UNIVERSITY OF
KWAZULU-NATAL

SCHOOL OF SOCIAL SCIENCES

UNDERSTANDING ILLNESS IN A LOCAL COMMUNITY: AN EXPLORATION OF THE SOCIO-CULTURAL IMPACTS OF HYPERTENSION IN PATIENTS AND THEIR FAMILIES IN SWAYIMANA LOCATION, KWAZULU- NATAL

BY

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A dissertation submitted in fulfilment of the requirements of a Master of Social Sciences Degree in Anthropology in School of Social Sciences

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08 January 2024

DECLARATION

I, NQOBILE P. SISHI declare that,

This essay does not encompass other individuals' writings, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, their words have been re-written, but the general information attributed to them has been referenced. Where their exact words have been used, then their writing has been placed in italics and inside quotation marks and referenced.

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ACKNOWLEDGEMENTS

First and foremost, I would like to thank God for making this journey possible and if it was not for him, I would not be here today. I would always be forever grateful.

I have to acknowledge my supervisor, Dr. Gerelene Jagganath, for all your help, advice, being patient with me and for always being there when I need your help or have questions to ask, your door was always open for me at all times. Thank you so much, you were sent from heaven, God bless you.

Additionally, I would want to express my gratitude to my parents, Mr. Sibongiseni Peter Sishi and Mrs. Nthabiseng Terresia Sishi, for their unwavering support and encouragement as I pursue my honors degree. If it weren't for your love, encouragement, and never-ending belief in me, I would not be here. I did this for you, mom and dad, and I really appreciate it. God bless you both and may I one day make you both proud.

Msizi Sishi, Nokubonga Sishi, Khawulani Sishi, Sphamandla Ndlovu, Sbusiso Shabalala and Enzokuhle Sishi, I did it for you guys, do not forget that the sky is not the limit when it comes to pursuing your dreams.

In addition, I would want to express my gratitude to each one of my study participants; without your participation, I could not have finished this research.

To my enemies and haters thank you for casting stones at me; it has made me stronger and encouraged me to pursue my dreams despite the challenges I faced, I remained strong and persistent. Thank you so much and God bless you all.

ACRONYMS

BP	Blood Pressure
COVID19	Corona Virus
CSG	Child Support Grant
DASH	Dietary Approaches to Stop Hypertension
DG	Disability Grant
F	Female
HTN	Hypertension
KZN	Kwa-Zulu Natal
M	Male
NCDs	Non-Communicable Diseases
PMB	Pietermaritzburg
SA	South Africa
SANHANES	South African National Health and Nutritional Examination Survey.
SSA	Sub-Saharan Africa
UK	United Kingdom
US	United States
USA	United States of America
WHO	World Health Organization

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CHAPTER 1

INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 Introduction

This chapter informs the reader of the researcher's background and motivation for the present study on the socio-cultural impact of hypertension to it patients and their families in Swayimana, Emahlathini area. In this chapter the researcher unpacks the chapter as follows; the aim of the research study is clarified as a rational consequence of the background and motivation and a chapter outline of the present study is provided*,* research problem, rationale of the study, objectives and research questions, definition of terms, and an outline of the present study is provided.

1.2 Background of the study

This study pursued an understanding of chronic illness in a local community in Emahlathini in KwaZulu-Natal (KZN). The researcher sought to explore the socio-cultural impacts of hypertension in patients and their families in Swayimana in Emahlathini. According to Miller (2011), illness is a perceived feeling of being unhealthy, influenced by spiritual, psychological, or individual worldviews, and encompasses health-related issues, diagnoses, healing, practices, healing, and prevention. For example, people, particularly in rural areas, believe that supernatural entities such as ghosts or ancestral spirits, or sorcerers, can cause an illness. As a result, only traditional healers can use their supernatural abilities to identify the cause of the illness and use that knowledge to cure it. (Miller, 2011).

Prior research has provided perspectives on the illness from the perspective of sufferers, society, culture, and knowledge of those who are vulnerable to it (Nyaaba et al*.*,2018 and Goma et al*.*, 2016). Alcohol abuse has a major contribution to the increase of sufferers in South Africa (S.A). In a current report by Naik (2021:1) the report indicated that "South Africans over fifteen years old consume 9.2 litres of alcohol while women consume 2.7 litres and men consume 16.2 litres of alcohol a day". This means that men might be more susceptible to hypertension due to behavioural factors while women are vulnerable to this chronic illness because of obesity (Naik, 2021). Padnanaban (2021) in their study argued that Discovery Health indicated that 31% of

men and 70% of women in South Africa are obese, meaning women are more susceptible to hypertension than men. Poverty is another issue faced by most South Africans especially in rural areas, because it limits hypertension patients' access to nutritious food, healthcare facilities, and treatment choices (Jennings, 2021). Khalikova (2021) stated that patients typically search for other alternating therapeutic options that work for them and their bodies. Thus, it is important to understand people's traditional practices, beliefs, and perspectives on spirituality, the supernatural and the use of indigenous methods as alternatives to treatment.

WHO (2017) suggests that hypertension can be managed through prescribed medication and self-care, with the type of hypertension and blood pressure levels determining the appropriate medication. While self-care involves taking part in regular physical activities and having a balanced diet, medication given to patients include Angiotensin Converting Enzyme inhibitors, Diuretics or water pill, Beta-blockers, Antihypertensive drug, Calcium-Channel blockers, and Vasodilators (WHO, 2017).

According to Fiandero (2023) regular aerobic exercises increase heart rate and lowers blood pressure levels and these exercises include cycling, running, swimming or brisk walking, as long as patients do not put too much pressure on themselves when doing these exercises. As for a balanced diet, patients can follow the DASH strategy which is a diet rich in vegetables; fruits, low-fat dairy products, and low salt and sugar intake (Oluwatoyin et al., 2021). WHO (2013) stated that hypertension does not usually show any symptoms, it can only be detected through a blood pressure levels reader thus, an awareness of symptoms associated with hypertension help for easy detection preventing conditions such as a stroke and cardiovascular diseases.

Hypertension is a chronic illness that cannot be cured, leading to individual behaviour changes and reliance on prescribed and indigenous medications (Tsabang et al.,2016). Hypertension patients combine prescribed and indigenous medications this is argued to be necessitated by cultural factors such as attitudes towards disease prevention, personal autonomy, and lifestyle changes, which clash with their cultural norms (Tsabang et al., 2016).

1.3 Research problem

Hypertension is a chronic illness that can only be treated not cured. It lies in a perception or feeling of being unhealthy and often influenced by spiritual or psychological or cultural factors tied to a worldview of an individual or health systems (Miller, 2011). Due to the failure in treatment sufferers seek explanations, often resorting to indigenous medications as a cure for the condition. According to Oluwatoyin et al. (2021), traditional dietary therapies, including mixed vegetables, grains, herbs, fruits, and plant parts, are widely used in African countries for managing stroke and hypertension for several years. Most of these plants are widely and commonly consumed, but some have been used in mixed mixtures as therapy for chronic disease management (Oluwatoyin et al. 2021). This is due to sufferers' perceptions, views, cultural and traditional beliefs of the disease (hypertension) which influence their decision-making and treatment options.

This study's findings could significantly impact Pietermaritzburg and South Africa by providing a comprehensive understanding of hypertension patients' perceptions, care management, medical awareness, and treatment involvement in Swayimana rural area. It was anticipated that the findings will provide a comprehensive understanding of the impact of the belief systems individual or societal perceptions and cultural beliefs on decision-making and treatment options within a South African context. De Graft et al. (2014), emphasizes the importance of identifying and understanding people's way of life; their cultural beliefs, norms and practises and how these shape their health seeking behaviours.

1.4 Aim of the study

The study aimed to understand the socio-cultural perceptions of hypertension in Swayimana, KZN, and its care management, its medical awareness and treatment involvement. The study sought to explore the role of culture, beliefs, and traditional practices in how hypertension is perceived in local communities and primarily seek solutions without negatively impacting treatment or patients practises.

1.5 Rationale of the study

Hypertension is a health condition that is characterized by blood pressure levels above or between 140/90mmHg, it is a result of environmental or genetic factors (Goma et

al.,2016). This chronic illness cannot be cured but treated through balanced diet, prescribed medication, regular physical activities, and other necessary behavioural changes like less salt intake and stop smoking or drinking coffee etc. (WHO, 2017). Apt to note is that when treatment fails or a condition cannot be cured like hypertension, behaviour changes in patients' and they try to find reasons or explanations linked to the condition e.g., self-medicating using indigenous medications (Tsabang et al.,2016).

According to Nyaaba et al. (2018) individual and societal perceptions, traditional, and cultural practices also impact social determinants of health, including education and household decision-making power, with cultural practices deeply embedded in spiritual beliefs. Nyaaba et al. (2018) argues that this blend of cultural and structural factors contributes to shaping community members' conceptualisation and understanding of hypertension and treatment options that can be used, and influence health practices and behaviour. For example, in a study by Goma et al. (2016), findings indicated that hypertension patients consume indigenous traditional herbal remedies from their native culture. These remedies are usually a combination of different plants or plant parts because the patient's traditional and cultural practices, beliefs, and perceptions influence their treatment choices.

This study sought for an in-depth understanding of the socio-cultural perceptions of hypertension, its care management and medical awareness, and treatment involvement in a rural area in Swayimana, in KwaZulu-Natal.

1.6 Objectives of the study

1. To explore the socio-cultural perceptions of hypertension in Swayimana community.
2. To explore both medical and local care management of hypertension in Swayimana community and the reasons behind the use of that particular treatment.
3. To determine the medical awareness of hypertension in the Swayimana community.

1.7 Research questions

1. What are the socio-cultural perceptions of hypertension in Swayimana community?
2. What are the medical or local care management strategies used in Swayimana community and reasons behind the use of that particular treatment?
3. What is the medical awareness of hypertension in Swayimana community?

1.8 Definition of terms

1. **Hypertension**: refers to “a chronic elevation of short-lived of blood pressure in the arteries which can cause cardiovascular damage if not treated” (Miller, 2011:7).
2. **Chronic illness**: According to Goma et al. (2016:156), “a long-term or chronic illness means having to adjust to the demands of the illness and therapy used to treat the condition and there might be additional stresses caused by the condition since it might require behavioural and dietary changes, change how the patient relate to others and see themselves” (Goma et al., 2016:156).
3. **Illness**: Miller (2011:2) defined “illness as a perception or feeling of being unhealthy and it can be caused by spiritual or psychological factors like disease or be tied to the worldwide view of an individual”.
4. **Western medication:** According to Goma et al. (2016:157), “Western medication refers to a method that healthcare professionals, such as therapists, medical doctors, pharmacists and nurses; use to treat diseases and its symptoms using radiation, surgery, or drugs”.
5. **African traditional medicine:** Refers to a holistic healthcare method, combining indigenous knowledge systems with herbalism, divination, and spiritualism, uses animals and plants to identify, treat, and maintain illnesses. (Goma et al., 2016).

1.9 Outline of the dissertation

Chapter 1: introduces the research, the aim of study, research problem, hypothesis, objectives, questions and justification, the research context and other background information that informs the study.

Chapter 2: focuses on the review of available literature on hypertension in South Africa and global. It also looks at the theoretical framework which allows the

researcher to critically analyse existing knowledge on the phenomenon of hypertension.

Chapter 3: explains the use of qualitative methods to make possible the gathering and analysis of data.

Chapter 4: The chapters offers an in-depth understanding of participant demographic characteristics.

Chapter 5: presents the findings as well as subsequent thematic analysis of the findings of the research. Also has narratives of hypertension sufferers.

Chapter 6: presents a conclusion, which includes a reflection on the entire research process, and a few key areas of academic interest raised in this study.

1.10 Conclusion

This chapter provided the reader with the groundwork and focus of the study, focusing on the background information and the rationale of the study and the research problem were discussed in this chapter. The aim of the study was specified, and a chapter outline of this research treatise was provided. The following chapter will provide an outline of relevant literature.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter reviews literature on the socio-cultural impact of hypertension on local communities, focusing on socio-cultural perceptions, care management, medical awareness, combining prescribed and indigenous medications. A theoretical framework will be explored to help one understand the phenomenon under study in more depth, aiming to provide a clear understanding of the matter.

2.2 The socio-cultural perceptions of hypertension.

Hypertension is a significant cause of various diseases like stroke, coronary heart disease, congestive heart failure, and peripheral vascular diseases, making it a significant challenge to treat in developing nations (Norman et al., 2007). Those who suffer the disease normally have individual or societal perceptions about the illness due to past experiences, shared knowledge, and beliefs which interfere with their understanding of the illness. Aristide et al. (2019) identifies the high salt intake, stress, and anxiety as some of the major causes of hypertension in Nigeria and Cote D'Ivoire while obesity, pregnancy-induced hypertension, high fat and alcohol consumption are the major causes of hypertension in South Africa.

Factors that make people susceptible to hypertension are discussed below:

2.2.1 Behavioural factors

These are considered as factors that have led to the increased rates of hypertension and these factors include excessive alcohol consumption, lack of physical activities, unhealthy diet (diet high in saturated fat and salt), being obese or overweight, chronic stress, old age, and smoking (2021). These are explored in-depth below:

2.2.1.1 Alcohol abuse

Naik (2021) suggests that poor lifestyle choices are the primary cause of the rising hypertension rates in South Africa, affecting 36.6% of women and 31.1% of men. The widespread abuse of alcohol in S.A. is a significant factor contributing to the rise of hypertension patients. In a report by WHO (2016) it indicated that South Africans over 15 years of age consume 9.3 litres of alcohol while women consume 2.7 litres, and

men 16.2 litres of alcohol on daily basis. Based on these figures S.A was therefore ranked 50th out of 189 countries in terms of high alcohol consumption (Naik, 2021).

2.2.1.2 Lack of physical activity

People who lack physical activities normally have higher heart rate which later affect their blood pressure levels. Lack of physical activities also cause weight gain leading to obesity (WHO,2017).

2.2.1.3 Unhealthy diet

According to Goma et al. (2016), an unhealthy diet; which is the high consumption of alcohol, salt intake, and fatty meats; is one of the reasons people become vulnerable to hypertension. WHO (2017) and Discovery Health (2020) who have indicated nutritional factors that make people susceptible to hypertension and stroke, these nutritional factors include high consumption of alcohol, cholesterol and salt, and consumption of foods high in saturated fatty acids (Oluwatoyin et al., 2021).

Aristide et al. (2019) identified the high consumption of fats and alcohol as one of the major causes of high blood pressure in South Africa while in Cote D`Ivore it is the high consumption of seasoning cubes and salt (cited in Oluwatoyin et al., 2021). Moreover, Deibe (2022) and WHO (2017) indicated that the high intake of salt, alcohol and caffeine, and smoking have an influence in people being diagnosed with this chronic illness.

2.2.1.4 Obesity

Discovery Health (2020) indicated that nearly 31% percent of men and 70% of women in South Africa are obese, which places women more at risk to hypertension because they are overweight (Padnanaban, 2021). Whilst a study by Goma et al. (2016) indicated that obesity, bewitchment, unhealthy diet, mental stress, chronic tobacco use, and lack of physical activities are cause of hypertension in Zambia.

According to Discovery Health (2020) maintaining a healthy weight (body weight between 18,5 and 25 body mass index) is effective in controlling hypertension. Exercising and a healthy diet is the most effective strategy for weight- loss and if a patient is obese (people with body weight above 25 BMI), they can be able to lose weight between five and ten percent in this strategy (Discovery Health).

2.2.1.5 Chronic stress

According to Wet, Ramulondi and Ngcobo (2015) in Maputaland, results indicated that the perceived cause of hypertension is stress and unhappiness. Likewise, in Nigeria stress, unhappiness, anxiety, and high salt intake were the major causes of hypertension (Aristide et al., 2019 cited in Oluwatoyin, 2021). Both these studies show that anyone can be susceptible to hypertension due to chronic stress regardless of their geographical area and having continuous stress can cause an elevation of blood pressure levels (WHO,2017).

2.2.1.6 Old age

According to Micklefields et al. (2022) in 2016 the South African Demographic and Health Survey (SADHS) revealed a nearly doubled hypertension prevalence due to old age. With 63% percent of women and 55% percent of men between 45 and 54 years of age, and 78% percent of women while men rates increased by 74% aged between 55 and 64 years old (Micklefields et al., 2022). This shows that more people are becoming vulnerable to hypertension due to old age, the more people age the more susceptible they become to diseases and chronic illnesses (WHO,2017).

2.2.1.7 Smoking

According to WHO (2017) the use of tobacco can cause arteries to narrow and increase risk of heart diseases. Second-hand smoking also increases the risk to heart conditions (WHO,2017).

2.2.2 Gender factors

According to Padnanaban (2021), Discovery Health (2020) indicated that nearly 31% of men and 70% of women in S.A are obese, which places women at high risk of being diagnosed with hypertension than men due to being overweight. Dissenting the study of anthropologists in Mosuo, a Chinese community in Yuman province, the findings specified that in patrilineal communities' cultural factors such as gender norms play a role in the differences in disease susceptibility for instance, women have a higher prevalence of hypertension than men (women have 37.4 % while men have 29.7%) (Reynolds et al.,2020). However, in matrilineal communities' results were reversed, males had a higher prevalence to hypertension than females. Also, household heads had a higher prevalence to hypertension regardless of whether they are male or

female when compared to other family members (Reynolds et al.,2020). This is due to self-sufficiency when it comes to better access to resources and decision-making (Padnanaban, 2021).

According to research done in Mosuo and data from Discovery Health, obesity and cultural norms are two distinct characteristics that make people more susceptible to hypertension. In contrast, the socioeconomic viewpoint approaches hypertension via the prism of public health. According to this viewpoint, sedentary lifestyles, heavy alcohol and salt intake, high blood pressure during pregnancy, high blood pressure after a stroke, diabetes, obesity, and a family history of hypertension all increase a person's risk of developing hypertension (Mbalati, 2021).

Similar to a study conducted in Zambia by Goma et al. (2016), the findings showed that individuals with hypertension believed they were being bewitched, that their diet was unhealthy (consuming a lot of alcohol, fatty meat, and salt), that they were under stress, that they smoked for a long time, that they were not physically active, and that they were obese. In contrast, the findings of the De Wet et al. (2015) study conducted in Northern Maputaland, suggested that stress and discontent are the primary causes of hypertension among those who experience it.

The South African Demographic and Health Survey (2016) revealed a nearly doubled prevalence of hypertension, with 36% of women and 55% of men aged 45-54 and 78% of women and 74% of men aged 55-64 living with hypertension. (Micklesfield et al., 2022). The shocking results of SADHS and SANHANES surveys have caused fear and hopelessness among hypertension sufferers and non-diagnosed individuals (Micklefields et al., 2022). Future results may be achieved by addressing behavioural factors contributing to hypertension.

2.2.3 Poverty

Poverty has also contributed to the increasing number of hypertension sufferers in South Africa (Jennings, 2021). Poverty is a significant vulnerability as it restricts individuals'' choices for a healthy lifestyle, including access to timely healthcare and nutritious foods (Jennings, 2021 cited in Naik, 2021). In South Africa statistics indicate that 40% of adults are inactive, which makes them more susceptible to diseases and illnesses (Naik,2021). Jennings (2021) reports that the most recent South African

National Health and Nutrition Examination Survey (SANHANES) revealed that people affected the most by hypertension are people in living in rural areas (39.6%), followed by those in urban areas (37.1%), with urban informal settlements having the lowest percentage area (cited in Naik, 2021).

The findings also showed that, in South Africa nine out of ten adult sufferers of hypertension are not screened, tested, or diagnosed, and that, of those who are, only 5.8 % receive a diagnosis but do not take treatment (Naik, 2021). The lack of funds and time to travel to medical facilities poses a challenge. Naik (2021) argues that those who are ill must take time off work to receive medication or other necessary treatments; hence, not working frequently equates to not getting paid. This demonstrates how those who suffer from financial hardships are occasionally compelled to make tough choices that frequently put their lives in danger. Some of them are breadwinners and cannot afford to miss work since they will not be compensated.

2.2.4 Belief Systems (African cultural beliefs)

Nyaaba et al. (2018), stated that traditional and cultural practices impact social determinants of health, including education and household decision- making power, with some cultural practices deeply embedded in long standing spiritual beliefs. This blend of cultural and structural factors contributes to shaping community members' conceptualization and understanding of hypertension (HTN), treatment options that can be used, and influence health practices and behaviour (2018).

Furthermore, previous research done in Ghana, indicated that perceptions and practices of each community are different from biomedical interpretations for childhood illnesses and childhood deaths, and infectious diseases like filariasis and malaria (Nyaaba et al., 2018). However, there is limited confirmation on such practices and perceptions being different to biomedical practices and factors that influence such practices and perceptions towards hypertension (Nyaaba et al., 2018:2).

According to Nyaabe et al. (2018), knowledge of how the community views hypertension (HTN) may be useful in comprehending the condition and may therefore influence decisions made about it and other chronic illnesses. Gaining insight into how community members perceive hypertension and the underlying factors that influence

their perceptions could aid in comprehending how they conceptualize and construct meanings for illnesses and treatment options (Nyaaba et al., 2018). This understanding is essential for creating innovative and culturally acceptable health interventions for the control and prevention of other NCDs, including HTN (Nyaaba et al.,2018).

In their study, Nyaaba et al. (2018:2) discovered a group of people known as the therapy management group, which is made up of family members and community members of hypertension patients. This group acts as a middleman between medical professionals and hypertension patients. The reason for this is that family and community members support, work with, and live with people who have hypertension, particularly those who reside in rural African settings. They also play a significant role in influencing individual health practices and behaviour towards hypertension control and treatment. For, instance, because of cultural practices and beliefs, a study conducted in Zambia among adult rural hypertension patients revealed that adults prefer utilizing alternative herbs and medicines to treat hypertension than Western medication (Nyaaba et al., 2018).

According to Goma et al. (2016), people with hypertension treat their condition with native traditional herbal treatments, which are typically blends of several plants or plant components. This could be because their therapeutic preferences are influenced by their traditional, cultural practices, beliefs, or perceptions. Many African nations support the use of traditional food remedies, which include whole fruits, grains, herbs, mixed vegetables, and plant components like leaves, seeds, and roots (Oluwatoyin et al., 2021). Zambia is among some of the countries that require therapy managing groups to assist in altering the mind-set of individuals suffering from hypertension (Nyaaba et al., 2018). These groups serve as a mediator between healthcare providers and patients, offering guidance on how to take prescribed medication to avoid self-medication.

As noted by Nyaaba et al. (2018), another study conducted in Nigeria demonstrated the critical role that social support plays in influencing adherence to B.P treatment or therapy, even when people from the same ethnicity hold different views about their diagnosis. For instance, some people, particularly in rural areas, believe that supernatural entities such as ghosts or ancestor spirits, or sorcerers, can cause

illness. As a result, only traditional healers can assist in using supernatural powers to locate the cause to cure an illness (Miller, 2011).

Moreover, identifying individual's perceptions regarding hypertension and the context in which they see it is crucial in understanding cultural norms and the variables influencing how people behave while trying to manage or control their hypertension. This is crucial for hypertension management and prevention of other illnesses or disorders associated to it, particularly in rural and low socio-economic societies. Previous studies have indicated that such societies are vulnerable to non-communicable diseases (NCDs) and are deeply entrenched in poverty as a result of the high expense of treating chronic diseases (De Graft et al., 2014). To maintain a connection to indigenous beliefs on illnesses, Western societies views and perspectives on chronic illnesses are bio-medically constructed.

According to cultural conceptions of health and the hierarchy of ailments within the healing system, traditional healers are essential in finding causes of illnesses (Roberts and Becher, 1993). When a condition is not curable but be treated, the patient's behaviour changes and they search for causes or explanations linked to the condition (Nyaaba et al., 2018). For example, people living with HIV/AIDS use African traditional medicine and Western medications to recover or find a cure, forgetting that chronic illnesses cannot be cured but managed through treatment.

2.5 An in-depth understanding of the care management and medical awareness of hypertension

According to Nkwi (1994), if people use hypertension treatments, hypertension will be normalized and their chances of being at risk to cardiovascular diseases will also decrease. The treatment of this illness and its maintenance remain a complicated public health problem regardless of its prevalence in Sub-Saharan Africa (SSA) (cited in Nyaaba et al., 2018). Agyemang et al. (2018), one of the reasons for some complicated public health problems with regards to the treatment and maintenance of hypertension is the lack or having less information about this illness, health practitioner's inertia to treat hypertension patients, non-adherence, lack of antihypertensive medications, long distance to health facilities, health system factors, and the difference between medical understanding and individual beliefs about hypertension (cited in Nyaaba et al., 2018). Therefore, patients are required to make

lifestyle and behavioural changes to maintain hypertension (WHO, 2013 cited in Nyaaba et al., 2018).

2.5.1 Awareness of hypertension symptoms

According to WHO (2013) this chronic illness (hypertension) does not usually show any symptoms; it can only be detected through a blood pressure level reader. If this reading indicates that blood pressure levels are above 140/90mmHg, then a person is hypertensive (WHO,2013). People who suffer hypertension are not aware of their blood pressure level elevation until they go for their routine screening at the clinic or when they visit the clinic for unrelated complaints (WHO,2021). The bodily discomfort related to hypertension are nosebleeds, headaches, changes in vision, irregular heart rhythms, buzzing in the ears, shortness of breath and dizziness (WHO, 2021). Apt to note is that, when blood pressure levels are severely elevated can cause nausea, fatigue, vomiting, anxiety, confusion, muscle tremors and chest pains (WHO,2021).

All these bodily discomforts can be present before and after hypertension has been detected, the only difference is that patients' experience these symptoms on different occasions (when one is diagnosed with this illness and when blood pressure is severely elevated) (WHO,2021). Previous studies have indicated that hypertension is positively associated with an increased risk of diseases (if left untreated) such as stroke, coronary heart disease, end-stage renal disease, peripheral vascular disease, and congestive heart failure if left untreated (Edward et al., 1998 cited in Sengwana and Puoane, 2004).

Goma et al. (2016:) argues that if hypertension is not treated it can lead to several complications such as pedal oedema, blindness, loss of speech, heart enlargement, precordial chest pain, and paralysis. It is therefore, described as an illness that affects the heart, causes body weakness, fast blood flow, and fast breathing and is a result of mental stress, social factors, obesity, and unhealthy diet such as the high consumption of alcohol, salt intake, and fatty meat (Goma et al., 2016).

2.5.2 The medical management or treatment for hypertension

(i) Eating a balanced diet

According to Oluwatoyin et al. (2021), nutrition plays a vital role in preventing stroke and hypertension. Research has shown that certain dietary factors can influence the

risk of developing hypertension and stroke. These factors include a high intake of alcohol and salt, cholesterol, and foods high in saturated fats (Oluwatoyin et al., 2021). These nutritional risk factors increase blood pressure; platelet aggregation, free radical production, low density lipoprotein (LDP), and cholesterol levels (Oluwatoyin et al., 2021). Likewise, Le Net (2022) stated that eating low-fat dairy products; fruits, wholegrains, and vegetables is essential for hypertension patients' because these food products contain magnesium, potassium, and calcium which help control hypertension together with a balanced diet and exercising.

Generally, foods that have been proven to provide defensive effects to hypertension and stroke patients include fruits, foods rich in whole grains, vegetables, fish and oil (e.g. Olive oil), and milk and dairy products (Oluwatotin et al., 2021). However, the most used strategy to manage hypertension globally is the DASH (Dietary Approaches to Stop Hypertension) strategy (Oluwatoyin et al., 2021). According to Oluwatoyin et al. (2021) This diet contains a diet rich in vegetables; fruits, low fats, low-fat dairy, and low salt and sugar intake, and is considered to have a significant effect in lowering hypertension. Likewise, Discovery Health (2020) indicated that including at least five helping vegetables and fruits in your everyday diet can help with a patient's well-being.

Another strategy that is relatively comparable to the DASH diet strategy that has been adapted and has a significant effect in lowering hypertension is the Mediterranean diet, which contains grains, legumes, fruits, vegetables, cereals, and fish (Oluwatoyin et al., 2021). Other dietary strategies that can help manage stroke and hypertension is the consumption of monounsaturated fats, and foods rich in proteins (Oluwatoyin et al., 2021). Replacing unhealthy trans and saturated fats (processed and fatty meats, butter, and full-cream dairy products) with unsaturated fats (peanut butter, fish, avocado, olive and sunflower oils, seeds and nuts) (Discovery Health ,2020). Avoiding oily foods (fried chips), white bread, biscuits, sweetened beverages, pure sugar, and foods rich in potassium can help patients maintain their blood pressure levels and prevent undiagnosed people from being vulnerable to this chronic illness (WHO,2017).

According to Deibe (2022:1), hypertension is commonly referred to as "The Silent Killer" since it typically exhibits no symptoms and accounts for almost 50% of heart attacks and strokes. In England, almost 40% includes have been diagnosed with hypertension; nevertheless, blood pressure can be rapidly lowered by implementing

minor lifestyle modifications. These lifestyle changes include the six following natural ways for lowering hypertension:

(ii) Less intake of salt

Excessive salt causes the body to retain water, and an excess of water puts pressure on the walls of blood vessels, raising blood pressure (WHO,2021). Consuming an excessive amount of salt-contaminated food can also increase the risk of stroke, heart disease, dementia, kidney disease, and other blood pressure-related conditions (WHO,2021). Consequently, it is critical to reduce the amount of salt used when cooking, stay away from extremely salty flavours and sauces, and always taste food before adding salt as it may not be necessary (Deibe, 2022). Deibe (2022) argues that hypertension patients should stay away from foods heavy in salt, such as olives, pickles, bacon, cheese, and mustard ketchup.

(iii) Less alcohol intake

Excessive alcohol consumption can increase blood pressure levels, and this can be caused by having more than three alcoholic drinks in one (WHO,2021). Excessive alcohol consumption or binge drinking means having five or more drinks within two hours for men and four or more drinks within two hours for women (Deibe,2022). It is therefore argued that alcohol consumption can cause weight gain since it has a heavy calorie count that is not suitable for hypertension patients.

(iv) Smoking

Chemicals used in making cigarettes causes the artery walls to be sticky, which makes fatty material to stick to the cells, clag the arteries, and reduce space for blood to flow correctly (WHO,2021). This is argued by Deibe (2022) lead to high blood pressure levels, increased heart rate, and low oxygen being transported to the body. Smoking increases blood pressure levels and chances of having a stroke or heart attack (WHO,2021).

(v) Magnesium intake

Eating lots of magnesium rich foods or taking magnesium supplements can decrease blood pressure levels (Deibe, 2022). According to Hollard and Barrett (2016), hypertension patients in the United States (U.S) who took magnesium had lower blood

pressure levels and their blood flow improved. This shows that magnesium intake helped in lowering blood pressure levels. Another study at Hertfordshire University (2012) indicated that the effects of magnesium intake on blood pressure levels depends on dosage used, which means the higher the intake dosage, the greater the chances of lowering blood pressure levels. Health experts argue that magnesium can be found in dark green leafy vegetables like; kale or spinach, wholegrain, pumpkin seeds, and foods like; lentils, dark chocolate, porridge or brown bread, and chickpeas (Deibe, 2022).

(vi) More Potassium intake

Foods that are rich in potassium are also of vital importance in managing hypertension. Potassium reduces sodium's effects on the body, the more an individual eats potassium, the more they lose sodium through urination (WHO,2021). Eating foods rich in potassium will ease the tension in blood vessel walls, causing blood pressure levels to be lowered even more (WHO,2021). Some scholars argue that adults should consume 4700 mg of potassium daily. For instance, if they were to consume a medium banana and plain mashed sweet potato each day, their blood pressure would be lowered because each food item has 420 mg and 475 mg of potassium, respectively (Deibe,2022). Avocados, apricot juice or apricot fruit, honeydew melon ad cantaloupe, fat-free yoghurt, fat-free or low-fat (one percent) milk, tuna, tomatoes, mushrooms, dates and raisins, potatoes, oranges or orange juice, grapefruit juice or grapes fruits, peas, and green vegetables are also foods high in potassium (Deibe, 2022).

(vii) Stop drinking caffeine

Blood pressure levels dramatically increases every time hypertension patients drink coffee since it contains caffeine (Deibi,2022). According to Mayo Clinic (2021) it is not clear what causes blood pressure levels elevation when patients drink coffee, but how blood pressure levels respond differ from one patient to the next. For some researchers, caffeine causes hormonal blockage, which could cause arteries to be narrowed (WHO, 2021). While other researchers believe that caffeine causes adrenal glands to release more adrenaline, which leads to the increase of blood pressure levels (Discovery Health, 2020). However, other researchers argue that people who do not drink caffeinated beverages have lower blood pressure levels when compared to those who drinks caffeinated beverages regularly (Deibe, 2022). People who drink

caffeinated beverages regularly develop caffeine tolerance, which means caffeine no longer has any long-term effects on their blood pressure levels (Deibe, 2022). Thus, by reducing the amount of caffeine intake by hypertension patients can help lower blood pressure levels if it is already high.

(viii) Regular exercises

Regular exercise helps a person's heart get stronger and lower blood pressure, which allows the heart to pump more blood with less effort (WHO,2021). Obese people should exercise regularly to lower their blood pressure and lose weight. Patients with hypertension are advised to engage in strenuous activity for one hour and ten minutes or moderate aerobic activity for two hours and thirty minutes (Mayo Clinic, 2021). Aerobic activities include any physical activity that causes an increase in heart rate and respiration, such as jogging, tennis or basketball, climbing stairs, cycling, gardening, dancing, raking leaves, mowing the lawn, strolling, and swimming. Hypertension patients should seek doctor's advice before they engage in any workout program. Fiandero (2023) recommends regular aerobic exercises due to its ability to increase heart rate and lower blood pressure levels. These exercises include cycling, running, swimming or brisk walking, as long as the individuals with the condition do not overwork themselves.

(ix) Prescribed medication

According to WHO (2017), hypertension can be managed through medication and self-care. Depending on the patient's blood pressure and the type of hypertension they have, different medications are used for different patients. While self-care involves; exercising regularly, eating a healthier less salted, and fatty diet and taking medication regularly as prescribed by health practitioners to help lower blood pressure levels (WHO, 2017). The following medications are prescribed to patients with hypertension: beta-blockers, diuretics (water pills), ACE inhibitors (such as lisinopril, benazepril, and captopril), calcium channel blockers (such as amlodipine and diltiazem), and vasodilators (WHO,2017).

In other words, there is for all hypertension patients have access to prescribed treatment available in local clinics and hospitals at no cost. Adams et al. (2021) states that South African public health facilities have no fees for health services like

medicines (treatment for any illness or disease) but indirect costs like time spent in health facilities (clinic or hospital) and transport becomes a disadvantage for the poor. Some scholars like Waxler- Morrison (1988) and Leslie (1992) encourages patients to follow and use doctors' prescribed medication and look at illnesses from a doctor's point of view. For example, illnesses like hypertension need Western medication to be managed not African traditional medication.

The figures below show prescribed medication given to some of the participants as medication parcel on the dates they collect their medication at a local clinic. Figure 2.1 and Figure 2.2. are the medications two participants in the study take.

Figure 2.1: Patients' prescribed medication

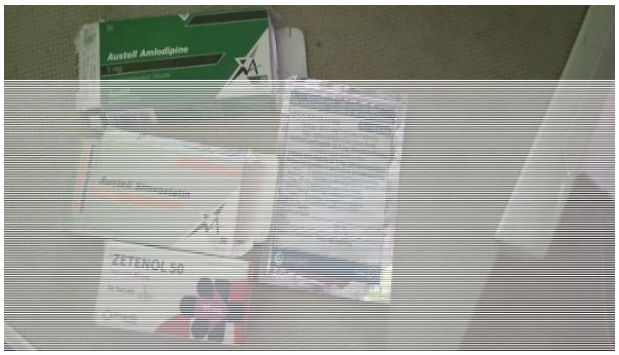


Figure 2.2: Patients' prescribed medication

2.6 Combining prescribed and indigenous medications

According to Khalikova (2021) hypertension patients typically search for other alternative therapeutic options that work for them and their bodies. The important thing to them is the effects produced by alternative medicine to their bodies, not whether African traditional medicines work in bringing determinate therapeutic relief or not. For instance, people in India insist that biomedicine offers immediate relief to the body but has several side effects (Khalikova,2021). At the same time, non-biomedical

medicines like Homeopathy and Ayurveda gradually work and is mild to the body (Khalikova, 2021).

Furthermore, alternative therapies are often used by hypertension patients in North America who are dissatisfied with biomedicine because they are perceived as instilling a sense of "well-being, comfort, and safety" by appealing to wholeness, harmony, and nature while offering treatments that complement the environment. Also, sufferers criticize biomedicine for failing to involve cultural and personal dimensions of suffering, and engaging disorienting, painful and disturbing treatments that do not comfort sufferers but cause biological efficacy (Khalikova, 2021:10).

Rahmawati and Bajorek (2018) in in their study in Yogyakarta Indonesia, confirmed that hypertension patients in rural underdeveloped areas use alternative medicines more frequently than biomedicine to lower their blood pressure levels Some studies have indicated that a patients' belief about safety and efficacy of natural plants; easy accessibility, not being costly, recommendation from friends or family members, and the fact that alternative treatments are culturally adequate, are some of the critical reasons for high usage of African traditional treatments (2018). Also, the use of African traditional treatments is interrelated to the fear of adversative effects from long-term use of biomedicine, which leads to poor treatment adherence (Rahmawati and Bajorek, 2018).

De Wet et al. (2015) conducted a study in Northern Maputaland in South Africa, based on the use of herbs by an unqualified group of people to treat hypertension in rural communities. The findings indicated that 31% of hypertension patients use both prescribed and African traditional remedies. Apt to note is that none of the patients had disclosed this to their medical professionals. De wet et al. (2015) argues that patients were aware of the side effects of biomedicine but not aware of the consequences of combining medications). Tsabang et al. (2016) argues that despite one's cultural beliefs, tradition and norms which play an integral role in one's health seeking behaviour, hypertension patients in rural areas rely more on herbs than biomedicine for several reasons such as expensive costs of Western medications, lifestyle changes, and a lack of access to health facilities.

In a study conducted in Yogyakarta Indonesia, Rahmawati and Bajorek (2018) found that hypertension patients consumed fruits such as lemon, cucumber, and watermelon

to lower hypertension levels. In tandem with Rahmawati and Bajorek (2018) findings, of De Wet et al. (2016) also revealed that watermelon is a commonly used fruit to lower hypertension levels by most patients in South Africa. Interestingly hypertension sufferers in Yogyakarta, believed that watermelon and cucumber extracts might have latent biomedicine, even though clinical practice evidence for this is weak (De Wet et al. 2016). Rahmawati and Bajorek (2018) categorized these fruits as alternative treatments since patients consume them with the intention of lowering hypertension, not as part of their daily diet. Unlike dietary approaches, this method does not support making long-term dietary adjustments to control high blood pressure. (2018).

According to Kato at al. (2014), lemon water intake has an oppressive influence on high blood pressure levels. Consistent with a 5-month study carried out in Japan on a group of one-hundred and one (n=101) Japanese women, the findings demonstrated that consuming lemon juice on a regular basis can lower hypertension levels when combined with taking a walk (Kato et al., 2014). Lemon contains polyphenols, that help improve endothelial function and blood vessel elasticity (Le Net, 2022). Given that both exercise and consuming lemon juice on a regular basis significantly reduces the risk of systolic hypertension, it may be concluded that these interventions are sufficient for those with hypertension.

Asgary and Keshvari (2013) argued that orange juice had similar effects of lowering hypertension levels. The findings indicated that consuming commercially produced orange juice lowered blood pressure in patients when compared to natural orange juice. Also, grapefruit intake affects hypertension, but it can also cause harm to patients because it may interfere with hypertension medication (Le Net, 2022).

According to Knibbs (2022) adding basil and parsley in one’s diet can help lower hypertension levels because they act as antihypertensive agents. Basil is a natural herb that adds flavour to food, and it is a popular substitute treatment because of its numerous mixtures (Knibbs, 2022). This herb is high in eugenol, and researchers link its antioxidants to various health benefits including lowering blood pressure levels (Le Net, 2022). Most studies argue that eugenol acts as a natural calcium-channel blocker, which helps reduce blood pressure levels (Le Net, 2022, Knibbs, 2022; Tabassum and Ahmad, 2010). It is believed that basil extracts can lower blood pressure levels within

two minutes of its intake because it has eugenol, which utilizes its unique effects on hypertension by acting as a calcium-channel blocker (Tabassum and Ahmad, 2010).

Parsley is another popular herb that has an impressive nutritional profile. According to Knibbs (2022) parsley contains various compounds that may help lower blood pressure, including dietary carotenoids and vitamin C. In the National Library of Health, a study in the United Kingdom (UK), indicated that parsley extracts were used to determine its antihypertensive activity. Findings confirmed that parsley extracts could lower both Diastolic and Systolic blood pressure levels, and it concluded that *parsley* is indeed an antihypertensive agent since it acted as a calcium-channel blocker (Knibbs, 2022). This shows that both parsley and basil can be used as antihypertensive agents since they both have high eugenol. Research has proven that these herbs can lower hypertension by acting as a calcium-channel blocker and they are not the only herbs that hypertension patients use but all fruits and plants high in eugenol can be used if it does not interfere with prescribed medication. As Knibbs (2022:1) said, “plants that a high in eugenol are used as alternative treatment to diseases and illnesses including hypertension”.

Besides, *momordica balsamina* also contains medicinal and nutritional compounds from its fruits, seeds, stem, and leaves (Ludidi, 2018). According to Ludidi (2018) *momordica balsamina* is an “African pumpkin” that belongs to the *Cucurbitaceae* plant family widespread in countries like Botswana, Swaziland, Namibia, and South African provinces. This plant is in the same family as *momordica charantia* and is called *“Intshungu”* in Zulu (Ludidi,2018). *Momordica balsamina* is one of the most used plant to lower hypertension in South Africa, and hypertension sufferers consume this plant more when compared with other plants used (Ludidi, 2018). For example, Ramulondi (2017) indicated that hypertension patients commonly consume *momordica balsamina* as alternative medicine for lowering hypertension compared to other plants like *Aloe marlothii* or *Aloe Vera plant*, while other patients combine *momordica balsamina* with plants like *Aloe marlothii* (Ramulondi, 2017). Moreover, De Wet et al. (2015) in their study in Northern Maputaland, South Africa, established forty-four hypertension sufferers who were self-medicating using *momordica balsamina* as a supplement for their prescribed medication.

Figure 2.3: Indigenous medicine

The figures above illustrate Momordica balsamina plant before and after it has been boiled and mixed with Aloe Vera plant and other plants.

2.6.1 Reasons hypertension patients use indigenous medicines

Due to hypertension being a chronic illness and the fact that it cannot be cured, patients' behaviour, views, and perceptions to prescribed medication has changed but traditional, cultural and beliefs have a major influence to decision-making and treatment options. More reasons are explained below in detail.

2.6.1.1 The African traditional belief system

Several African countries have faith in the use of traditional dietary therapies such as mixed vegetables, grains, herbs, whole fruits, and parts of plants like the leaves, seeds or roots (Oluwatoyin et al., 2021). In African countries traditional dietary therapies have been established to manage stroke and hypertension. The majority of these plants are widely and commonly consumed although some have been used in mixed mixtures as therapy for chronic diseases management.

Liwa et al. (2017) in their study in Tanzania, findings indicated that herbal and African traditional therapies used for hypertension management include garlic, ginger, carrots, honey, pawpaw seeds, avocado seeds, onions, lemon, Aloe Vera, and moringa oleifara. But the most consumed herb for prevention of hypertension in Tanzania is garlic (Liwa et al.,2017). While another study in Nigeria articulated that plants or fruits extracs used for traditional remedies by hypertension patients comprise of *bitter leaf, basil, avocado, guava, pawpaw, baobab, hog plam, garlic, ginger, moringa oleifera, onion, tamarind, acalypha godseffiana, senna occidentals, piper guineense, talinum triangulare, aloe Vera, peperomia pellucida, lorianthus spectobulus, aframomum melegueta*, and *rauwolfia vomitoria* (Osamar and Owumi, 2010). Whereas De Wet et al. (2016) in South Africa, revealed that *watermelon fruits; banana red flower bracts,*

groundnuts seeds, lemon peels, cannabis sativa, momordica balsamina leaves, and *guava* roots are the most consumed and acknowledged plants that can help with hypertension management (2016). All these studies are conducted in different geographical areas and in different years, but they are proof that fruits or plants extracts can be used to make African traditional medicines to help manage hypertension and this has been done for a very long time (from the earliest generations to the current generations) with the belief that they will cure hypertension unlike prescribed medication.

According to Kumar (2021) plants such as *momordica balsamina; bitter leaf, avocado*, and *ginger* are rich in magnesium and/or potassium which is effective in the management of hypertension. This argument is in tandem with lifestyle changes advocated by Deibe (2022). In her study she argues that the intake of magnesium and potassium is effective in maintaining hypertension. While plants like garlic have both a dietary and medicinal impact on human health, this plant contains hydrogen sulphur and allicin components which possess vasodilation effects and angiotensin inhibiting effects which helps hypertension reduction (Kumar, 2021).

Furthermore, guava has been broadly consumed due to its medicinal and nutritive value (Oluwatoyin et al.,2021). It is extensively used as an anti-diabetic; anti-hypertensive, anti-diarrhoea, anti-cancer, anti- inflammatory, and anti-obesity therapy (Oluwatoyin et al., 2021). The leaves, roots, pulp, seeds, bark, stems, of *guava* fruit have all been used for treating various diseases such as gastrointestinal and respiratory disorders, since they contain bioactive compounds like gallic acid and caffeic acid for therapeutic purpose as they are secondary metabolite (Kumar, 2021). Irondi (2016) conducted a study using hypertensive rats, results indicated that pink guava puree contain anti-hypertensive components. While another study by Elias (2017) conducted on normotensive guinea pigs, results proved that *guava leaves* extract significantly reduce blood pressure.

2.6.1.2 Individual views and perceptions on Indigenous methods

Hypertension patients prefer African traditional medicines because of their personal opinions, perceptions, and cultural or traditional beliefs (Nyaaba et al., 2018). These reasons for such are largely influenced by societal and individual perception they hold about both western and African traditional medicines, the ease of access to and safety

of alternative therapies, the high expense of Western treatments and their dietary requirements, and the adverse effects of prescription medications. Some patients with hypertension, however, are not happy with prescribed medications and believe that African traditional medicine is a better option for treating localized ailments (Khalikova, 2021).

Choosing a specific medication against another or combining African traditional medicine and biomedicine led to the formation of a theoretical framework called medical pluralism (Khalikova, 2021). This theoretical framework gives an in-depth understanding of different treatments, medical approaches, and institutions available to treat or manage illnesses (Khalikova, 2021). With the help of this framework, communities, medical professionals, and patients may all have a say in how diseases like hypertension are managed. Additionally, by moving away from a reductionist contradiction of ethno-medicine against biomedicine, medical pluralism is a framework that analyses biomedicine as another tradition, which is one of many possibilities' sufferers use worldwide (Khalikova, 2021). This theoretical framework will be expounded in depth in the following section.

2.7 Theoretical framework

2.7.1 Medical pluralism

According to Khalikova (2021), medical pluralism can be defined as a theoretical framework that can designate and have an in-depth understanding of different treatments, medical approaches, and institutions that can be used to treat or maintain illnesses. Medical pluralism commonly deals with the use or combination of alternative and western medicine, for instance, women who want to get pregnant can combine home remedies with yoga and hormonal treatments, or cancer patients complement religious healing and acupuncture with chemotherapy (2021).

In the second half of the twentieth century, medical pluralism was developed as a theoretical framework that examines the diversity of local medical traditions, competition and co-existence, and western or biomedicine (Khalikova, 2021). However, medical pluralism maintains its systematic significance in the current globalization setting for investigating rationally or internationally alternative remedies for illnesses, as well as the expanding market for conventional, natural, and holistic

therapies. Previous studies in anthropology focused on local medical traditions in Non-Western societies but a lot has changed since then because nowadays anthropologists focus on plural medicine in different countries such as North America and Europe (Khalikova,2021).

The nomenclature and definition of medical pluralism have increased because of scenario changes. For example, anthropological studies on this phenomenon are now discussing integrative or complementary and alternative medicine from all societies, rather than just one (Khalikova, 2021). According to Khalikova (2021), anthropological studies that concentrate on various viewpoints of non-biomedical practices have simply looked at perspectives, ignoring the roles that patients, governments, markets, and medical professionals have played in influencing these various perspectives. One advantage of medical pluralism is that it enables the study of medicine to transcend the binary distinctions between traditional and modern, Western and non-Western, global and local (Khalikova, 2021). This is achieved by demonstrating how diverse, culturally permeable, and dynamically evolving all practices and knowledge can be either local customs or the application of biomedicine (Khalikova, 2021).

The interest in anthropological studies of non-Western medicine started in the early twentieth century, when River (1924:125) stated that “medicine should be preserved as a distinct knowledge system”. However, scholars like Foster (1953) have shown the vital importance of acknowledging impacts of global and colonial processes on local medicine, leading to the eclecticism of medical therapies and concepts as practiced in societies or patients’ everyday lives. Khalikova (2021) argues that medical anthropologists need to have an in-depth understanding of local medicine and classify the diverse practice and medical knowledge as holistic systems, just like other anthropological studies that deal with systems, either religious or kinship systems. Every system must be treated equally since it is vital in anthropological studies either holistic, kinship, or religious. According to Khalikova (2021), medical pluralism can be a framework that studies biomedicine as another tradition, which is one of many options that sufferers use around the globe through broking away from a reductionist contradiction of ethno-medicine versus biomedicine.

2.7.2 Social construction theory

The Social construction theory developed by sociologists Thomas Luckmann and Peter L. Berger (1966) was used in this study. This theory was first presented in a 1966 book titled "The Social Construction of Reality." Emile Durkheim, Karl Marx, and George Herbert Mead were among the intellectuals who influenced the concepts of these sociologists (Luckmann and Berger, 1966). Most significantly, though, Mead's idea of "Symbolic Interactionism," which held that social interactions form the construction of identity, impressed sociologists even more (Berger and Luckmann, 1966). Most academics refer to this idea as the social constructionist theory.

According to Berger and Luckmann (1966) this theory states that classification of reality and knowledge are normally created and are a product of individual's interactions, symbolic and social relationships; either among patients or family members can help provide support to hypertension patients where they can open-up about the challenges they face and provide solutions to deal with those difficulties. In other words, interactions and symbolic or social relationships play a crucial role in constructing reality and knowledge. The way people perceive things, construct reality, and understand life is based on life experiences and interactions, which makes it possible for patients to share crucial information about this chronic illness and give each other advice as patients or friends. Berger and Luckman (1966) affirm that "what people perceive about reality is based on shared assumptions, and that knowledge about the world is developed in a social context" (1966:5). The researcher argues that without the shared information among patients or with family members/ friends and past experiences; perceptions that patients have about hypertension will not be formed. Perceptions about hypertensions are either societal or individually inspired. These perceptions were either perceived due to personal experiences, cultural or traditional practices, and shared knowledge. Also, a lack of trust in western medications and financial constraints lead to patients looking for other alternative medications to cure hypertension, such as indigenous methods which are usually shared among patients e.g. Momordica balsamina being the leading plants or herbs sufferers consume to maintain blood pressure levels.

Berger and Luckmann (1991) placed their focus on how knowledge is constructed and nature; the significance of knowledge to society and how it develops. These

sociologists believe knowledge is created through individual interactions within a community significant to constructionism (Shwandt, 2003). Berger and Luckmann (1991) argue that there are two types of reality that exists, objective and subjective reality, within society. Objective reality is formed through people's interaction with the social world, which in turn influence people's actions resulting in habits and routines e.g. through people's interactions patients were able to identify indigenous plants and fruits that can help lower blood pressure levels and physical activities they can engage in. Meaning, any action that is frequently reaffirmed becomes a pattern, which is reproduced without any effort. This allows people to involve themselves in innovation rather than to start everything afresh. In time, knowledge is formed when habits become entrenched as routines. Objective reality is institutionalised by society for future generations to experience and is continuously repeated in interactions between individuals (Berger and Luckmann, 1991).

Subjective reality involves being given identity and place in society and it is made up of experiences of society while achieved through primary and secondary socialization (Berger and Luckmann, 1991) for example, the impact societal and individual perceptions, experiences, and cultural practices have in treatment selection and how patients perceive hypertension. Undeniably, Burr (1995) stated that identity is not formed inside an individual but on a social realm. When objective reality is mediated, given meaning and internalised by individuals in society, this is done through socialization. According to Berger and Luckmann (1991) maintaining a conversation is of vital importance in modifying reconstructing and maintaining subjective reality. Subjective reality refers to a shared understanding and meaning in which ideas are assumed and taken for granted in daily talks, eliminating the need for constant definitions (Berger and Luckmann, 1991 cited in Andrews, 2012).

This theory has proven very helpful in understanding the socio-cultural perceptions of hypertension since cultural factors influence people's attitudes toward and reactions to illnesses, as well as how they perceive, and make decisions about them. For instance, prior research on hypertension has shown that most patients use traditional medicine because of factors such as high unemployment rate, poverty, and limited access to healthcare facilities. Tsabang et al. (2016) there are several variables that contribute to the use of traditional medicine such as the growing number of patients with diabetes and hypertension, anthropological concerns, the chronic nature of these

illnesses, and the high expense of contemporary treatment. This theory has allowed the researcher to look at this phenomenon from a broader perspective and gain an in-depth understanding of hypertension, from patients' socio-cultural perceptions of this illness to its care management, medical awareness, and treatment choice of hypertension in Swayimana location, Emahlathini area in KZN.

2.8 Conclusion

It can be concluded that patients contemplate alcohol abuse, poverty, gender factors, and African cultural beliefs (bewitchment and ancestry entity) as the reasons people could be prone to this chronic illness and, that African traditional medications can help lower blood pressure levels more effectively. Through prescribed medication intake, balanced diet, regular physical exercises, and other necessary behavioural changes (not consuming alcohol or too much caffeine), hypertension can be managed, and awareness of symptoms be identified. The following chapter will explicate the methodology employed in this study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter explicates the methodology employed in the current study drawing its approach from a qualitative design and approach. This chapter is organised into ten headings namely, research approach, research design, study location, selection of participants, data collection method, research instrument, data analysis, trustworthiness of the study, ethical considerations, and lastly a conclusion is proffered.

3.2 Research approach

According to Alzahrani and Bach (2014), explained that qualitative research studies deal with real world situations in order for narrative descriptions to be generated and to entail analytical and descriptive explanation of the concept. Qualitative research method is a method that understands aspects of social life, and it is an approach whose methods generate words instead of numbers as data (Patton and Cochran, 2002). Moreover, it uses a realistic method to understand the matter at hand in a naturalistic state (Patton and Cochran, 2002), where the researcher takes an independent position towards the findings of the study. Also, qualitative research method is employed when human variables are broadly discussed, therefore, it cannot be quantitatively analysed (2002). For instance, this study was based on an in-depth understanding of patients, their challenges and how they perceived this illness, it was not going to be possible if data was quantitatively analysed. Less information would have been provided while the core information is not provided.

According to Quinn and Keough (2002), one of the benefits of qualitative research method is that it allows the researcher to study selected and broader issues of research. It also helps to identify a relationship and the type of information that forms during the collection and analysis of data (Quinn and Keough, 2022). According to Stebbins (2001), qualitative research method answers questions of why, how or what in a social phenomenon instead of arithmetical data, which are questions answered by a quantitative research method.

According to Neuman (2014), through ethnography, the researcher can conduct research in a naturalistic environment or setting and thus, includes taking part on the participants' daily activities. This empirical study was a qualitative inquiry which used an ethnographic research method which sought to understand chronic illness in a local community in KwaZulu-Natal. This method enabled the researcher to analyse and identify unexpected issues using in-depth interviews. In-depth interviews were conducted under strict COVID-19 protocols which includes, the ensuring strict adherence to hygiene, social distancing and the wearing of face masks always. Also, since this research required human contact, it was conducted under strict precautionary measures which included only the researcher and the participants. That is a maximum of eight participants for focus group discussions and one participant in each interview for in-depth interviews. The reason for conducting this study was to get an in-depth understanding of hypertension and participant's socio-cultural perceptions on the disease. Interviews allowed the researcher to gain a deeper understanding of this illness and the challenges that hypertension patients and their families face on daily basis.

3.3 Research design

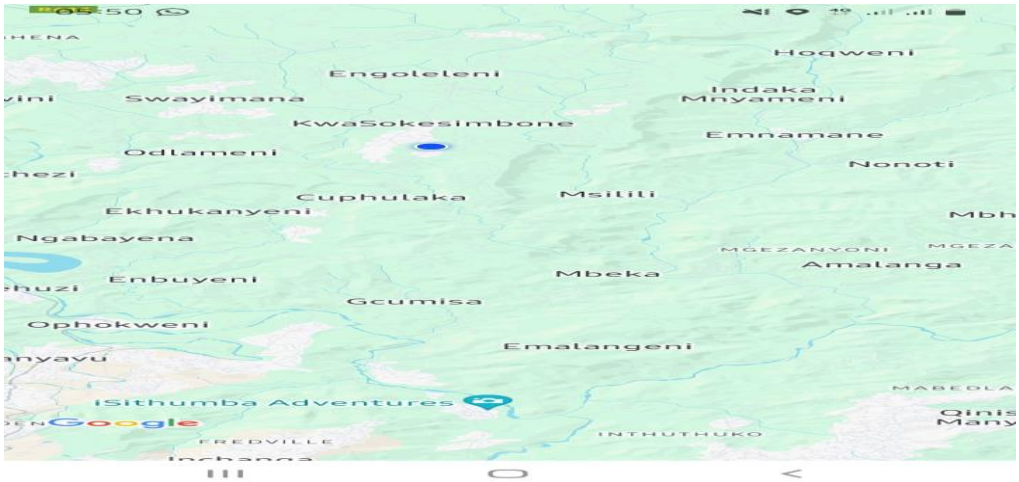
Lewis (2015) described a research design as the outline used to carry out a study, which gives detail of when, how and where the study will be conducted and how data will be analysed; in short, a research design is a strategy that is used when executing a study. MacMillan and Schumacher (2001) defined a research design as the overall plan for research which provides the overall framework of the research which includes, the study location, sampling strategy, data collection and analysis technique, and, finally, answers to research questions.

For the purposes of this study an exploratory research design was employed. According to Polit (2001), an exploratory research design is used to discover studies that are seen as new areas to be explored in which little understanding about the study interest area is demonstrated. In this research, the exploratory research design was chosen because the researcher sought to make inferences about socio-cultural perceptions of hypertension patients on the care and management of hypertension in Swayimana.

3.4 Study location

The area of the study is Emahlathini in Swayimana, KwaZulu Natal, South Africa. Swayimana is a location closer to Wartburg in Pietermaritzburg under Umshwathi Municipality in KwaZulu Natal (Kruger and Mathebula, 2018). Swayimana is led by King Nkosiyezwe Gcumisa who is the youngest son of the Gcumisa clan, who is known for following and believing more on cultural and traditional practices as the foundation and the roots of all human beings (Kruger and Mathebula, 2018). The area is best known for its rich soil in food production including sugarcane, sweet potatoes, mammy or potato of the tropics (amadumbe), beans and maize (Kruger and Mathebula, 2018) Several studies in the area have been conducted on food production, for example a study by Kruger and Mathebula in 2018 based on the rich soil and food production in Swayimana Emahlathini area. In Emahlathini area most people rely on traditional medicine since modern medicine is costly, and their cultural beliefs and traditional practices play a massive role in their lives and the choices they make (Kruger and Mathebula, 2018). Farming is part of their daily activities, and they normally have plants that are helpful to them without having to buy them, for example, they have the blackjack and aloe Vera which they use to manage hypertension levels (Kruger and Mathebula, 2018). The Swayimana Emahlathini area is relevant to the study objectives but most importantly, the location of this study provided easy accessibility to participants. This study was conducted in Swayimana because that is where the researcher resides and it was easy for the researcher to access participants because of the lack of funds, limited time and strict COVID-19 protocols.

Figure 3.4 Swayimana, Emahlathini area



3.5 Selection of participants

Those interviewed in the research were chosen using purposive sampling or what other scholars refer to as non-probability sampling. Here samples are chosen that “will yield the most relevant and plentiful data” (Yin, 2011: 88), and from whom the research will “obtain the broadest range of information and perspectives on the subject of study” (Kuzel, 1992: 37). Purposive sampling refers to a procedure in which one cannot specify the probability that any member of the population will be included in the sample (Cozby, 2007). Neuman (2003) stated that in purposive sampling, the researcher uses his own judgment to select the research participants for them to be able to correspond with the research aims. Also, this sampling method provides sample size which can be measured as the representation of the whole population based on the inclusion criteria used to recruit participants (Neuman,2002).

Further, the researcher engaged a chain referral technique which is sometimes referred to as snowball sampling (Naderifar et al., 2017). This sampling technique is usually employed when potential subjects are difficult to find, therefore the available participants select or recruit future participants among their associates or friends. The participants recruit future participants who may be willing to take part in the open-ended interview and who met the criteria of this study. For instance, African males and females who are residents of the Swayimana Emahlathini area, who are also hypertension patients or a family member (caregiver) of a hypertension patient. Some of the advantages of this sampling method is that it provides a researcher an opportunity to be able to communicate better with the participants since they are friends or colleagues of the first participants. This sampling method is not time consuming; it allows the researcher to access participants that are considered to be impossible or difficult to recruit (Neuman,2003). This method may be of help in discovering characteristics about the population that the researcher was not aware that even existed (Naderifar et al., 2017).

3.6 Data collection method

The chosen data collection method for this study were in-depth interviews with open ended questions. Apt to note is that a semi-structured interview permits researchers to take a comprehensive and holistic look at the people who are being studied and allow the respondents to deliver replies in their own words (Neuman, 2014). By using

a one-on-one open-ended interview, the researcher had an in-depth understanding of the Swayimana community members' socio-cultural perceptions of hypertension, its care management and medical awareness. The one-on-one open-ended interviews were tape recorded and the recorded data were only used for this study. The one-on-one open-ended individual interviews were conducted in a naturalistic and non-clinical setting.

3.7 Research instrument

This section focuses on the study's research instrument(s), namely the researcher and the interview guide. Questions on the interview guide were generated after a thorough review of relevant literature and scrutiny of the research problem, research questions and study objectives.

3.7.1 Researcher as key instrument

The researcher in qualitative research is the key instrument (Patton, 1990). Thus, the researcher is inseparable from the research (Jackson, 1990); this has wider implications. For instance, the credibility of the researcher is pertinent in qualitative research, because he/she is the main instrument in both data collection and analysis (Fusch and Ness, 2015; Patton, 1990; Shenton, 2004). The researcher in this study was at the vanguard of data collection. The researcher was intricately aware that amid other factors, the quality of data is reliant on the researcher's competence, therefore adequate time and resources were dedicated to researcher training and preparation for quality data collection.

3.7.2 Interview schedule/guide

Interviewing is dependable with an interpretive approach which "aims to explain the subjective reasons and meanings that lie behind social action" (Blanche and Durrheim, 2006:7). The researcher used an interview schedule as a data collection tool in this study. It was used to gather data that was relevant to answering the key research questions. The structure and order of the questions contained in the interview guide was not concrete but rather fluid as they could always be adjusted depending on how the conversation would unfold. The key areas of exploration included: the socio-cultural perceptions of patients about this illness, its care management and medical awareness, and treatment involvement (western and indigenous). Krueger (1998)

identifies a typology of opening, introductory, key, and ending questions. Similar issues were explored in these interviews.

Table 3.7: Participants' profile

AGE	Males	Females	Total
30- 39 yrs. old	0	2	2
40-49 yrs. old	0	5	5
50-58 yrs. old	3	10	13

As the table shows above, the study consists of twenty participants two participants between 30 and 39 old, five participants between 40 and 49, and 13 participants between 50 and 58 years of age. The sample had three males and seventeen female participants who took part in this study, females were more willing and comfortable to talk about hypertension and challenges faced.

3.9 Data analysis

Ibrahim (2012) defines theme analysis as a technique for analysing data in a qualitative study. This method involves classifying and analysing the data as well as presenting patterns related to the data that was gathered. Thematic analysis in this study offered potential connections that could be utilized to contrast different viewpoints and concepts from the research and to contrast these concepts with previously gathered information from other studies or contexts in the research's literature review chapter.

This study adopted the six stages of thematic analysis which were presented by Braun and Clarke (2006). These six stages include, familiarisation of data, coding, search for themes, revisiting themes, defining and naming themes and writing up.

a) **Familiarisation of data**- in this stage the researcher absorbed the collected data, and this was achieved through reading and re- reading of transcripts and listening to audio-recordings. This was of vital importance since it helped the researcher to get familiar with data (Clarke and Braun, 2013).
b) **Coding**- At this stage data was being illustrated by the researcher using labels, which was of great importance. The researcher looked for certain characteristics in the collected data for the study questions to be answered and considered both conceptual and semantic data reading (Clarke and Braun,

2013). Data for this study were coded manually, that is; each transcript was marked with a black pen to answer each research question, and the resulting driven codes of data were arranged into groups that were expressive. The time and date of the interviews were labelled and coloured, and patterns that were highlighted were utilized to set the data apart for convenient access. This helped to prevent the duplication or reuse of a particular set of data. This was also ideal for creating patterns using the data that was gathered.

c) **Searching for themes**- Clarke and Braun (2013) asserts that themes provide summaries to things that provide critical importance using a response approach that is patterned, and within these themes, reactions need to be present in the research questions. At this stage, the researcher was actively searching for similarities, codes and themes that are formed from the gathered data. The researcher needed to have a clear understanding of themes and be familiar with them, to avoid mixing up themes.

Themes for this research were generated from the collected data and created through the sorting of codes into themes. These themes that were identified from the data were: (i) the socio-cultural perceptions of hypertension, (ii) medical and local care management of hypertension and its medical awareness in Swayimana location, (iii) lastly treatment used by community members and reasons for doing so. These are the themes that emerged from the research questions and assimilated the use of the Social Construction theory by Berger and Luckman (1966). All these themes emerged from the study findings and were primarily based on the framework of the study objectives, which was done to ensure that there is a flow in the collected data, and that it also corresponds with the study objectives and questions.

d) **Revisiting themes**- based on Clarke and Braun (2013), it is of vital importance for the researcher to revisit the originally formed themes through the selection of a theme which will best work for a full set of gathered data. At this stage, some themes were reduced or expanded for suitability with the set of data. This was done through constant listening of the recordings. Moreover, it should be well-known that analysis was generalised as each theme emerged and was then used to address each research question.

e) **Defining and naming themes**- During this stage, themes were developed in a way that the researcher preferred and understood the data, and the naming of

themes was based on the researchers' preference. Therefore, this stage focused on a detailed analysis of each identified theme and then proceeded to be written. The researcher was able to have an in-depth understanding of the story that each theme was elucidating while developing a relationship with the overall collected data (Clarke and Braun, 2013). Each research question was broken down into smaller meaningful codes for the themes to emerge, which was easy to do, since a set of collected data was represented by each theme. For example, the first research question was, what are the socio-cultural perceptions of hypertension in Swayimana community? This was advanced into a theme which read: *Understanding the socio-cultural perceptions of hypertension* and this theme was marked using a pink highlighter, while following questions marked with different colours.

f) **Writing up**- This is the final and the most important stage of the entire analysis of data. During this stage, the collected data was expressed in a word-based form, therefore, the researcher identified the sets of data which provided answers to the research questions. In other words, this stage was the core stage of the whole research since it allowed the researcher to provide a consistent, analysed and detailed information of data findings.

3.10 Trustworthiness of the study

Ensuring the trustworthiness of a study is an indispensable part of qualitative research. Babbie and Mouton (2001:277) aver that "trustworthiness is dictated by asking how 'an inquirer' [can] convince their audience that the findings of an inquiry are worth focusing on or worth assessing". Drawing on Guba and Lincoln (1994), Babbie and Mouton (2001) describe a trustworthy study as one that is credible, transferable, dependable, and confirmable, and stress that these four measurements are interlinked. The researcher guaranteed the credibility, transferability, dependability, and confirmability of this study as follows:

3.10.1. Credibility

Credibility seeks to discover similarity between the constructed realities that exist in the minds of the participants in a study and those that are credited to them (Babbie and Mouton, 2001). At the end of the day, the findings presented by the researcher must match the participants' encounters and what they shared during data gathering.

Credibility can be accomplished through a few systems and in this study the researcher employed: peer review and persistent observation.

(a) Peer review

Peer review is described as the evaluation of work by one or more people with similar competences as the researcher. Peer review was accomplished through the researcher engaging with the supervisor. During this process, the researcher and the supervisor discussed the study in-depth, and the supervisor scrutinized the questions and findings to check for validity, reliability, and authenticity.

(b) Persistent observation

Babbie and Mouton (2001) describe persistent observation as “pursuing interpretations in different ways, engaging in constant and tentative analysis, looking for multiple influencers and searching for what counts and what doesn't count”. In this study, the researcher ensured this by not only being observant during the interviews but also by exploring the data further and focusing on the relevant aspects. During the interviews, the researcher was aware of non- verbal communication. This was noted down immediately after the sessions so as not to interrupt or make the participants anxious. The observations assisted the researcher in making connections between what the participants were saying and what they were feeling. This enabled the researcher to be aware of any contradictions, inconsistencies and incongruences.

3.10.2 Transferability

According to Babbie and Mouton (2001:277), the term “transferability refers to the extent to which the findings can be applied in other contexts or with other respondents”. They further elaborate that qualitative researchers are “not primarily interested in (statistical) generalisations and believes that all observations are defined by the specific context in which they occur” (Babbie and Mouton 2001:277). Transferability involves the degree to "which the researcher’s working hypothesis can be applied to another context" (Zhang and Wildemuth 2009:6). Thus, qualitative researchers do not claim that knowledge gained from one context will necessarily have relevance for another context or the same context in another time frame. To achieve transferability, qualitative researchers, use the strategies of purposive sampling and thick descriptions (Babbie and Mouton, 2001). This is to enable the readers of a given

research report to form an informed opinion about the applicability of its findings to a different context that they may be interested in.

In this study, the researcher employed both strategies (use of strategies of purposive sampling and thick descriptions). As discussed above, this study's sample was purposively selected based on prospective participants' abilities to provide rich information in relation to the topic under investigation. According to Babbie and Mouton (2001: 277), thick descriptions occur when researchers provide "sufficiently detailed descriptions of data in context and [report] them with enough detail and precision to allow judgments about transferability to be made by the reader".

3.10.3 Dependability

As indicated by Babbie and Mouton (2001), an inquiry must provide its audience with proof that if it somehow managed to be repeated with the same or similar participants in the same or similar setting, its findings would be comparable. To this end, Guba and Lincoln (1994) (cited to in Babbie and Mouton 2001) attest that a request review ought to be utilized. Gasson (2004:94) proposes that "clear and repeatable procedures concerning the manner in which we conduct the research be required to ensure the dependability of findings". She suggests that making explicit the process through which findings are derived is a useful way of ensuring their dependability.

3.10.4 Confirmability

Gasson (2004:94) proposes that "distortions regarding confirmability be minimised by the researcher making explicit assumptions and frameworks regarding research findings". Confirmability is accomplished through the upfront explanation of a researcher's suspicions and potential biases. To guarantee confirmability and dependability, the researcher kept an audit trail. Other than the audio recordings and ethical documents, this also included observation notes, a reflexive diary, member checks, peer review and transcripts. Throughout this study, the researcher kept a reflexive diary where personal feelings and biases were entered. This helped the researcher to recall information that couldn't be captured on audio recording.

3.11 Ethical considerations

The researcher obtained Ethical clearance (appendix a) from the University of KwaZulu Natal Ethics Committee after the gatekeeper clearance (appendix b) from

the Gcumisa king and the traditional counsellor was obtained at the Swayimana location before the collection of data. This clearance was giving the researcher permission for the gathering of data using the Swayimana community members. The consent form (appendix c) was also made available to participants to sign after the researcher had explained everything concerning the study and their rights as participants to the study. The written informed consent was acquired before conducting interviews.

All written information was made available in IsiZulu since Swayimana is dominated by IsiZulu speaking people. Participants were made aware that they can withdraw anytime from the study without being harmed in anyway and that they are not forced to take part in this study. Utmost anonymity and confidentiality were ensured by use of pseudonyms. The researcher took all the necessary steps to ensure that all the collected data (tape recorded) are stored in a secured area, after five years all this data will be destroyed. Besides this, autonomy, confidentiality, privacy and justice to all participants were safeguarded to ensure that participants' freedom and rights were not violated in any way.

a) **Autonomy**: data was collected through face-to-face interviews; thus, the researcher did ask for permission from the participants who took part in the study and explained to them that they can pull out anytime or choose not to answer a specific question if they feel uncomfortable. Everything was explained to the participants before signing a consent form and taking part in this study.
b) **Anonymity and Confidentiality**: the confidentiality of all the participants was protected by using an informed consent form which was signed by the participant before taking part in this study. Pseudonyms were used to hide the identity of the participants. As the researcher it was my responsibility to protect the participants therefore, I used pseudonyms to protect their identities and not to be recognized in anyway. In tandem with arguments put forward by De Vos et. al. (2005), neither the researcher nor other people should be able to identify participants based on collected data. Also, only the researcher and the participants had the knowledge of who participated in this study for anonymity and confidentiality purposes.
c) **Privacy**: Since it is the responsibility of the researcher to protect participants, the researcher ensured that no harm or injuries were done to participants during

the interviews or if they decided to pull out their privacy would be ensured. Also, the researcher made sure that during interviews no participants were pressured or made to feel uncomfortable in their homes since interviews were conducted in a naturalistic and non-clinical setting. All COVID19 protocols were followed when these interviews were conducted.

The COVID19 protocols followed during face-to-face interviews include,

I. The wearing of face masks during the interviews.
II. Use of sanitizers both the participants and the researcher.
III. Interviews were conducted outside the participants' homes not indoors.
IV. Limited number (three members) of family members were allowed during the interviews.
V. Pregnant and family members who are hypertension patients but do not use prescribed medication were excluded from being part of the interviews.

d) **Justice**: all participants were treated equally and no participant was discriminated despite their gender or age. No participants were discriminated or treated unfairly or unwanted due to their experiences or perceptions regarding this illness.

e) Inclusion Criteria: The target population for this study was hypertension patients either male or female aged between 18 and 58 years old. All participants were community members of Swayimana.

f) **Exclusion criteria:** People below 18 years and above 59 years of age were excluded in this study. Due to their high risk, pregnant women, persons with hypertension who are not taking their medication, and people who were not patients or family members of someone with hypertension were also excluded.

3.12 Conclusion

The methodology of this study was discussed in this chapter of the thesis. The present chapter presented the research methodologies and procedures employed in participant selection, data collection and processing, and analysis. The chapter came to a close with a discussion of how the study's credibility was ensured. The findings of this study are presented in the following chapter.

CHAPTER 4

PRESENTATION OF DEMOGRAPHIC CHARACTERISTCS OF PARTICIPANTS

4.1 Introduction

This chapter presents data from participants' demographic characteristics The chapter outlines the demographic characteristics of the participants in a bid to give the reader an in-depth understanding of the participants. Several characteristics such as their age and gender, family size and treatment challenges are expounded in this chapter.

4.2 Demographic characteristics of participants

The participants were hypertension sufferers from Swayimana, Emahlathini area in Pietermaritzburg, KwaZulu-Natal. Participants were between the age of 38 and 58 years of age.

Table 4.2: Demographics

Pseudonyms	**Age**	**Gender**	**Occupation**	**Treatment**	**Diet**	**Treatment collection and support**	**No. of family members**	**No. of employed family members**
1.Jenny	47 yrs.	F	unemployed	Western	healthy	clinic	6	1
2. Helen	39 yrs.	F	unemployed	Western	healthy	clinic	15	2
3. Maria	57 yrs.	F	employed	Both	balanced	clinic	6	1
4. Amanda	48 yrs.	F	Child Support Grant (CSG)	both	healthy	clinic	5	0
5. Susan	58 yrs.	F	unemployed	both	Own preferences	clinic	8	1
6. Velabahleke	46 yrs.	F	CSG	both	healthy	clinic	10	2
7. Mandy	38 yrs.	F	CSG	both	healthy	clinic	12	3
8. Dorothy	58 yrs.	F	Disability Grant (DG)	both	Whatever is available	clinic	9	1
9.Ouma	50 yrs.	F	CSG	both	healthy	clinic	30	5
10. Themba	56 yrs.	M	DG	both	healthy	clinic	15	0

11. Mbali	53 yrs.	F	CSG	Western	healthy	clinic	8	2
12. Samkelisiwe	55 yrs.	F	CSG	both	Can afford	clinic	13	1
13. Thobeka	56 yrs.	F	DG	both	Own preference	clinic	13	0
14. Sebenzile	42 yrs.	F	CSG	both	healthy	clinic	6	0
15.Makhuluphala	57 yrs.	F	Informal Employment (IE)	both	healthy	clinic	10	1
16. Benzeni	53 yrs.	F	DG	both	healthy	clinic	20	2
17. Bhekizwe	58 yrs.	M	DG	Western	healthy	Clinic	3	0
18. Thuleleni	58 yrs.	F	DG	Western	Healthy	clinic	4	0
19. Snakho	44 yrs.	F	CSG	Both	Healthy	Clinic and hospital	10	0
20.Thulasizwe	54 yrs.	M	DG	both	healthy	hospital	10	0

The table above presents the demographic characteristics of the study paying attention to participants' demographics. The table has proven that anyone can be diagnosed with hypertension irrespective of their gender or age and the researcher was able to gather data from a wide variety of hypertension patients who represented different age groups, social contexts, and gender. As indicated in the table above pseudonyms were used to protect the confidentiality and anonymity of all participants involved in this study.

The demographic characteristics of participants are explained in detail using the above table (Table 4.2) however, other tables will be presented for an in-depth understanding.

4.3 Age and Gender

Previous studies have indicated that hypertension is a global problem, and anyone can be diagnosed regardless of your age, gender, or geographical area (WHO, 2023; Nyaaba et al.,2018; and Micklefields et al.,2022). Although this illness is a global problem, SANHANES (2020) indicated that rural areas have many hypertension patients (Naik, 2021), so does Swayimana since it is located in the rural areas.

From the table below it is important to note that the study had three age groups, two (n=2) participants were between 30-40 years, five (n=5) were between 40-49, while (n=13) participants were between 50-58years old. The youngest participant among the sample was 38 years old and the eldest was 58 years old.

Table 4.3 Participants age group

Age groups	No. of participants
Between 30 to 39 years old	2
Between 40 to 49 years old	5
Between 50 to 58 years old	13

When compared, each age group had distinct ways of thinking about and handling the difficulties they encounter daily. In addition, compared to younger participants, older individuals reported greater symptoms of hypertension and possessed more essential knowledge about traditional African plants used for blood pressure maintenance. Younger participants' bodies react to treatment more quickly and experience less difficulties than those of old age since the older one gets, the more susceptible they are to illnesses.

It can also be stated that the study was predominately female because it included (n=17) female participants and (n=3) male participants. Three females and one man were the oldest at fifty-eight years old, while the youngest female was 38 years old, and the male was 44 years old. Because women were more willing and comfortable participating in the study than their less verbal counterparts. Female participants were willing to give information regarding the illness, including its causes, its management, and home remedies for hypertension, as well as medication.

Although older patients receive greater attention, both genders reported receiving treatment at the neighborhood clinic, where they are treated equally and had equal access to all medical services. Although the majority of the clinic's employees are female, all sexes have easy access to treatments, are given whatever assistance they may require, and get crucial information in an impartial and equitable manner. For clinic staff, both genders and age groups are extremely important; neither is viewed as superior to the other or better.

4.4 Challenges to treatment

4.4.1 Alcohol consumption is a challenge faced by participants

Among the sample seven participants admitted to alcohol consumption, three males and four female participants. But two participants consumed alcohol with treatment which later caused fatigue and swelling of the body, and these side effects last for two to three days.

4.4.2 Employment status

Unemployment is a big issue faced by many South Africans, whether it is the youth or middle-age, and it is difficult to deal with especially when they have families to fend for, Swayimana area is no exception. Among the twenty participants, eighteen participants were unemployed but fifteen of them had other means to fend for their families. While one participant was employed by the government (nurse) and the other was in informal employment (traditional healer).Apt to note is that among the fifteen participants who had other means to support their families; eight participants were dependent on the Child Support Grant (CSG) and the other seven were dependent on the Disability Grant (DG).

The table below show employment status of the sample.

Table 4.4.2: Employment status of the sample

Employment Status	No. of Participants	Females	Males
Child Support Grant (CSG)	8	8	0
Disability Grant (DS)	7	4	3
Unemployed	3	3	0
Employed	1	1	0
Informal Employment	1	1	0

Based on the table above, it is evident that most participants were dependent on CSG and DG to support their families, although most participants relied on both these grants, it was not enough to cater for all their monthly needs. From the findings it was

indicated that subsistence farming became every participant's hope to provide for other family needs. One participant indicated that:

"It is R200 a day (to work eight hours)".

It must be noted that hypertension sufferers cannot work long hours, hence their hope to provide for their families is hinged on subsistence farming.

Due to unemployment, participants are limited when it comes to dietary choices and healthcare services since they tend to have less access to nutritious food, less adequate treatment support, and more financial constraints. The participants had family members who are employed but do not necessarily provide any financial support to participants. Only three participants in the study reported that they had their families' financial support, which was a rare occurrence for most participants in the study.

4.4.3 Form of treatment

The World Health Organization (2017) states that there are different medications for different types of hypertension prescribed depending on the patient's diagnosis. ACE inhibitors (such as lisinopril, benazepril, and captopril), diuretics, or water pills, beta-blockers, antihypertensive medications, calcium-channel blockers (such as amlodipine and diltiazem), and vasodilators are among the medications prescribed to patients with hypertension. From the study it was noted that participants were taking medication that was prescribed to them. Five of the twenty participants solely use biomedicine that has been prescribed to them, whereas the other participants take both prescribed and native drugs.

The table below show the different types of medication given to hypertension sufferers.

Table 4.4.3.1: Prescribed medications for the sample

Prescribed Medications	No. of participants
Calcium-Channel Blockers e.g. Amlodipine	15
Angiotensin Converting Enzyme e.g. Enalapril	12
Diuretics or Water pill e.g. Ridaq	20
Beta-Blockers e.g. Atenolol or Zetonol	5

Reductase Inhibitors or Statins e.g. Simvastatin	1

As the table below shows, fifteen participants take Calcium-Chanel Blockers known as Amlodipine, twelve participants are given Angiotensin Converting Enzyme inhibitors called Enalapril, while twenty participants were prescribed Diuretics or water pill known as Ridaq. Five participants are given Beta-blockers called Zetonol, and lastly one participant is prescribed to take Statins known as Simvastatin. Of importance to note is that the water pill is the most consumed or prescribed medication among hypertension patients in Swayimana location. It must be noted that participants are prescribed to different medications and dosages e.g. some participants admitted to taking medication once a day while others twice a day, all depending on how high or moderate blood pressure levels are and the type of hypertension a participant is diagnosed with.

Furthermore, as the researcher has mentioned before fifteen participants are not only using prescribed medication, but they also use indigenous plants to maintain hypertension. When it comes to indigenous plants, different parts can be used like the leaves, stem, roots or seeds, even vegetables, fruits, herbs, and grains can be used as traditional dietary therapies (Oluwatoyin et al.,2021). The table below indicates the different African traditional plants that some participants consume or have heard of that can maintain hypertension.

Table 4.4.3.2 Indigenous plants sufferers consume

African traditional plants	No. of participants
Momordica balsamina	19
Aloe Vera	12
Aloe Arborescens	6
Blackjack	2
Eucalyptus	1
Incense bush	1

Above are some of the African traditional plants that participants in the study consume as self-medication. Nineteen participants consume *Momordica Balsamina*, twelve participants consume *Aloe Vera*, six participants drink *Aloe Arborescens,* two participants consume *Blackjack*, while one participant drinks *Eucalyptus*, and the other participant consume *Incense bush*. Participants indicated that these plants can be mixed to create one medication.

Hypertension patients rely on indigenous methods than prescribed medications for several reasons which include expensive costs of prescribed medications, lifestyle changes (diet), and lack of access to health facilities (Tsabang et al., 2016). Based on this study, the participants indicated that the use or combination of medications was prompted by the side effects of biomedicine and dietary changes.

4.4.4 Diet

Hypertension cannot be maintained with prescribed medications only, but sufferers need to make positive behavioural and lifestyle changes such as; having regular physical activities or exercises, have a balanced diet e.g. eat boiled vegetables, fruits and food that contain less starch (Deibe, 2022). Participants in this study indicated to have a range of copying strategies in managing their diet, own preferences, and views on what is suitable for them. Most hypertension sufferers indicated that what is available to them or food they can afford, and produce through farming e.g. vegetables (Yams, Sweet potatoes) and fruits (Avocado and Oranges). However, due to poverty and unemployment sufferers are limited to nutritious foods.

The table below shows various food products that participants consume to manage hypertension in Swayimana.

Table 4.4.4 Various foods sufferers consume

Food consumed by the sample	No. of participants
Boiled vegetables e.g. yams, spinach, and sweet potatoes	17
Fruits e.g. red apples	4
Oily food e.g. fried food	2
Salty food e.g. dairy like cheese	2

Meat e.g. red meat, tripe (usu)	1

The table above indicate that seventeen participants consume boiled vegetables, four participants consume fruits, two participants consume oily food, other two participants consume salty food, while one participant admitted to consuming red meat. Participants indicated that the vegetables that they consume are those which they grow and produce in the area. Hypertension patients are required to have three balanced meals a day but due to poverty and unemployment, most participants normally have two meals per day while some participant with large families have one meal per day.

4.5 Treatment collection and Support

As mentioned above, hypertension patients have prescribed medications to consume, and this medication can be collected at a local clinic or a nearby hospital. Nineteen participants collect their medications at Gcumisa clinic, a local clinic close to community members and sufferers, while one participant collects their treatment at North dale hospital close to town.

The table below indicate the amount of money spent on transport to collect treatment

Table 4.5: Transport fees

Location	Transport fees
From home to Gcumisa clinic	R30,00 per day +return
From home to North dale hospital	R100,00 per day +return

As indicated in the table above, most participants reported to spend thirty rand per day (return) transport fee, while the hospital patient spent hundred rand a day (return) on transport. These expenses exclude expenses spent on food eaten by participants while waiting on long queues on treatment collection days at the clinic or hospital. The local clinic is nearby, and participants can walk to and from but not all participants are able bodied to walk the long stretch in the morning as they are worried about getting on the queue first.

Participants who collect their medication at the clinic indicated that they had never faced any trouble or ill-treated by the clinic staff. They also reported that they always get their medications, and no shortage of these medications were experienced. Every six months there is renewal of patients' files and full-body examinations or check-ups done at the clinic and hospital for hypertension patients. Participants indicated that they are given medication parcels four time a year and medication given lasts them two full months without having to collect any medication during that time until their next appointment.

During the collection of medication parcels, clinic clerks give out parcel to all patients and each parcel has the patient's details on it. Apt to note is that the parcel has all the medications required by the patient for the next two months. During parcel collection, patients do not have any communication with health practitioners (doctors/nurses) unless there is an emergency, or the patient is sick.

4.5.1 Support (House Calls)

The local clinic provides house calls as part of support to patients with hypertension. Health practitioners (nurses) provide house calls to elderly patients; bedridden patients those patients who miss treatment collection dates more often in order to check their progress. When medication collection dates are missed more often, it normally means the sufferers is not taking medication regularly as instructed, thus, medication can only be effective when taken daily or as instructed by health practitioners. Patients normally do not take their medication daily due to hunger, individual or societal perceptions about the medication.

The table below shows the number of patients that are part of house call patients and the reason for being on a house call list.

Table 4.5.1: House call participants

Type of house call patients	No. of participants
Elderly patients	8
Medication collection dates missed frequently	1
Bedridden	0

From the table above, it can be deduced that nine participants are part of house call patients, eight are elderly patients while one is a patient that frequently misses their medication collection dates. For a patient to qualify to be on house call, he/she must be fifty- five years and above (normally considered elderly patients), suffering from a severe stroke or bedridden, and patients who are starting treatment or miss treatment collection dates.

During house calls check-ups such as high blood pressure readings are provided follow-ups on the progress of the patient, providing support to patients who experience stigma, patients with challenges accepting their condition or disease. It must be noted that during house calls there are services that are not provided like a thorough or full-body examination, counselling, medication collection and pregnancy tests as these are only provided at the clinic or hospital. Thus, if a patient is part of house call patients, he or she needs to collect treatment at the clinic or hospital, but the difference is that they do not have to join the queue, house call patients are placed first in line along with emergencies.

The table below shows that house call patients are also counted in clinic patients because medication can only be collected at the clinic or hospital not during house calls. Therefore, nineteen participants are clinic collectors while one participant is a hospital treatment collector.

Table 4.5.2: Place where patients collect their medication

Place medication is collected	No. of participants
Clinic collector	19
Hospital collector	1

4.6 Family size and employed family members

One of the most difficult thing hypertension patients must deal with is having a large family size, comprising of parents; their children, grandchildren, and sometimes great-grandchildren (commonly known as extended families). In South Africa there are different types of families, but the most common type is the extended family (Teasley, 2021) and this is also evident in Swayimana area.

Based on this study, the participant's families fall into three categories. The participants' families were (i) Nuclear families (seven participants), (ii) Extended families (thirteen participants), and (iii) Single-parent families or female headed households (five participants). It should be mentioned that while one person is a member of a nuclear family, the other four participants are members of extended families and single-parent households. The table below shows the type of families the participants belong to.

Table 4.6.1: Types of families' sufferers have

Types of families	No. of participants
Nuclear families	7
Extended families	13
Single- parent families (female headed households).	5

It is evident from the table above that extended families predominate in the Swayimana area. It should be mentioned that in this study, single-parent households are led by women.

The table below shows the marital status of the participants,

Table 4.6.2: Marital status

Marital status	No. of participants
Single	5
Married	9
Widow	6

From the table is can be deduced that nine are married participants, six widows, and five single participants. Families are supposed to be united and supportive to each other but due to poverty and having large family sizes makes this impossible, especially in nuclear and single female headed households. Living arrangements are also not conducive for hypertension patients and their families to live in but nothing can be done since they are unemployed. Most of the participants live in metal roofs

and un-plastered brick houses which in most cases have two or three bedrooms and needs to be shared among family members. Sometimes others may be required to sleep on the kitchen floor and the metal roofs normally have leakages because they are old and worn out, this affects patients' mental and physical health. The health of every family member is also affected especially children and elders who are most prone to illnesses. It was gathered from the findings that a few of the participants (four participants) had roof tiles and plastered brick houses.

As previously indicated, most participants were dependent on Disability and Child Support Grant to provide necessities to their family members. From this study eleven participants had family members who work; five participants reported to have informal jobs (three taxi drivers and two traditional healers); two participants were reported to be self-employed (tuckshop owners); and four participants reported to have government jobs (police officer, school cook, and two school cleaners). Family members who were working were not always willing to help those with hypertension.

Since most households have children, grocery expenses are split between all grant benefactors and working family members (in extended families). A patient will receive unfair treatment inside the family, and their children will too, if they are unable to contribute because of other costs. Most patients and their families experienced elevated blood pressure, stress, and restricted access to nutritional food as a result of not receiving equitable and fair treatment. Relatively few patients rely on their three siblings or families for financial help.

The participants' family sizes are displayed in the table below. Extended or single-parent families can be classified as having seven to twelve family members, which is the most prevalent family size.

Table 4.6.3: Family sizes

No. of family members	No. of participants
Having 1 to 6 family members	6
Having 7 to 12 family members	8
Having 13 to 18 family members	4
Having 19 and more family members	2

As can be seen from the above table, six participants had families of one to six members, eight had families of seven to twelve, four had families of thirteen to eighteen, and two had families of nineteen or more members.

4.7 Conclusion

This chapter provided readers with an in-depth understanding of the lives of those affected, highlighting the difficulties they encounter in meeting basic needs such as large families, restricted access to nutritious food because of unemployment, and reliance on Child Support and Disability Grants that are insufficient to cover all monthly expenses. The following chapter analyses the data from interviews carried out in the study.

CHAPTER 5

DATA ANALYSIS AND DISCUSSION OF FINDINGS

5.1 Introduction

The chapter presents data from interviews carried out with (n=20) participants who were chosen in the sample. Data is analysed in this chapter and themes and subthemes that emerged are presented and discussed. In this chapter, all the verbatim quotations from the participants are presented in italics and are block indented. Individuals were not identified by name this was in line with the policy of anonymity discussed in the previous chapter.

5.2 Emergent Themes

After data was thematically analysed, themes and subthemes emerged in correspondence to the aim of the study and research questions. The themes that emerged are as follows (i) the socio-cultural perceptions of hypertension patients in Swayimana, (ii) understanding care management and medical awareness of hypertension in Swayimana, and (iii) issues relating to combining Western and indigenous medications. The themes that emerged together with their sub-themes are presented in the table below.

Table 5.2: Themes and Subthemes

Themes	Sub-themes
1. The socio-cultural perceptions of hypertension patients in Swayimana.	(i) Age and gender factors. (ii) African traditional medication. (iii) Obesity. (iv) Family history. (v) Belief systems (supernatural and spiritual beliefs).
2. Understanding care management and medical awareness of hypertension in Swayimana.	(i) Awareness of hypertension symptoms. Hypertension is managed in the following ways: (ii) Prescribed medication

	(iii) Regular exercises (iv) Balanced diet
3. Issues relating to combining Western and indigenous medications.	(i) Indigenous medications (ii) Reasons participants combine medications.

5.3 The Socio-Cultural perceptions of Hypertension patients in Swayimana

According to the findings, hypertension patients' perceptions are based on personal experiences and what has been shared with family members, friends or community members. Some participants believed that hypertension is a disease that is related to age and gender factors. One participant indicated that:

"Anyone can have this illness regardless of your age or gender" (Themba).

From the findings participants indicated that African traditional medications can help maintain this hypertension. Participants believed that the use of herbs can help alleviate the hypertension levels. One participant said:

"I have heard that indigenous medications help to lower this illness. Plants like Aloe Vera, Aloe Arborescens and Momordica balsamina" (Makhuluphala).

While some participants subscribed to the belief that herbs were helpful in regulating hypertension levels some believed that obesity can cause hypertension. One participant believed that:

"it affects everyone but being overweight place people at high risk of being diagnosed with hypertension" (Susan).

Some held the perception that family history played a role in the genetically inheritance of hypertension. Another participant said:

"Hypertension can be transferred from one generation to the next, but anyone can have this illness regardless of your weight or age" (Velabahleke).

5.3.1 Age and Genders Factors

Apt to note, is that the leading perception held by most participants was that most hypertension patients were affected by their age and gender factors which played a

huge role in exacerbation of the illness. Although there were differing opinions among the participants regarding the aetiology of hypertension, the majority of them firmly believed that hypertension was an illness that could affect anyone, regardless of age. One participant said:

> *"No, anyone can have this illness regardless of gender but when it comes to age. Not every age group is prone to hypertension. This illness usually affects people who are stressed or elders not children"* (Jenny).

While Some believed that children were not susceptible to the disease some held a different view to that. Some participants argued that anyone could have hypertension despite their age. One said:

> *"No, anyone can have this illness regardless of your age or gender"* (Thobeka).

Even though elderly participants are more prone to illnesses, some participants argued that age was not the only factor to consider when looking at one's susceptibility to the illness. Participants were from different age groups and this is argued that all age groups can be susceptible to hypertension.

5.3.2 African Traditional Medications

From the findings it is important to note that participants were of the notion that consuming medications made of bitter plants can help maintain hypertension. One participant averred that:

> *"When one has hypertension, they should drink bitter natural plants like Momordica Balsamina" (Samkelisiwe.)*

It can be deduced from the findings that *Momordica balsamina* was the most trusted plant in Swayimana when compared to other plants that are believed to help with this illness. Some participants indicated that:

> *"I consume Aloe Vera and Momordica Balsamina (Cucurbitaceae). Based on my experience high blood pressure is scared of bitter food products. BP will drop when one eats bitter foods, drinking water and black tea also helps" (Maria).*

"I normally drink a lot of water especially when I have to run some errands in town and I also drink Momordica Balsamina" (Amanda).

Indigenous methods have been used for many years, and some individuals, including several of the participants, continue to support the use of traditional African medicines. The sample's preference for using native plant-based remedies is expressed in the following excerpt:

"They normally say that drinking bitter plant medications (like Momordica balsamina and Aloe Vera) helps in controlling this illness" (Velabahleke).

The above excerpt demonstrates how some participants believed that indigenous approaches may be used to treat hypertension in general. Many African countries, according to Oluwatoyin et al. (2021), believe in the use of traditional dietary remedies that include whole fruits, grains, vegetables, herbs, and plant components including leaves, seeds, and roots.

5.3.3 Obesity

Apt to note, that some participants in this study argued that obesity play a role in exacerbation of hypertension. Some participants said:

"Yes, being overweight places one at risk of getting this illness. While for others being stressed can elevate their blood pressure levels" (Thulasizwe).

"It affects everyone but being overweight can make someone be at risk of getting this illness and eating oily food places one at risk…Being overweight places one at high risk of being diagnosed with this illness" (Susan).

The excepts above demonstrate that being overweight can have a negative effect to one's health. Meaning gaining weight is not good for hypertension patients because it can cause elevation to their health. Being overweight can lead to countless illnesses and diseases excluding hypertension. One participant said:

"For me, being overweight makes a person prone to hypertension and other illnesses and diseases as well" (Amanda).

Participants have shown having a deeper understanding of the importance of having a healthy weight and the health effect of being obesity since it makes people vulnerable to chronic illnesses like hypertension and other diseases. Maintaining a

healthy weight is of vital importance in preventing the elevation of blood pressure levels and being prone to illnesses.

> *A healthy weight is between 18.5 and 25 BMI while obesity is having a body mass index above 25. Hypertension patients are encouraged to maintain a healthy weight because it is effective in controlling hypertension.*

Some studies indicate that women may be at a high risk of being diagnosed with hypertension than men due to obesity (Naik,2021). Naik (2021) states that nearly 31% of men and 70% of women in S.A are obese in South Africa; obesity is a common condition that has been shown to disproportionately affect women. This could be because women are more likely than men to be obese due to the foods they eat, particularly in rural areas where people are less likely to exercise or pay attention to what they eat.

5.3.4 Family history

Some participants in the study argued that since hypertension is determined by an individual's blood pressure levels rather than family history, having a parent or family member with hypertension does not guarantee that one will receive a diagnosis of the condition anytime soon. One participant said:

> *"Yes, hypertension affect certain people. For instance, if that family has a history of being diagnosed with hypertension, then family members may be at risk to hypertension as well" (Maria).*

However, some participants indicated that stress, physical exertion, and pregnancy were some of the factors that could raise one's blood pressure levels. Participants argued that such conditions meant that it was inherited. One of the female participants acknowledged that her pregnancy had caused her blood pressure to rise and was not sure if this could translate to her child also being diagnosed with hypertension in the future. One participant said:

> *"Yes, not everyone can have this illness. If one has hypertension in the family, there is a high chance for other family members to be diagnosed too. Hypertension can also be passed on from mother to child"* (Thuleleni).

The belief that hypertension is hereditary may have arisen from the fact that people with hypertension may have two or three family members who also have this chronic condition. This demonstrates how one's knowledge about an illness and the decisions one makes, particularly in the case of traumatic situations, can be influenced by family members' past experiences. Few participants believed that genetics had a role in hypertension and that it is passed down from mother to child or generation to generation.

5.3.5 Belief system

Belief systems can be considered as values and norms that guide our daily lives and they have an impact in our normal lives (Nyaaba et al., 2018). These belief systems affect how people view the world and others around them. In this study it was evidenced that African traditional beliefs played a pivotal role in one's sickness or health. For example, ancestors and witchcraft. Believing in the supernatural and spiritual realm is a practice which dates back to the ancient times of our forefathers and this is passed on from one generation to the other (Miller, 2011) The supernatural or witchcraft is believed to be done by a sorcerer to cause harm or death to another. For example, one participant argued that witchcraft was used to exacerbate her condition:

> *"Yes, due to the way that I was diagnosed with this illness. Sometimes witchcraft can cause hypertension" (Maria).*

Some participants in the study indicated that their blood pressure levels are high, or they are hypertensive because they are prohibited by their ancestral belief system in the use of western medication. One participant said:

> *"When my blood pressure levels are high, I normally believe that it because my ancestors are angry with me for using Western medication since I am a traditional healer" (Benzeni).*

This finding is in tandem with arguments put forward by Miller (2011) who argued that an illness can be caused by actions of an agent like a sorcerer, witch or supernatural entity, ghost or ancestor spirit therefore, only traditional healers can help with the use of the supernatural to find the cause in order to help cure the illness especially in rural areas.

Miller (2011) through his study highlights the need to undertake research on the role played by the supernatural realm in causing sickness or illnesses. Through this study it is evident that participants were able to express their thoughts and perceptions about the role played by the supernatural world in exacerbating hypertension levels in patients. Participants cited a range of reasons why they believed people could be vulnerable to hypertension caused by witchcraft and other supernatural beliefs held. Participants responses were evidence that this chronic illness was undeniably complex.

5.4 Understanding care management and medical awareness of hypertension in Swayimana area

Without a medical understanding of hypertension, care management cannot be comprehended. Participants indicated that despite the varying treatment options patients used they all at some point had to have knowledge about hypertension drawn from medicine. One participant said:

> *Despite the varying beliefs that people have about hypertension, to treat or manage it we ought to acknowledge that we need to have an understanding of the condition what it entails and what it means to be hypertensive.* (Maria)

Findings suggest that patients with hypertension should be well-versed in the mechanisms underlying this condition to facilitate its management and to teach their loved ones the value of leading a healthy lifestyle. One participant said:

> *"There is no easy way to prevent ourselves from getting this illness, but we need to cut down on salty food. People should eat chilly food and drinking a lot of water can play a role in preventing this illness. Drinking a lot of water will flush out unwanted waste from the body. We cannot control our emotions, being angry cannot be controlled but not eating oily food helps a lot (replacing oily food like fries with boiled vegetables and fruits), exercising and consuming prescribed medication on time…No, there is no easy way to prevent or detect hypertension" (Amanda).*

It was articulated in the study that since hypertension rarely exhibits signs, patients should be made aware of potential symptoms so they can monitor their health.

Participants indicated that if they had knowledge of the chronic illness maybe they could have changed their lifestyle.

> *We need to be made aware of the symptoms or signs of hypertension well in time so that we can spot these and seek help soon…. Had we known about how it manifests we could have change our eating habits as well as exercise (Amanda).*

5.4.1 Awareness of hypertension symptoms

Findings in this study indicate that most participants have or/and are still experiencing bodily discomfort which helped with detecting hypertension. It is apparent to note that these symptoms vary across patients, with the elderly and female participants projecting more of these symptoms hence their susceptibility to hypertension compared to males.

> *"When I did not take my medication my body responds differently and I can tell by how I'm feeling that I need to take my treatment. Even your heart responds differently when I have not taken the treatment" (Jenny).*

From the findings it is evident that hypertension has proven to be a complex illness and responds according to individual's bodily vulnerability (elderly are more prone to illnesses) when it comes to symptoms. Some excerpts below indicate how some participants experienced symptoms of hypertension.

> *"I was experiencing strong and fast heartbeats and hearing noises in my ears. Sometimes feel sweaty and fatigue which goes with a severe headache" (Benzeni, 53 yrs. old).*

> *"I always experience a severe headache and fatigue, but it is different for each individual for instance, hypertension can cause stroke to others" (Snakho, 44 yrs. old).*

> *"I was having eyesight problems in such a way that I had to use spectacles. Other factors that can cause BP include stress and anxiety" (Susan, 58 yrs. old).*

WHO (2013) indicates that patients' bodies are different therefore, they respond differently to both medication and the chronic illness (hypertension). The researcher

argues that in their study for the World Health Organization to not mention any symptoms also indicate that any bodily discomfort can be regarded as hypertension symptoms and that it varies for each sufferer (what one sufferer consider to be hypertension symptom can still be new to another). The excerpts above, illustrate a variety of bodily discomforts hypertension sufferers experience before or/and after dictation. Participants understood hypertension as a chronic illness that exhibits symptoms that vary from one individual to the other.

From the study it can be deduced that some hypertension patients experience hypertension symptoms before or after being diagnosed with this illness. Participants indicated that the bodily discomfort that patients experience does not necessarily go away, these symptoms are always present when there is an elevation in one's blood pressure levels.

> *"When my blood pressure levels are high I experience fatigue, and a severe headache" (Amanda).*

The ability to recognise the symptoms of hypertension allows patients to treat their condition effectively. Findings indicate that if patients understand that the symptoms existed both before and after their diagnosis, they can effectively manage their condition.

> *"I had a high blood pressure after having a stroke and I was transmitted to the hospital. The stroke caused too much damage in my head because the scan revealed that I had a clot of blood in my head and I needed to go for operation. Having a headache, feeling sweaty, eye failure and swollen ankles are other symptoms I was experiencing after having a stroke (when BP was detected) and I am still experiencing these symptoms even today…I normally drink lots of water or black tea to stop the headache" (Maria).*

Findings further suggest that a balanced diet, frequent exercise, and prescription medicine are effective ways to manage this chronic illness. Participants indicated how these healthcare routines have helped them in managing their condition from time to time.

> *"Having hypertension requires people to change their lifestyle to accommodate the illness and prevent its elevation. Having a balanced diet, exercising*

(walking), and following all the necessary information from the clinic (how treatment should be taken) helps to manage BP" (Maria).

"Yes, by following instructions from the clinic which are based on the type of food we should eat and taking treatment on time regularly. For example, we eat red apples, small portion of meat and one small cheese slice" (Thobeka).

The researcher argues that (n=20) participants from the study consume their prescribed medication, while (n=17) participants were involved in regular exercises, and (n=20) participants relied on a healthy diet. From this information or data, it can be concluded that prescribed medications, regular exercises, and having a healthy diet can help maintain this chronic illness.

5.4.2 Access to prescribed medication

The management of hypertension is of vital importance to hypertension patients. Participants indicated the need to maintain and prevent severe illnesses or diseases like stroke and heart diseases that may result from hypertension levels increasing. They indicated that taking their medications as prescribed by the doctor was important to manage the condition.

"I am using three different tablets which was given to me at the clinic. I do not want my blood pressure levels to be high. Taking your medication as instructed by health practitioners can prevent having a stroke" (Amanda).

Despite other challenges that hypertension patients faced it is important to acknowledge that the provision of their medication at no cost is a great advantage. Some participants indicated that the government provided hypertension patients with medications to help maintain this chronic illness free of charge.

The prescribed medications are free to all sufferers and made available to patients in all local clinic and hospitals all over S.A.

While participants acknowledged the strides made by the government to provide medications for free, some indicated that the time spent collecting these medications in local clinics or hospital was relatively too much. Participants indicated that they were indirect costs that they incurred in the process ranging from time spent in the health facilities and transport costs to and from these locations.

Most hypertension patients in Swayimana collect their medication in a local clinic and they spend R30 a day transport fee but there are people in S.A who live far from health facilities who need to pay double or even triple the amount the participants pay for transport to collect treatment.

The time we spend at the clinic is too much and time lost at the clinic means time lost in making money because at the end of the day we have families to feed and we also need to access food … so, we need not to spend so much time at the clinic but use this time to make something out of it.

In tandem with the findings of this study, Adams et al. (2021) argued that South African public health institutions do not charge for medical services such as medications (which treat any ailment or disease); however, the impoverished patients suffer from indirect costs such as time spent in clinics or hospitals and transportation.

It is important to note that the specific instructions for taking hypertension medication can vary depending on the type of medication and the individual's health condition. From the findings it is important to note that the administering or prescribing of hypertension medication was largely dependent on how the body or immune system responded to the medications, the type of hypertension one is diagnosed with, and how severe it was.

"Yes, I do. health practitioners also explained that if my blood pressure levels become high one can even have a stroke. But in my case I used to have low blood pressure levels, lower than a child's pressure but they gave me treatment that was able to boost it. I take four different tablets" (Jenny).

Participants indicated that hypertension medication is consumed daily, and the instruction given by healthcare workers was that the medication should be consumed after having a proper meal in the morning and in the evening. Participants cited several reasons for this instruction.

Some antihypertensive medications may interact with food or other drugs if taken together. By taking these medications after eating, potential interactions can be minimised.

Taking medications with food can help minimize potential side effects. Some antihypertensive drugs may cause stomach upset or irritation, and having food in the stomach can help mitigate these effects.

Food can slow down the absorption of drugs, leading to a more gradual increase in blood levels. This can contribute to a more stable and sustained effect of the medication, helping to control blood pressure consistently over time.

The dosage is also different, medication is consumed twice a day (morning and night) with food while some consume medication once a day (morning or night).

As indicated in the findings, medications were consumed at specific times every day. Some participants indicated that they used their phone alarm to remind themselves to consume their medication all the time and carried their medication wherever they go.

"I consume my medication twice a day at eight o'clock both in the morning and night. I set my alarm every day at 8 pm and 8am and I know it is time. So even when I go visit I carry my medication with me" (Snakho).

Participants further indicated that they were obliged to take their medications as per prescription and did so religiously because they avoided having their blood pressure levels rising. This is indicative of the knowledge they have about the repercussions of not taking their medications; risks such as stroke among others. One participant said:

"I am using four different hypertension medications which were given to me at the clinic. I do not want my blood pressure levels to be elevated. Taking medication can prevent stroke" (Amanda).

Moreover, if medications are consumed with drug substances like alcohol, can have a negative impact to the sufferer's body such as fatigue and swelling of the body. In the study some participants admitted to taking alcohol and sometimes combining alcohol and their medications despite the knowledge of the repercussions of doing so.

"I do take alcohol and sometimes I combine alcohol with prescribed medications which later leads to fatigue and swelling of the body which lasts two to three days. So at the end of the day I decided not to consume my medication when drunk". (Bhekizwe)

Every six-months full body examinations are done to hypertension patients to monitor their progress. Participants indicated that blood samples are collected to check if patients are not diagnosed with other illnesses or diseases. This is only done twice a year while parcels are collected four times a year.

> *"Yes, I do take my medication but for the last couple of months (two or three) I have not been collecting medication parcels. Because I do not believe that I am diagnosed with hypertension. Also, there is this new system (parcels) of collecting medication without seeing a health practitioner, which also has a negative impact to patients wellbeing. For instance, some patients have had strokes while on medication or became blind due to continuous treatment consuming without being observed by a doctor but collecting parcels" (Maria).*

5.4.3 Regular Exercises

For this study, most participants admitted to partaking in regular exercises daily. Participants understood regular exercises as any physical activity as long as it does not cause any harm and it is not strenuous. These activities include farming, house chores (cooking or washing dishes), and handy work.

> *"By doing house chores but doctors said I should not overwork myself" (Dorothy).*
>
> *"Yes, by doing house chores and farming" (Sebenzile).*
>
> *"Through handy work but during sunny days my body feels fatigues and I do not work on those days" (Bhekizwe).*

The excerpts above, indicates that participants generally understood regular exercises as any physical activities that allow movement of the body without causing harm or strain to the body. According to Fiandero (2023) regular aerobic exercises increases heart rate and lowers blood pressure levels and these exercises include; cycling, running, swimming, or brisk walking; as long as sufferers do not put too much pressure on themselves when doing these exercises. Hypertension patients are encouraged to take part in any physical activity that increases their breathing or/and heart rate, and they should also seek advice from a health practitioner before partaking in any exercise regime (Fiandero, 2023).

5.4.4 Eating a balanced diet

Based on this study, participants demonstrated all the necessary information required to maintain this chronic illness and all participants admitted to that as well. From their responses, it can be said that having a balanced diet is of vital importance and is a priority to all patients and their families.

> *"By following instructions from the clinic which are based on the type of food we should eat. For example, we eat red apples, small portion of meat and one small cheese slice" (Thobeka).*

> *"Having a good diet which means eating a healthy food, like boiled vegetables and meat, eating fruits and drinking a lot of water. Do not eat oily and salty food" (Maria).*

Most participants also admitted to having a balanced diet daily even with poverty and unemployment as a challenge, but they still try their best to do so. Some participants eat once or twice a day instead of having three to four meals a day, this shows how poverty has limited patients to having nutritious meals and it can also be reason why people became susceptible to hypertension.

> *"Eating healthy makes me happy but I buy food products that I can afford. We live in a rural area which is rich in soil therefore, farming is good for us. I do not use any chemicals in my vegetables" (Samkelisiwe).*

Also, some participants indicated that prescribed medication seemed to not work for them because they eat when there is an availability of food then medication will be taken on those days, but without food medication cannot be consumed. Thus, the availability of food determines if medication will be consumed and for how long.

> *"It means eating boiled food but for me it different because when I follow these instructions of eating boiled food my blood pressure levels will be high but when I eat any kind of food whether it is healthy or junk food my blood pressure levels will be normal" (Snakho).*

Furthermore, a balanced diet does not necessarily mean eating vegetables and fruits only, but individuals can also eat starch (rice and maize meal). From the findings it was evidenced that not every participant could afford food products with less starch or

even fruits on a daily. Findings indicated that the most important thing for patients was eating food products they could afford and available (food they can produce) to them like avocados, beans, sweet potatoes, and yams. These products are produced by participants since most of them are involved in subsistence farming.

> *"Living a healthy lifestyle helps in fighting illnesses in the body. I normally eat boiled food and vegetables from my garden like sweet potatoes and yams" (Benzeni).*

In Swayimana, women cultivate vegetables in their gardens, including green peppers, carrots, onions, and cabbages, which they sell and use for their families' food. Community members can grow these vegetables on a big scale with government assistance, but it is difficult to produce enough of them for urban areas due to weather variations that pose problems to cultivation.

> *"When one has hypertension, they should not eat oily food and in the rural areas we eat vegetables like sweet potatoes, mealies, and spinach mixed with Momordica Balsamina but sometimes the weather makes it difficult to produce food at a large scale or for selling" (Sebenzile).*

According to Oluwatoyin et al. (2021) nutrition plays an important part in preventing stroke and hypertension. Previous researchers have identified nutritional factors that elevate blood pressure levels (while causing people to be prone to hypertension when not diagnosed) and these nutritional factors include high consumption of alcohol and salt, cholesterol, and consumption of foods high in saturated fatty acids (Oluwatoyin et al.,2021). Foods that have been proven to provide cautious effects to hypertension and stroke sufferers include; fruits, foods rich in whole grains, vegetables, fish and oil (Olive oil), milk, and dairy products (WHO,2023). However, the most used strategy is DASH (Dietary Approaches to Stop Hypertension), this diet is rich in vegetables; fruits, low fats, low-fat dairy products, and low salt and sugar intake (WHO, 2023).

Participants in the study indicated that they consumed boiled vegetables while some participants admitted to eating meat, while some indicated that fruits were a major part of their diet. However, some indicated that they ate oily food, some consumed salty food, while others admitted to eating meat. The following responses give an idea of

participants views and preferences when it comes to a balanced diet and how they stick to it:

> *"Living a healthy lifestyle is a challenge to everyone since we have to be careful of what we eat and do regular exercises. Some people are even overdosing their medications due to not having someone to assist with medication intake, good nutritional food is of vital importance, and it include eating a fruit once a day (balanced diet). People should take their health seriously and be careful of what they eat…Having a good diet means eating healthy food like boiled vegetables and chicken meat, fruits, and drinking lots of water. Do not eat oily and salty food" (Maria).*

> *"Eating healthy food can prevent and maintain BP for example, an individual should not eat oily and salty food, and too much starch like eating rice continuously but eat boiled vegetables and do regular exercises…It means making necessary lifestyle changes to make life better and follow all health practitioner's instructions, but sometimes I eat tripe (usu) (it has too much saturated fats). I normally drink warm water after eating to flush saturated fats to prevent any harm to my health" (Susan).*

The excerpts above, indicate that there is a general understanding of the importance of making dietary changes and how participants tried to manage hypertension using a balanced diet. Naik (2021) states that the aging population, urbanization, and poverty have also contributed to the increasing number of hypertension patients in S.A. Thus, poverty is seen as a significant vulnerability because it limits hypertension patients' choices for a healthy lifestyle, such as access to timely healthcare and nutritious food. This was the case with study participants in Swayimana who indicated that they relied on subsistence farming and growing their own food to be able to overcome poverty and unemployment.

In another study by Risenga (2002) indicated that some hypertension patients die before reaching the hospital and cited that lifestyle changes that require behavioural adaptations and long-term regimes were the likely causes. In most cases, behavioural changes usually present challenges to traditions, cultural values, and patterns that involve daily activities, lifestyle, and dietary habits (Risenga,2002).

It must be noted that participants had their own preferences and views when it comes to food products, they could eat and how it should be prepared. For example, some participants admitted to consuming alcohol and red meat; too much salt and oil intake and eating high-fat dairy products.

> *"Well, I eat too much cheese and meat, even though we are not allowed to do so but I always make sure that I eat boiled food, fruits and vegetables. Cheese is my favourite that is why I cannot stop" (Thobeka).*

> *"It means eating boiled food, but I put too much salt and oil in my food when I am cooking, eating food without oil or salt is impossible" (Ouma).*

It is important to note that these challenges may have a negative effect on the health of people with hypertension and their families because they increase the risk of developing the same chronic illness (as well as other illnesses and diseases). This may cause patients to believe that their hypertension is inherited or has a family history. For instance, some study participants acknowledged using medication and alcohol together, which led to bodily oedema and exhaustion.

> *"No, I do not. For example, if I am drunk, I will not take my treatment because my body will be swollen and I also experience fatigue for days" (Bhekizwe).*

According to Naik (2021) poor lifestyle choices that people make should be blamed for the increasing number of hypertension patients among South Africans. Hypertension statistics have increased by more than thirty percent in Africa, with a predictable 36% of women and 31% percent of men in S.A affected. The latest South African National Health and Nutritional Examination Survey (SANHANES) also indicated that "people affected the most are the ones in rural areas with 39.6%percent, followed by Urban areas with 37.1 %, and urban settlements being the lowest area" (Jennings cited in Naik, 2021:1).

Naik (2021) and Jennings (2021) argue that behavioural adaptations play a crucial role in the wellbeing of hypertension patients. Thus, hypertension patients in Swayimana area are not any different either, especially since it is a rural area. Making behavioural changes and taking long-term regimes seriously can help maintain blood pressure levels for hypertension participants in Swayimana and S.A. at large.

5.5 Combining Western and Indigenous medications

The use of African traditional medications has been done for a very long time, even during the Khoi San era, they relied on plants and fruits to cure illnesses and diseases (Goma et al., 2016). The researcher argues that combining both medications makes it difficult to determine the effective of prescribed medication and the negative impact of indigenous methods. According to Tsabang et al. (2016) patients search for other alternative medications and reasons why chronic illnesses like hypertension cannot be cured but be maintained with prescribed medication. Due to community development and improvement in people's lives, Western medications were introduced to make life easier and better (Goma et al.,2016). Research and tests have been done to prove the capability and side effects of Western medications for all diseases and illnesses (WHO,2017; Discovery Health,2020; Micklefields et al., 2022).

5.5.1 Indigenous medications

Based on this study, some participants admitted to combining prescribed medication with indigenous plants to maintain this chronic illness. However, some participants were not convinced about the use of indigenous plants but have heard of the plants that they could use to maintain this illness through communicating with friends, family members and other patients.

> *"I do not use any indigenous medications. I have heard other patients saying that they use Aloe Vera plant but I haven't tried it before since I'm scared of bitter herbs" (Jenny).*

> *"I have heard that plant medications help in lowering this illness. Plants like Aloe Vera, Aloe Arborescens and Momordica Balsamina" (Makhuluphala).*

According to Oluwatoyin et al. (2021) when it comes to indigenous plants, different parts can be used like the leaves; stem, roots or seeds, even vegetables, fruits, herbs, and grains can be used as traditional dietary therapies by hypertension patients.

Participants had interesting responses when it came to the use of indigenous methods, they used to maintain hypertension. *Momordica balsamina* was the most consumed plant among participants and they indicated that the plant could be consumed on its own or mixed with other indigenous plants like *Aloe Vera* and *Aloe Arborescent*, to make African traditional medication. Below are some of the responses of the sample,

who cited are range of African traditional medicines that participants consume to maintain hypertension:

> *"I drink my Momordica balsamina in the morning than take prescribed medication before going to bed (at night). African traditional plants or medicines work better than Western medications which is the reason why I take both medications…Yes, I drink Momordica balsamina and if missed my blood pressure levels will be high" (Dorothy).*

> *"Yes, I drink Aloe Vera, Aloe Arborescent, Momordica balsamina, and Blackjack. These plants work better than Western treatments" (Snakho).*

The extracts demonstrate that the participant's understanding of the use of traditional medicines to manage hypertension was universally accepted. From the findings it was noted that participants typically combined plant-based remedies with Western prescription drugs. The excerpts also demonstrated that participants combined several plants to create these medications; for patients, the results are more important than the harm that combining medications may have on their bodies.

5.5.2 Reasons participants combine medications

Hypertension patients use indigenous methods for different reasons for example, financial constraints due to hours spent in clinics instead of working and transport costs, behavioural changes, long-term regimes, and belief systems. However, for this study, hypertension patients' in Swayimana area consume African traditional medications because of its convenience, belief systems, and side effects caused by Western medications.

5.5.2.1 Availability of African traditional medication

Indigenous methods of medication are used by most participants due to its availability and less time used to prepare it. From the findings it was evidenced that African traditional medications can be made in the comfort of their homes without having to spend money on ingredients because these are natural plants that participants have in their homes.

> *"I drink Momordica Balsamina which I have in my garden and if I missed drinking these herbs my blood pressure will be high" (Dorothy).*

In most cases, participants used plant leaves to make their medication but for *Aloe Vera*, they used the jelly found inside the green outside layer. Participants cited the advantages of traditional medication over western, for example, *Momordica balsamina* leaves can be added when cooking spinach or boiled with water.

> *"I am not using any home-made remedies, but I have heard that drinking boiled or chewing Momordica Balsamina leaves helps to lower hypertension" (Mbali).*

Findings indicated that traditional medication was an advantage for many participants because there was no prescription and instructions on it on how it can be consumed. Participants in the study cited that they consumed indigenous medication anytime they want even during the day there is no specific time, and they choose how they want to use medication.

> *"I normally boil Momordica Balsamina, Aloe Vera, and Eucalyptus. you can take these herbs in an empty stomach and at any time but Western medication must be taken after eating" (Susan).*

Plant medications that the study participants mentioned can be taken once or twice a day, without food, and at a dosage of half a glass. However, some individuals acknowledged taking prescribed medication at night after consuming traditional African drugs in the morning due to the combination of western and indigenous medications. Participants who take their prescription once daily do this, but even those who take it twice daily acknowledged using this strategy, provided that a period of time passes between doses due to the fact that the medications have separate mechanisms of action and must be taken for both to be effective.

> *"I drink my Momordica Balsamina in the morning than take my medication before I go to bed. Traditional herbs work better than Western medication which is why I take both Western medication and traditional herbs" (Dorothy).*

Participants had their own views and preferences on how they preferred to take indigenous medications for instance, some participants admitted to chewing the plant leaves, while others boil or mix the leaves of indigenous plants when cooking food like spinach. The responses below, are a range of ways participants make or consume indigenous medications:

“I drink Momordica balsamina which lowers my blood pressure levels… When an individual has hypertension, they should not eat oily food and in rural areas we eat vegetables like spinach mixed with Momordica balsamina leaves. In other words, Momordica balsamina can be added in food when cooking” (Sebenzile).

“I chew Momordica balsamina leaves, not every day though” (Ouma).

“I normally boil Momordica balsamina, Aloe Vera, and Eucalyptus. You can take this medication without food, but Western medications must be taken with food” (Susan).

The excerpts above illustrate the convenience and less time used to prepare African traditional medications when compared to western medication that came with a lot of instructions on dosage and times set to consume them. Participants saw this as an advantage and cited that these indigenous plants are not costly and could be found in their homes (gardens). The researcher points out that participants reported suffering certain adverse effects from taking hypertension tablets, and she suggests that these side effects could be brought on by a mix of prescription and over-the-counter medications. Western medicine is sometimes blamed for these adverse effects since participants have a strong belief system that values their traditional therapeutic practices.

5.5.2.2 Adverse reactions to prescribed medication

Previous research indicates that all medications have some negative impact on the health of their users; the only distinction is that each person's side effects are unique due to the differences in how each person's body responds to medicine (WHO,2023). Because of this, some patients may have adverse effects while others may not; similarly, in this study some participants reported having side effects while others did not. Some scholars argue that every patient has a varied response to treatment, but the most important thing is to ensure that the patient's everyday activities are not negatively impacted. Most study participants acknowledged that they have had side effects from prescribed medication ever since they began taking medication. Apt to note is that these side effects differed from one individual to the other. Below are excerpts elucidating this finding.

“Ever since I started taking treatment, I feel sweaty, dizzy and I experience a severe headache” (Ouma).

“The Western treatment does not lower my blood pressure instead it causes a headache” (Makhuluphala).

“I still have this headache but once I have taken my medication, I will be fine. I always experience body pains” (Benzeni).

*H*owever, native herbs have negative effects, but participants are either unaware of them or may not be paying enough attention to them. Some participants further indicated that, if medication is not taken as prescribed, it may not be beneficial and could even be harmful to the patient's health. The following responses express the samples experience with prescribed medication:

“When I missed taking treatment on a particular day, I will experience a severe headache and fatigue” (Mandy).

“When I was diagnosed with hypertension, I did not experience any symptoms at all. I had leg pain which elevated my blood pressure levels. After starting medication, I experienced severe headaches especially when my blood pressure levels are high” (Samkelisiwe).

“For some people, when they are taking treatment their hypertension levels drop in a way that affect them negatively. I can say that taking Western medications can have both positive and negative effects in human life. For me, I normally experience a headache and eyes problems especially when it’s hot. Drinking lots of water and black tea also helps in curing the headache without taking any medication. Also, taking Western medication affects my religious practice of fasting, since I need to take medication with food daily. When fasting, I am not supposed to eat anything which is the reason I do not take treatment during my fasting period” (Maria).

Findings suggest that some participants believed that most of the time, taking medication on a regular basis can make it less effective for the user because it is used for longer than necessary. Below is an excerpt indicating the argument made;

“My heart will beat slowly when I missed taking my treatment. Since I also take another treatment for another illness, I was told to take these treatments on

different days. So if on Monday I took my hypertension treatment than on Tuesday I have to take my bones treatment not the hypertension treatment which causes my heart to beat slowly and having sleepless nights. This causes medication to not be effective" (Thuleleni).

The excerpts above illustrated views and personal preferences regarding Western medications. Participants seemed to rely more on African traditional medications than on Western medications, due to what they considered as side effects of this treatment. Similarly, Khalikova (2021) stated that patients normally search for other alternative therapeutic options that works for them and their bodies. For patients, what matters most is the impact that the alternative medicine has on their bodies, not whether or not African traditional medicines provide specific therapeutic treatment.

From the findings it was evidenced that belief systems play a crucial role in people's lives and in understanding their surroundings. In this case it is African traditional beliefs, where patients believe that indigenous methods can cure illnesses or diseases since prescribed medication can only manage this illness. From the study it was evident that hypertension patients are trying to look for a cure that will work for their bodies and through social interactions, they share indigenous plants they consume which works for them and how to make the medication.

De Wet et al. (2015) in their study outlined that thirty-one patients out of fifty hypertension patients were using both prescribed western and alternative medications to treat hypertension but none of them had revealed this to their health practitioners. This was also evidenced in the findings of this study where fifteen patients out of twenty hypertension participants admitted to combining Western and African traditional medications but had never indicated that to their healthcare practitioners.

According to Rahmowati and Bajorek (2018), people with hypertension choose alternative drugs because they are cost-effective, readily available, safe, and recommended by friends or family. They also utilize African traditional medications because they are culturally appropriate. According to Tsabang et al. (2016), however, people with hypertension depend on traditional medicines since Western treatments are costly, they have different lifestyles, and they are unable to visit medical facilities. According to the study's findings, people with hypertension in the Swayimana, Emahlathini area prefer African traditional medicines since they are more convenient,

needless preparation time, and don't have the negative effects that come with Western drugs.

From the findings it was indicated that participants typically learnt which plants to use or combine through routine interactions at the clinic when they gather to pick up their prescriptions. This behaviour is explained by the theory of social construction, which holds that reality can be objective and that knowledge is constructed and understood via daily interactions (Berger and Luckman, 1991).

5.6 Conclusion

The findings pointed to two primary problems: first, the patients believed that traditional medicines could more successfully control blood pressure, and second, they believed that characteristics such as obesity, age and gender, family history, and belief systems could contribute to an individual's susceptibility to hypertension. It was deduced from the findings that this chronic illness can be managed, and symptoms can be recognized. Patients' primary choices for managing hypertension included combining prescription and traditional medicine because of cultural convictions, availability of native plants, and budgetary limitations. The following chapter will conclude the study.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter begins by meditating on the thesis title below to refresh the reader's mind and dwells on the relevance of theory adopted in this study. Findings from the study are briefly discussed in this chapter. The chapter describes the limitations of the study and explores the contribution that the study makes to the body of knowledge. Finally, recommendations, and conclusion are presented.

6.2 Title of the dissertation

Understanding illness in a local community: an exploration of the socio-cultural impacts of hypertension in patients and their families in Swayimana location, KwaZulu-Natal is the title of this thesis. This title was influenced by the daily challenges, cultural and societal beliefs hypertension patients and their families have in Swayimana. The challenges that they face regarding this chronic illness and perceptions or cultural practices that in most cases influence their decision- making and treatment choices. The research solidly fits within the realm of medical anthropology studies.

Since its inception, medical anthropology studies have placed strong emphasis on average people's lived experiences "subjective experiences" rather than wholly or detached academic studies, and in current years, this has extended to "life tales" of everyday challenges, coping strategies they use to cope with life experiences, and culturally or societally influenced decisions made by patients and their families. This approach of paying close attention to narratives of patients and their families- their socio-cultural perceptions and understanding of the phenomenon, their every challenges, their care management and way of giving awareness, and coping strategies (type of medication they consume either prescribed or indigenous) with the help of their families- seemed to make significant contribution to the medical anthropology field studies.

The title took on a socio-cultural tinge by hypertension patients and their families (voluntary) as essential participants, a population segment that its cultural beliefs, perceptions, traditional practices, and daily challenges are considered irrelevant and are not acknowledged in health policy developments and most medical study

endeavours in South Africa. The researcher argued that given the countless burdens that patients and their families faced on a daily basis, they deserved to be heard and their cultural beliefs or practices needed to be acknowledged as well.

6.3 Summary of the study findings

This study aimed to ultimately discover the role of culture, beliefs, and traditional practices in how hypertension is perceived in local communities, and primarily find solutions and more information that can assist public health and those who suffer from hypertension without negatively affecting their treatment use, cultural and traditional practices and beliefs. Findings indicated that patients' decisions are influenced by both social and individual perspectives, some which are based on shared experiences and others on personal experiences. Additionally, it was deduced that hypertension patients employ a variety of strategies to manage and control their condition, including dietary modifications, consistent exercise, and the use of herbal remedies in addition to prescription drugs. The summary of the findings is presented below:

6.3.1 Socio-cultural perceptions

It is evident that participants in the study had their perceptions drawn from personal experiences and shared knowledge from friends, family members, and other patients' The literature revealed that sufferers' perceptions are related to their cultural beliefs, traditions, and practices. The study findings however revealed that sufferers in Swayimana area believed that age and gender factors; obesity, family history, and belief systems cause people to be susceptible to hypertension. Age and genders factors were the dominant cause among sufferers in Swayimana, Emahlathini area. Literature indicated that the supernatural and spiritual factors (witchcraft, sorcerer and ancestor) can be a cause of illnesses and only traditional healers with the use of the supernatural methods can determine the cause and find a cure (indigenous medicines) especially in rural areas (Miller,2011).

6.3.2 Care Management and Medical Awareness

Based on the study findings, was evidenced that patients understood the importance of having necessary information about this illness, its care management, and medical awareness. Having all the necessary information was argued to help prevent people from being prone to this illness and learn ways to do so. From this finding it was

indicated that patients' bodies are different, and they also respond differently to illnesses and treatment for example, elderly people are more susceptible to hypertension compared to young people, and they experience multiple bodily discomfort. participants admitted to experiencing bodily discomfort which they considered to be hypertension symptoms and these included shortness of breath, severe headache, and fatigue. These symptoms differ from one individual, and they are present when there is an elevation of blood pressure levels.

To manage hypertension, participants admitted to consuming prescribed medications, doing physical activities, and having a balanced diet. Participants consumed different medications and dosages were notably different as well, but medication was commonly consumed twice a day (at the same time every day). Due to unemployment and poverty which limits most hypertension patients' access to healthy food, the availability of food determines how long medication will be taken and the dosage, meaning medication is only consumed when food is available only.

participants also indicated their need to take part in physical activities that does not cause bodily harm or strain, activities such as cooking and handwork, they considered these activities as part of their regular exercises. Lastly, patients normally have a healthy diet but it must be noted that they consume foods affordable to them, available, and food that they could produce like yams; spinach, sweet potatoes, and beans. Food products that participants consumed in the study included boiled vegetables; fruits (red apples), oily food (fried food), salty food (high fat dairy products like cheese), and meat (beef). Having a balanced diet, doing regular exercises, and prescribed medication intake seemed to work for most participants in managing this illness since it cannot be cured.

6.3.3 Combining Western and Indigenous medications

From the findings it was evidenced that some participants in the study combined their prescribed treatment with indigenous plants, such as Momordica balsamina, Aloe Vera, Aloe arborescent, blackjack, Eucalyptus, and incense bush to cure hypertension. For participants, it was not about whether indigenous medications work in bringing determinate therapeutic relief or not but what mattered to them was the effects that indigenous plants produced in their bodies. The reasons for combining medication were mainly drawn from participants' African cultural beliefs; the convenience that

indigenous plants have, and the side effects caused by consuming western treatments. When prescribed medications are consumed for a long period of time or when not needed, they are arguably not effective; medication should be used when needed with the right dosage, and on daily basis at the same time for it to be effective.

6.4 Implications of the Social Constructionism theory

The care management, medical awareness, treatment involvement, and how sufferers perceive hypertension can be better understood drawing arguments from the Social Constructionism theory. The theory of *Social Construction* highpoints the significance of knowledge to society and how it develops; how knowledge is generally constructed and shared. This theory emphasizes that knowledge is constructed through social interactions, symbolic, and social relationships. In other words, social relationships or interactions needs to take place for knowledge to be created and shared either among family members, friends or people in general. Some knowledge is passed on from one generation to the next becoming habitual among family members or in a community for instance, cultural practices or beliefs (spiritual factors).

Furthermore, this theory states that there are two types of reality namely objective and subjective reality. Objective reality is formed through social interactions with the social world, which later influence individual behaviour leading to routines and habits (Berger and Luckmann, 1991:1). While subjective reality is “being given identity and place in society”. It involves shared experiences and understanding during social interactions, it may be primary or secondary socialization for instance, sufferers are provided with the necessary information about hypertension; its cause and treatment but due to social interactions and shared experiences, they have established their own opinions, preferences, and understanding about this illness, its causation, and treatment involvement. These opinions and inclinations become habits due to both realities, which may have an impact in how traditions; African traditional beliefs, and cultural practices were created.

Each community seems to have their own beliefs, norms, and practices but so does each and every family, this leads to the diffusion of culture where Western and African traditional beliefs are diversified, like when an individual move from their society to an Urban area (i.e. S.A to U.K), they have to familiarize themselves and abide by the

society's cultural practices, norms and way of living. This leads to developing new habits and knowledge being shared among people of different geographical areas.

Nevertheless, the *Social Construction* theory is more concerned with the construction and understanding of knowledge, it tries to understand how people construct and understand knowledge and reality. Based on the findings, implications of *Social Constructionism* used in this research are as follows:

6.4.1 Socio-cultural Perceptions

Findings indicated that hypertension sufferers in Swayimana, Emahlathini area had their own views and understanding of who can be susceptible to hypertension. The way sufferers perceive this illness was either due to personal experiences or societal beliefs and shared knowledge. According to the theory of Social Constructionism, how reality is perceived is based on shared assumptions and knowledge is developed in a social context (Berger and Luckmann, 1966). Knowledge can never be created by one individual but requires social relationships and interactions to be created and shared, so does patients' perceptions about this illness. Some patients needed to face difficulties or traumatic experiences to have an in-depth understanding of this illness or shared experiences during social interactions with friends, family members or other sufferers. This shared knowledge or personal experiences give them insight and a better understanding leading to various perceptions from people of the same geographical area due to their experiences, understanding, and opinions.

6.4.2 Care management and medical awareness

In Swayimana, Emahlathini area hypertension patients experience bodily discomfort which differs for everyone, as previous studies states that elderly patients have weak bodies and are more susceptible to illnesses and diseases compared to younger sufferers (WHO,2023). The findings indicated that patients manage hypertension through prescribed medication taken daily (once or twice a day- daily dosage), doing regular physical activities like house chores, and balanced diet intake. Patients had their own preferences and views of food acceptable to them and they considered foods they could afford and available to them as a suitable diet for hypertension. The availability of food also determines medication dosage and the period in which medication will be taken because on some days' medication is not taken due to lack

of food. The high rate of unemployment has limited sufferers to have access to nutritious foods.

The theory of social constructionism takes into account the impact made through social relationships and interactions in creating and sharing knowledge or reality. It also understands that reality can be objective and that social interactions influences individual's actions resulting in habits and routines. Meaning, frequently reaffirmed actions become a pattern reproduced without effort, allowing people to be involved in innovation than to start everything afresh i.e. consuming medication twice or once a day becomes a habit when patients are diagnosed with hypertension. Social interactions allow patients to share knowledge with friends, family members, on ways to manage the condition.

6.4.3 Combining Western and Indigenous medications

Findings indicated the impact of the belief system that most participants had. The African traditional belief system was seen as the most influential system which most participants ascribed to. This belief system can be argued to have led to the intake of both Western and African traditional medications by participants citing financial constraints, side effects of prescribed treatment, and convenience of indigenous plants. As the Social Construction theory states, knowledge is created through social interactions within a community and it encourages everyday communication between individuals, which leads to the construction of reality through language. Meaning that, the supernatural, spiritual factors, and African traditional medication beliefs were created and shared among patients through social interactions, with friends; family members or other sufferers, or through shared past experiences.

To conclude, the Social Constructionism theory accentuates the vital importance of recognizing belief systems (supernatural or spiritual beliefs or indigenous methods belief), cultural perceptions and social experiences of hypertension patients regardless of age group or gender social interactions and relationships. It is important to note that paying more attention to sufferer's beliefs and past experiences can contribute immensely to how the condition can be managed on a wider spectrum.

6.5 Contributions and Recommendations of the study

This study makes the following contributions and recommendations:

1. This research contributes to anthropological evidence that Swayimana, Emahlathini area hypertension patients combine western and indigenous medications due to the accessibility of African medicine and the negative side effects caused by prescribed treatments.

2. The *Social Construction* theory gave an in-depth understanding of hypertension patients' phenomenological experiences in a detailed context. This theory was of great help to the researcher in having a better understanding of the socio-cultural perceptions, its care management and medical awareness, treatment involvement of hypertension, and challenges that patients face on daily basis at Swayimana, Emahlathini area.

3. The findings also revealed that patients experience bodily discomfort which they considered to be hypertension symptoms, they experience these symptoms before and after hypertension has been detected. The symptoms interfere with their daily activities and they differ for each patient. As WHO (2013) stated that hypertension does not usually show any symptoms but further investigations should be done on whether hypertension shows any symptoms or not, if it does, indicate the symptoms that are associated with this chronic illness.

4. It is recommended that patients are forewarned about combining prescribed medication with herbal remedies because negative side effects for doing so are not known.

5. It is recommended that future studies on a similar research design integrate all races and age groups. The findings of a more demonstrative sample can be generalized.

6. Due to the fact that hypertension is a global problem, there is a dire need for all embracing qualitative research to explore the socio-cultural impacts of hypertension to its patients and their families during crisis situations (such as the pandemic).

7. It is also recommended that future research be done probing the reasons why male hypertension patients find it difficult or uncomfortable to talk about this chronic illness and the challenges they face every day.

8. It is recommended that the government provide support to patients and their families because they have a lot to deal with excluding hypertension and it challenges. Poverty is one of the factors that has limited patients and their families to a balanced diet.

9. Acknowledging patients and their families' cultural perceptions, beliefs, and preferences can help in finding better ways to decrease the high rate of hypertension in South Africa.

10. Having programs in clinics or in communities especially in rural areas that encourage regular physical exercises can also help patients be motivated in doing these exercises even at home. Like having classes during treatment collection dates where patients are shown exercises they can do at home.

11. Counselling to be also provided not only to patients but to their families as well because they are the ones who should provide more support to patients and have to face challenges like financial constraints while they still have to maintain their behavioural changes. All of these challenges can lead to stress especially to old people.

6.6 Limitations of the study

This study had the following limitations:

i. The study was conducted in one area at Swayimana, Emahlathini area in Pietermaritzburg therefore, the findings cannot be comprehensive and generalized to other areas in PMB or KZN.
ii. The collection of data was done during the COVID-19 pandemic era where protocols and safety measures restricted access to hypertension patients who are not pregnant, on medication, and age restriction of eighteen and fifty-eight years old. Likewise, the researcher obeyed all the rules as anticipated by the University of Kwa-Zulu Natal (UKZN) Research Ethics Committee and COVID-19 national protocols.

iii. The study conducted one-on-one interviews and not focus groups, which limited the depth and range of data to some level. Since this is an Anthropological study, it would have been advantageous to have an insight into collective experiences of hypertension patients through focus group discussions, but due to COVID-19 restrictions it was not possible.

iv. This study recruited more female participants than males and it was older female participants, few middle-aged females took part, possibly because older female participants were more willing, comfortable, and found it easier to speak about hypertension and their everyday challenges when compared to the counterparts.

6.7 Conclusions

The socio-cultural impact of hypertension to its patients and their families in Swayimana, Emahlathini area of PMB, KZN were explored in this study. The care management, medical awareness, patients' perceptions, and treatment involvement were the primary focus of this research. This study was guided and shaped by the Social Construction theory, which made it possible to have a thorough understanding of difficulties, challenges, beliefs, perceptions, and the management of hypertension to patients and their families. This was a qualitative enquiry, open-ended interviews (one-on-one) were used to gather data which was later analysed paying attention to the tenets of thematic analysis.

Additionally, the findings of the study made some strong numeral vital facts. Foremost, the health sector does not necessarily take into account sufferers' views and challenges. Evidently participants in the study have experienced a lot and their knowledge and understanding are influenced by their experiences and beliefs. According to participants in the study people are susceptible to hypertension because of factors such as obesity; age and gender factors, belief systems, genetic factors, and indigenous methods can be of help in decreasing blood pressure levels. Participants hold these perceptions due to past experiences, personal opinions or shared knowledge from family members, friends or other sufferers.

The participants' views and preferences on how to treat and raise medical awareness of this chronic illness varied. People were made aware of the signs of hypertension that they should be aware of, as those who suffer from the condition must have a clear

knowledge of what to look out for. The patients acknowledged feeling a range of physical aches and pains both before and after their hypertension was identified. Even though the World Health Organization stated that there are typically no signs for this chronic illness and did not include any specific symptoms, more research is necessary to validate this because each person's body is unique and reacts to illnesses differently. Patients with hypertension can better control their condition by taking their prescribed medications as directed, getting regular exercise, and eating a balanced diet.

In general, the research highlighted the critical role that the Social Constructionism theory plays in developing a thorough grasp of the perspectives that individuals with this illness hold on its medical knowledge and management, as well as their involvement in treatment. When participants were looking for alternative treatments, their perceptions may have had an influence on how they combined prescription and herbal medications. Because of their affordability, convenience, and perceptions of African traditional medicines, native plants were used for self-medication to control participants' high blood pressure.

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Appendix A: Ethical clearance approval

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

21 August 2021

Miss Nqobile Princess Sishi (215001108)
School Of Social Sciences
Howard College

Dear Miss Sishi,

Protocol reference number: HSSREC/00003052/2021
Project title: "Understanding chronic illness in a local community: an exploration of the socio-cultural impact of hypertension in patients and their families at Swayimane location, KZN".
Degree: Masters

Approval Notification – Expedited Application

This letter serves to notify you that your application received 30 June 2021 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

This approval is valid until 21 August 2022.
To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

All research conducted during the COVID-19 period must adhere to the national and UKZN guidelines.

HSSREC is registered with the South African National Research Ethics Council (REC-040414-040).

Yours sincerely,

[redacted]

Professor Dipane Hlalele (Chair)

/dd

Humanities and Social Sciences Research Ethics Committee
Postal Address: Private Bag X54001, Durban, 4000, South Africa
Telephone: +27 (0)31 260 8350/4557/3587 **Email:** hssrec@ukzn.ac.za **Website:** http://research.ukzn.ac.za/Research-Ethics
Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville
INSPIRING GREATNESS

Appendix B: Gatekeeper clearance

GCUMISA TRADITIONAL COUNCIL

TEL.: 033 5030 678

FAX: 033 5030 678

CELL: 079 851 7761

CELL: 079 416 7014

P.O BOX 35604

WARTBURG

3233

PERMISSION TO CONDUCT A STUDY

I ..MAJOLA KHALEZI [illegible].......in my capacity as Inkosi/ Induna grant you gatekeeper clearance to conduct your study at Swayimana location, Emahlathini, towards your Master's degree. We note the title of your research is:

"Understanding chronic illness in local communities: an exploration of socio-cultural impacts in patients with Hypertension at Swayimana location, KZN".

It is noted that you will be constituting your sample by conducting interviews with hypertension patients as well as with people who are living with hypertension patients at Emahlathini, Swayimana Location, KZN. During interviews no participants should be treated unfairly or made feel uncomfortable and all the collected data must be treated with due confidentiality and anonymity even with the use of recording tapes, no one should listen to those recording tapes excluding the researcher and supervisor. All the collected data should only be used for your Master's degree project and must adhere to all the COVID 19 protocols during those interviews.

Yours Faithfully

[redacted]..............

Inkosi/ Induna

GCUMISA TRADITIONAL COUNCIL

2021 -03- 09

P.O. BOX 35604 STAMP
WARTBURG 3233

Scanned with Fast Scan

Appendix c: Consent form

INFORMED CONSENT FORM UKZN 2020
MASTERS RESEARCH

UKZN INFORMED CONSENT DOCUMENT (RESEARCHER: NQOBILE SISHI)

Dear Participant,

My name is Nqobile Princess Sishi. I am a Masters candidate studying at the University of KwaZulu-Natal, Howard College. The title of my research is: *Understanding chronic illness in a local community: an exploration of the socio-cultural impacts of hypertension in patients and their families at Swayinana location, KZN.* The aim of the study is to have an exploration of peoples understanding, perceptions and challenges that they face daily since they live with hypertension. I am interested in interviewing you so that you can be able to share your experiences and observations on the subject matter.

Please note that:

- The information that you provide will be used for scholarly research only.
- Your participation is entirely voluntary. You have a choice to participate, not to participate or stop participating in the research. You will not be penalized for taking such an action.
- Your views in this interview will be presented anonymously. Neither your name nor identity will be disclosed in any form in the study.
- The interview will take about 30 minutes.
- A recording tape will be used to record the interviews as proof that interviews were conducted.
- The record as well as other items associated with the interview will be held in a password-protected file accessible only to myself and my supervisors. After a period of 5 years, in line with the rules of the university, it will be disposed by shredding and burning.
- If you agree to participate please sign the declaration attached to this statement (a separate sheet will be provided for signatures).

I can be contacted at: School of Social Sciences, University of KwaZulu-Natal, Howard College Campus, in Durban. Email: 215001108@stu.ukzn.ac.za

My supervisor is Dr Gerelene Jagganath who is located at the School of Social Sciences, Howard College Campus, and Durban of the University of KwaZulu-Natal. Contact details: Phone number: 031 260 7332.

The Humanities and Social Sciences Research Ethics Committee contact details are as follows: Ms Phumelele Ximba, University of KwaZulu-Natal, Research Office, And Email: ximbap@ukzn.ac.za, Phone number 0312603587. **Thank you for your contribution to this research.**

DECLARATION

I..... (Full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project. I understand that I am at liberty to withdraw from the project at any time, should I so desire. I understand the intention of the research. I hereby agree to participate. I consent / do not consent to have this interview recorded (if applicable).

SIGNATURE OF PARTICIPANT DATE

....

ANTHROPOLOGY, MASTERS RESEARCH 2020
STUDENT: NQOBILE SISHI, 215001108
SUPERVISOR: DR GERELENE JAGGANATH