement. She called clinic and told me which day the doctor would be there." (R05, female, 42). "Before we spend money, I usually ask two or three people in the village who had the same problem. Their experience tells us whether the trip is worth making." (R14, male, 33). "My sons arranged the transport and money. Without them I would probably have delayed another day, even though I knew I needed treatment." (R21, female, 48). "Sometimes family advice helps, but sometimes it delays us. Everyone has a different remedy; lose time deciding whose advice to follow." (R29, male, 58).

Theme 4: Moving between Informal & Formal Care

It did not constitute an easy formal versus informal dichotomy. The patients would switch from one care provider to another such as home treatment, pharmacies, informal providers, public providers, and private providers based on level of severity, cost, convenience, and prior experience. Informal health care served as the first option since it was readily available. "For a small problem I first go to the person nearby because it is quick and I can pay later. If there is no improvement, then I go to the health center." (R07, male, 39). After two days the fever returned, so I insisted that we should get a proper test from the hospital." (R13, female, 27). "The traditional treatment is familiar to my family, but for some problems I want the doctor. We choose depending on what we think the illness is and happened last time." (R25, female, 51). "Private care is faster but expensive. Public care is cheaper but sometimes we wait. We move between them depending on money and how urgent case feels." (R32, male, 46).

Theme 5: Experience & Trust Reshape Next Healthcare Journey

The previous encounters had a great effect on future decisions. The polite communication, expertise, availability of drugs, improved treatments raised trust levels. Impolite communication, unexpected payments, referrals, delays in treatment or unsatisfactory treatments lowered trust levels leading to changes in doctors or delay in decision-making. Therefore, trust was not just an attitude but a process that would influence future medical decisions. "I returned to that clinic because the doctor

explained what the medicine was for and asked me to come back if the symptoms continued. That made me feel they were taking the problem seriously." (R01, female, 45). "Last time we waited many hours and then medicine was not available. Now, unless the problem is serious, I try another place first." (R12, male, 50). "When a provider listens and explains, I am more willing to follow the advice. If they speak harshly, people in village remember and tell others not to go." (R26, female, 36). "Trust comes from what happens after treatment. If the patient improves and the charges are clear, we go again. If not, next decision starts with doubt." (R34, male, 63). The five analytical categories map directly onto the five research questions. Thus, in the completed study, each mapping should be demonstrated through the verified coding, contrasting cases, and verbatim evidence from the final NVivo 11 projects.

Table 2 Questions & Categories

Research Question	PAC	Core Issue Addressed
RQ1	Theme 1	Illness recognition and seriousness threshold
RQ2	Theme 2	Financial, geographic and resource constraints
RQ3	Theme 3	Family and community influence
RQ4	Theme 4	Formal, informal and traditional provider negotiation
RQ5	Theme 5	Prior experience, trust and future healthcare-seeking

Emergent Grounded Explanation

As such, the categories provide a framework for an initial provisional model involving the activities of recognizing-negotiation-mobilizing-selecting-reassessment. First, families determine whether there is a need for external help since there is health condition that is above a particular threshold. The family then negotiates with family and community members for the urgency of the situation, mobilizes resources, makes choices from both formal and informal avenues, and does reassessment of process. The reassessment process ends up as accumulated trust or distrust in the process of next healthcare journey.

DISCUSSION

The results present access to rural healthcare as a process and not just a binary indicator of services utilization. Perception and negotiation of seriousness relate to the ability to identify need in the Levesque typology, but the household narratives introduce an important relational element into the process – perception can be enhanced, postponed, or modified within family discussion. This is in line with research from Pakistan, which indicates significant role of husbands and elder family members in decision making related to medical treatment and lack of awareness of warning signs for delaying medical care (Qureshi et al., 2016; Habib et al., 2021). Thus, combining distance, the transportation and cost as one category shows how access barriers accumulate in reality. Despite analytical separation of availability and affordability, households might perceive dimensions as a single barrier of resource mobilization for purpose of paying the transportation cost, losing income due to visiting the healthcare facility, purchasing medicine and tests and receiving proper referrals. Rural studies from Pakistan confirm the combined effect of transportation, costs, availability of facilities, and geographic isolation on healthcare utilization (Qureshi et al., 2016; Habib et al., 2021; Ahmed et al., 2023).

Therefore, reduction of consulting fees alone might leave real barrier untouched if transportation and availability of services are still poor. Informal healthcare systems include family & community networks. They can ease transportation, financing, guidance, company, and provider information, but may also hinder formal treatment through their normalization of the symptoms or emphasis on home-based treatments. The above pattern is in line with qualitative research from rural Pakistan where household power and local social networks influence care pathways (Qureshi et al., 2016; Habib et al., 2021; Ahmed et al., 2023). The innovative feature of current model lies in considering such networks within the chain of decisions, rather than assuming static social support. Switching from informal treatment to formal care refutes idea that households opt for one stable healthcare system for resource allocation, health education, policies aimed at reducing inequities in access to healthcare. Patients start from home remedies, pharmacies, local practitioners or any other easily available form of help, move to formal care in case of non-recovery, worsening of their condition, or need for the tests.

Such switching pattern, from cultural treatment to biomedical treatment, was identified in rural Pakistan as well (Ahmed et al., 2023). Interventions designed to promote early formal health care seeking have to consider the factors that make the first approach attractive, such as accessibility, financing, family approval etc. The notion of trust is generated dynamically through the act of care, which becomes relevant for subsequent access to resources about satisfaction with public primary healthcare facilities. At the same time, informal practitioners remain important because of their accessibility and affordability. Good communication, perceived competence of staff, availability of medicine, transparent billing process, and positive changes in health condition post-service can enhance the likelihood of repeat visits, while bad communication and poor performance can divert attention to other service providers. Perceived quality of public antenatal services in Sargodha, as well as in rural Pakistan in general, is found to be an essential issue in the literature. In the context of grounded theory model, trust is thus both a consequence of one healthcare service episode and an input of another.

CONCLUSION

The analysis looks at the healthcare seeking behavior in rural Sargodha Division in a way that considers it to be an ongoing process rather than a onetime event in the household. In this way households can perceive symptoms, evaluate their urgency, mobilize their resources, use their social network, switch providers and update their trust levels after treatment. Process-oriented analysis be useful for finding points of intervention for the transportation, referrals, service communications, community outreach, building trust amid providers. This study will contribute to patient-centered access theories over understanding how the dimensions of service are interconnected in household's decision-making processes. Rural Pakistani qualitative research proves the role of family decision-makers, financial resources, informal providers, and illness progression. This study will contribute to the health care seeking literature for rural populations through the conceptualization of trust as a feedback loop. In the sense that past experiences influence the future ability to seek and access health care. The grounded theory adds process element to access model by explaining transitions between access phases.

Recommendations

1. Improve transport and referral coordination for the communities where distance creates both direct and opportunity costs in realizing the potential benefits. There is a need to design the outreach communication around household decision processes as impact treatment timing as well as provider choice.
2. Increase transparency about expected fees, medicine availability, referral procedures and clinic schedules to reduce uncertainty before travel. Train frontline providers in respectful communication and explanation as trust is accumulated over repeated encounters and can influence future utilization.
3. Engage credible community networks in health information and early-referral strategies while monitoring risk of misinformation. Use verified NVivo 11 case comparisons to identify typical healthcare pathways across participants, districts rather than assuming that all rural households behave uniformly.

Implications and Limitations

The NVivo 11 visualizations have the potential to increase transparency and assist in identification of patterns; yet they cannot be confused with grounded theory that is being generated. Frequent word queries have possibility of focusing on frequent mentions of ideas which are of low conceptual significance, while rare events may be very vital from a theoretical point of view. Tree Maps and cluster analysis too are contingent on coding choices and need to be understood in that light as well. The study needs to focus on coding, constant comparison, Memoing, categorization, negative cases and verbatim data.

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