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Accessing health care in impoverished communities: The experiences of women living with hypertension and related conditions in the townships of Kwatsaduza, Gauteng province

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Supervisor: Dr Somaya Abdullah
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DEDICATION

This mini dissertation is dedicated to the people mentioned hereunder who have played a positive role in my academic journey.

God, whose amazing grace and favour saw me through every doubt in my academic journey. Thank you for giving me the strength and courage to complete this dissertation.

My prayerful grandmother, Tsepile Mabel Mokone-Ngwenya. You have been supportive throughout the years, from my undergraduate up to date. You believed in my vision and supported me financially, emotionally and spiritually. Your prayers pulled me through my toughest days. Thank you for allowing me to fly her. My brother, thank you for the random cups of coffee and lollipops that kept me going.

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ABSTRACT

This study explores the experiences of women living with hypertension and related medical conditions in accessing healthcare services in the townships of Kwatsaduza in Gauteng. The objectives of the study are to: understand the effects of hypertension and related conditions on women living in poverty in Kwatsaduza; explore the impact of poverty on treatment adherence for hypertension and related conditions; explore the experiences of accessing healthcare services by women living with hypertension and related conditions in Kwatsaduza; and to examine how women cope with their diagnosis. The participants in the study received supplementary services from Itshudu Projects, an NGO that provides psychosocial and nutritional support to women living with hypertension and other health conditions.

A qualitative research design and purposive sampling technique were implemented to recruit participants using the services of the organisation. Semi-structured one-on-one interviews were conducted to gather in-depth data from 20 participants. All participants were females aged between 18 and 35 who had been diagnosed with hypertension or a related medical condition, which included diabetes, hypertensive retinopathy, gestational hypertension, aneurysm, anxiety and obesity.

The main findings of the study revealed that the diagnosis of hypertension and related conditions caused feelings of fear, stress, and self-blame. The study found that the required lifestyle changes that came with the diagnosis resulted in the participants losing close relationships with family and friends. In addition, the study found that the participants struggled to adhere to treatment due to lack of support from family and friends and inability to afford food. The study further revealed that while some participants had good experiences in the healthcare facilities, others received poor treatment and lack of confidentiality from nurses and doctors. The main recommendations are that there is a need for collaboration between individuals, families, and various government and non-government organisations in supporting women living with hypertension and related conditions in Kwatsaduza.

Keywords: Hypertension, Healthcare, Health Disparities, Social Determinants of Health, Impoverished

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CHAPTER 1: INTRODUCTION

1.1 Introduction

Poverty is a major cause of ill health and a barrier to accessing healthcare (World Health Organisation, 2022). People in impoverished communities lack information on required health practices, available resources and means to prevent chronic illnesses such as affording a balanced diet (Bhatt & Bathija, 2018). Studies have shown that people who live in low-income communities are not guaranteed better access to healthcare services as compared to people who live in middle and upper-income communities (Umeh & Feeley, 2017). To support this notion, Bhatt and Bathija (2018) connote that poverty is directly correlated with poor health outcomes and it is crucial to acknowledge the impact that financial limitations have on one's quality of life and health. This suggests that the management of chronic diseases is dependent on a patient's financial situation and social standing. This brings us into the main focus of the study, which is women living with hypertension and related conditions in impoverished communities.

The literature shows that hypertension is a complex health condition, leading to many other health conditions such as cardiovascular disease, stroke and kidney failure (Fisher & Curfman, 2018). Owing to the health risks associated with hypertension and the large population of people living with the condition and its complications, the issue has become a public health concern globally. This health burden is unevenly distributed in South Africa; the black population has a higher prevalence of hypertension than the white population (Cuevas, Williams & Albert, 2018).

Efforts have been made to increase awareness about healthy lifestyles, hypertension, healthcare services and the treatment and management of hypertension. However, health disparities in hypertension persist, and large numbers of individuals are diagnosed with hypertension annually (Cuevas, Williams & Albert, 2018). The World Health Organisation (WHO) (2018) indicates that the health of women and female children is of concern because they are disadvantaged by discrimination rooted in sociocultural norms. Maas (2019) supports this notion, stating that women are affected by many of the same health conditions as men, but experience them differently because of genetic factors and social constructions of gender. One such condition is hypertension.

Thomas et al. (2017) state that hypertension is a leading cause of death and disability globally. Similarly, Boima et al. (2023) state that hypertension is one of the leading risk factors for coronary heart disease and mortality. Some studies have shown that at a younger age, high blood pressure is more prevalent in men than in women, but the ratio reverses gradually after the age of 50 (Maas, 2019). According to Laar et al. (2019), hypertension has been identified as a major co-existing disease with a number of cardiovascular diseases, also known as hypertension-related conditions. Multiple studies have showed that the majority of individuals living with hypertension are later diagnosed with health conditions such as diabetes mellitus and hyperlipidemia (Laar et al., 2019). Similarly, Wang et al. (2017) state that if not managed, hypertension may lead to adverse health problems including stroke, kidney failure and heart attack.

This dissertation explores the topic of women's experiences of hypertension and related conditions in Kwatsaduza, Gauteng. All of the participants were also accessing state health services at local clinics and, like most residents of the townships, lived in conditions of poverty. This chapter provides background information on the topic and a contextual understanding of the research problem. It discusses the rationale and significance of the study, the study aims and objectives, the research questions, and the study's assumptions. It also gives a definition of key concepts, and discusses the study's ethical considerations, limitations and challenges.

1.2 Statement of the problem

Moscelli et al. (2018) note that people in poor countries have less access to health services than those in developed countries. Baeten et al. (2018) add that poverty and low-income status are linked to various adverse health outcomes, including shorter life expectancy, higher infant mortality rates, and higher death rates. In addition to these issues, women face adverse health outcomes as a result of poor neonatal and maternal experiences, terminations of pregnancies, sexually transmitted illnesses, and cardiovascular disease, amongst others, all of which lead to health complications (StatsSA, 2020). According to Ahmad and Oparil (2017), cardiovascular disease is the leading cause of death among women in developed countries and most developing countries. Hypertension, the most common risk factor for cardiovascular disease, is estimated to occur in 85.7 million adults in the United States – 44.9 million women and 40.8 million men (Ahmad & Oparil, 2017). Najar, Sanabria and Pita (2020) state that hypertension is one of the leading causes of morbidity and mortality globally, with over 1 billion people living with hypertension. These authors also observe that by 2015, one in every four men and one in every five women were living with hypertension.

Similarly, in 2015, WHO compiled a list of the top issues for women's health. The list included reproductive health, cancer (breast and cervical), maternal health, HIV, sexually transmitted infections, violence against women, and noncommunicable diseases. The noncommunicable diseases most affecting women are hypertension, diabetes mellitus, kidney disease, heart disease and stroke (WHO, 2015). These conditions are classified as hypertension or hypertension-related conditions. Ceiling (2019) found that the problems women face included patriarchy, sexism, racism, economic inequality, trauma-centred feminism, maternal mortality, and access to equal opportunity, all of which lead to stress-induced health problems, including but not limited to hypertension, stroke and depression (Laar et al., 2019). Both the findings by WHO and Ceiling show that women are faced with multiple social and health issues that put them at risk of developing hypertension and related conditions.

In addition to the conditions identified by Ceiling (2019), another common issue faced by women is poverty (WHO, 2015). The South African government measures poverty by three threshold points: the upper-bound poverty line, which denotes an income of up to R1 335; the lower-bound poverty line of R890; and the food poverty line, which denotes an income of R624 (StatsSA, 2021). Statistics South Africa (StatsSA) (2021) has also shown that 52.2% of women fall below the upper-bound poverty line (UPBL), compared to 46.1% of men. This indicates women's higher vulnerability as compared to men. Segalo (2015) highlights that women living in poverty in South Africa are more exposed to other social issues such as gender-based violence and substance abuse than women who are not living in poverty.

While numerous studies have been conducted on hypertension, there is limited research focusing on access to healthcare amongst women living with hypertension and related conditions, and none, to the author's knowledge, located in the townships of Kwatsaduza, Gauteng province. There is a need for studies that examine women's experiences of accessing healthcare services in impoverished communities for the treatment of hypertension and related conditions, given that women suffer disproportionately from conditions that act as precursors to hypertension. This study addresses this research gap.

1.3 Rationale and significance of the study

In South Africa, the realities of women's lives are still determined by social status, race and access to opportunities. Poor black women's access to resources and opportunities is limited in the country (Segalo, 2015). A plethora of social issues in the country have compromised the quality of healthcare in South Africa. Maphumulo and Bhengu (2019) conducted a study on the challenges that impact healthcare service delivery in South Africa, identifying staff shortages, prolonged waiting times, poor infection control measures, staff attitudes and shortages of medical equipment as common challenges (Maphumulo & Bhengu, 2019). Information on the experiences of women living with hypertension and related conditions could help the providers of healthcare services in Kwatsaduza to develop a better understanding of the challenges faced by their patients. An enhanced understanding may motivate healthcare services to offer a better quality of service. The study could also inform national and provincial policies, programmes and initiatives aimed at improving access to healthcare for the disadvantaged, especially the management and treatment of hypertension and related conditions. In addition, knowledge and an understanding of the experiences of women living in poverty in the townships of South Africa could help scholars and the government identify gaps in current intervention strategies. Scholars might be inspired to undertake further relevant research to assist the government to devise tailored intervention plans that would not only improve access to healthcare and the management of hypertension, but also reduce the severity of social issues linked to women's poverty, such as gender-based violence and substance abuse. These conditions have been shown to make women prone to adverse health conditions such as hypertension and related conditions. Moreover, the study is significant for South Africa's attainment of Sustainable Development Goal (SDG) 3, which seeks to promote health and wellbeing for all people of all ages.

1.4 Area profile

Kwatsaduza is a big community that compromises of three sub-communities mainly, KwaThema, Tsakane, and Duduza. The name Kwatsaduza is short for all three communities which will be individually profiled. KwaThema is a township in the South-West of Springs in the Ekurhuleni district of Gauteng and was established in 1951. According to the City-Facts (2019-2023). KwaThema has a population of 105 614, 49.4% being females and 50.6% being males. The population comprises of 102 894 Black Africans, 112 Whites, 163 Asian, 274 Coloured and 284 fall under Other. The predominant languages are isiZulu and SeSotho. The health institutions in the township include KwaThema Clinic and Bophelong Medical Centre.

As part of developing the township, a shopping center was opened in 2020 which comprises of over ten shopping facilities. The township is a neighbor of Tsakane.

Tsakane was established in the early 1960s. The available Census is dated 2011, which is twelve years ago hence latest information is needed for an accurate area profile. According to City Facts (2019-2023), Tsakane has a population of 142 501, 49.4% being male population and 50.6% being the female population. IsiZulu and SeSotho are the two predominant languages in the community. Just as in KwaThema, Tsakane is home to the low and middle- class featuring RDP houses, modern houses, and informal settlements with shacks and poor sanitation. Tsakane has a public hospital named Pholosong Regional Hospital and serves people from Kwatsaduza while not excluding people from outside of Kwatsaduza. There is also three public clinics, and private clinics and pharmacies. In addition, Tsakane has fifteen primary schools and seven secondary schools. On the other hand, Duduza is the smallest township amongst KwaThema and Tsakane with a population of 77 087, with 49.2% male population and 50.8% being a female population (City Facts, 2019- 2023). IsiZulu is the dominating language. The township has twelve primary schools and four secondary schools. Statistics have shown that 99% of the population of Duduza are Black Africans with IsiZulu as the dominating language. The township has one public Clinic and mobile clinics are placed in the community every two months.

Overall, Kwatsaduza is home to the low and middle- class featuring the Reconstruction and Development Programme (RDP) houses, modern homes, and informal settlements. The efforts made to develop the townships include having a mall, two shopping centers, a police station, Magistrates court, leisure parks, a stadium, radio station and municipal offices.

1.5 Aim of the Study

To explore the experiences of women living with hypertension and related conditions in the townships of Kwatsaduza, Gauteng province.

1.6 Main research question

The main research questions is: What are the experiences of women living with hypertension and related conditions in Kwatsaduza?

1.7 Research objectives

The study seeks to contribute to a better understanding of the experiences and challenges of women living with hypertension in impoverished communities. Therefore, the participants in this study were interviewed one-on-one in depth to fulfil the following objectives:

- to understand the effects of hypertension and related conditions on women living in poverty in Kwatsaduza:
- to explore the impact of poverty on treatment adherence for hypertension and related conditions;
- to explore the experiences of accessing healthcare services by women living with hypertension and related conditions in Kwatsaduza; and
- to examine how women cope with their diagnosis.

1.8 Main assumptions

According to Raniga and Ringson (2021), poverty has a detrimental effect on women's welfare, health and living conditions. This observation supports research by Segalo (2015), who revealed that women living in poverty are more likely to experience violence, substance misuse, crime and mental illness than women not living in poverty. A low-income places restriction on access to healthcare, according to Moscello et al. (2018). This suggests that women who are poor and have diseases such as hypertension find it difficult to acquire healthcare services and manage their conditions as they should. The researcher therefore presumptively expected the participants to identify a range of healthcare constraints, such as accessibility, affordability and location.

The researcher further had methodological assumptions. Cresswell (2014) indicates that methodological assumptions refer to assumptions made by the researcher regarding the methods that will be used to conduct the study. In this study, the researcher used an interview schedule to gather data, assuming that the participants would answer the questions honestly and factually.

1.9 Limitations of the study

One of the limitations of the study was its small scale, as it was conducted only with 20 women accessing services from an NGO in Kwatsaduza township on the East Rand. The study therefore lacked representation from other townships or well-developed areas in Gauteng. While the experiences of women living with hypertension were revealing, they may pertain mostly to women in impoverished communities. Other experiences may be found among women living in different circumstances.

1.10 Clarification of terms

1.10.1 Hypertension and related conditions

Hypertension, also referred to as high blood pressure, is a condition in which the human blood vessels have raised blood pressure (Fisher & Curfman, 2018). Blood pressure is caused by the force of blood pushing against the walls of blood vessels and exerting pressure as it is pumped by the heart (Fisher & Curfman, 2018). This suggests that high blood pressure forces the heart to work harder to pump blood. According to Skeen (2017), blood pressure is measured using two numbers: the first measures systolic blood pressure and the second measures diastolic blood pressure, with the figures shown in relation to each other. For example, if a blood pressure measurement reads 100 for systolic blood pressure and 90 for diastolic blood pressure, it would be written as 100/90.

Health studies have shown that a normal blood pressure is lower than 120/80 (Skeen, 2017). Above 120/80 but less than 139/89 is referred to as the prehypertension level, which suggests that one is at risk of developing high blood pressure (Skeen, 2017). A blood pressure of 140/90 or higher is referred to high blood pressure or hypertension (Skeen, 2017). Hypertension may lead to conditions such as heart failure. Equally, conditions such as obesity may lead to hypertension, just as other conditions may be caused by hypertension; both are referred to as hypertension-related conditions (Ahmad & Oparil, 2017). These conditions include but are not limited to chronic kidney disease, coronary artery disease, diabetes, heart failure, stroke and chronic obstructive pulmonary disease (Ahmad & Oparil, 2017). Hypertension is asymptomatic, although in rare cases, symptoms may be felt in the form of headaches, dizziness and blurry vision (Skeen, 2017). A common type of hypertension among women is gestational hypertension, which refers to the development of hypertension during pregnancy after twenty weeks' gestation (Braunthal & Brateanu, 2019). The condition is different from chronic hypertension; it applies only when the pregnant woman did not have hypertension before the pregnancy, but developed it during the pregnancy. In such cases, the hypertension is expected to go away after the birth of the child.

1.10.2 Itshudu Projects

Itshudu Projects is a non-profit organisation based in Kwatsaduza, particularly Kwathema, established in 2019 to take care of vulnerable community members in Kwathema and

Daggafontein. Because of demand for its services, the organisation recently expanded its target market to Tsakane and Duduza townships. The organisation caters for individuals living with various chronic illnesses, including HIV/Aids, hypertension and diabetes. Its staff provide psychosocial support in the form of individual counselling, group counselling and food parcels, along with rehabilitation and treatment adherence programmes. The organisation was the focus of the study because the researcher completed her Master's internship there, where she observed how the organisation assists women living with hypertension and related conditions.

1.10.3 Supplementary services

The Centre for Management Research (2018) defines a supplementary service as an additional service provided to increase the outcome of a core service. In this study, supplementary services refer to a broad range of services offered by an NGO to assist individuals living with hypertension and related conditions. These services are provided to supplement those provided by the clinics and hospitals.

1.10.4 Poverty

According to Wolff (2020), poverty is defined as a lack of financial resources needed for access to basic needs and services. Poverty may be defined as a situation in which one's earnings are insufficient to meet one's fundamental human needs (Raniga & Ringson, 2021). Poverty is categorized as either absolute poverty or relative poverty, with women in Kwatsaduza associated with both forms. Absolute poverty applies when a household's income is below a certain level, which makes it impossible for the family to meet their basic needs (Ravallion, 2017). Relative poverty is defined as a living standard that is lower than the economic standards of the surrounding population (Ravallion, 2017). In 2022, over 18 million people in South Africa lived in absolute poverty (StatsSA, 2021). In this study, two of the participants earned gross income of R15 000 and seven earned a gross income of R6 000 while eleven participants were unemployed.

1.10.5 Healthcare

According to Lee et al (2020), healthcare is the process of enhancing one's health through the diagnosis, treatment and prevention of illnesses, injuries and diseases. Adler, Glymour and Fielding (2016) add that healthcare constitutes all efforts made to maintain physical, mental, or emotional wellbeing by health professionals. A range of healthcare services is available in South Africa, including*preventative care, nutritional support, dental care, physical and occupational therapy, prenatal care, psychological support, pharmaceutical care, and mental healthcare (Young, 2016). In addition, there are two main sectors in healthcare in South Africa: the private sector and the public sector. The focus of this study is the public sector, which is funded by the state (Young, 2016).

1.10.6 Health disparities

Health disparities refer to the inequalities and differences in the health status and quality of health of different groups of people (Lee et al, 2020). According to WHO (2018), health disparities are health inequities and discrepancies that affect underprivileged and disadvantaged people more than other population groups. Every age, race and sex are impacted by health disparities, which governments strive to avoid in order to ensure the health of all citizens. Studies have shown that black women often encounter barriers in accessing quality healthcare, which compromises their wellbeing. These barriers include gender roles, a patriarchal culture and income inequality; as a result, black women are three times more likely to be hospitalized for hypertension, heart failure and depression than men or their white counterparts (Lewis-Evans & Day-Page, 2022).

1.10.7 Social determinants of health

The social determinants of health are non-medical factors that affect health outcomes (WHO, 2022). These are the conditions in which people are born, grow and live (Adler, Glymour & Fielding, 2016). According to Kelley (2020), they include factors such as education, employment, social support, socioeconomic status, policies, systems and access to healthcare. Adler, Glymour and Fielding (2016) point out that the social determinants of health cause health disparities and inequalities. For example, people who are unemployed and cannot afford healthy foods suffer from malnutrition. This puts them at risk of health conditions such as hypertension, diabetes and heart disease (Glymour & Fielding, 2016). The study aims to understand the non-medical factors that render women prone to developing hypertension.

1.10.8 Health comorbidity

Jystad et al. (2023) define a health comorbidity as any coexisting health condition. This term applies when there are two or more different health conditions that exist at the same time in the same person. Examples of comorbidities include heart disease, diabetes, asthma, obesity and high blood pressure (hypertension), which are often accompanied by other conditions. Research shows that there are also mental health comorbidities, such as depression and anxiety or depression and substance use disorder (Jystad et al., 2023). In this study, comorbidities refer to the health conditions that co-exist with hypertension.

1.10.9 Treatment adherence

The World Health Organisation (WHO) defines adherence as "the extent to which a person's behavior—taking medication, following a diet, and/or executing lifestyle changes—corresponds with agreed recommendations from a healthcare provider" (Pan et al., 2021: 3). In this study, it refers to the extent to which the individual complies with the prescribed medication and diet to treat or manage their hypertension. Compliance to medication is fundamental to the effective management of any medical condition and a critical requirement for participants in this study.

1.10.10 Wellbeing

Goldman (2018) defines wellbeing as the state of being healthy and presenting with good mental health. It includes having a sense of belonging, a sense of purpose, and the ability to cope in difficult situations (Slade, Oades & Jarden, 2017). Research has shown that wellbeing is more than happiness and life satisfaction. Ruggeri et al. (2020) state that wellbeing includes the ability to maximise one's potential, maintain a sense of control over one's life, enjoy positive interpersonal relationships, and thrive in stressful situations. Equally important, wellbeing is linked to positive health outcomes. Therefore, this concept is important in a study on hypertension, since a sense of wellbeing may prevent hypertension and help those with hypertension and related conditions to thrive.

1.11 Ethical considerations

Ethical considerations in research are a set of principles that guide the research design and its implementation (Fouche, Strydom, & Roestenburg, 2021). These factors uphold scientific integrity, strengthen study validity, and safeguard the rights of research participants (Dougherty, 2021). This study conformed to the ethical norms and standards of research ethics on human subjects in the social sciences as outlined below. Further, the University of Cape Town's ethical clearance was attained through the Department of Social Development ethics committee, with which the researcher is registered. The ethical clearance reference number for the study is SWK-REC2022-SR022.

1.11.1 Informed consent

Ketefian (2015) defines informed consent as a voluntary agreement to participate in a research study. The decision to participate in the study must be given to participants; they must not be coerced or otherwise forced to do so (Fouche, Strydom, & Roestenburg, 2021). The researcher gave the participants the freedom to voluntarily accept or decline participation in the study. The researcher formulated an informed consent form and gave it to prospective participants to sign (see Appendix 1). This form provided the following information: title of the study, nature and purpose of the study, risks and benefits of participating, and the rights of participants. Ketefian (2015) states that prospective participants must be given all the information they need about the research to help them decide whether or not they wish to participate. In this study, the researcher gave prospective participants a chance to read the consent form, then explained it to them in isiZulu, the dominant language in Kwatsaduza. Before consenting to participate in a study, prospective participants should understand what the research is about and what participation will entail (Newman, Guta, & Black, 2021). The participants' consent to participate in this study was obtained only after a thorough explanation of various aspects of the study, and all indicated their understanding and consent.

1.11.2 Beneficence/avoidance of harm to respondents

Beneficence is the obligation on the part of the researcher to maximise the benefits of participation while minimising the risks of harm (Ketefian, 2015). It includes the prevention of deliberate harm to participants, whether physical or emotional in nature (Dixon & Quirke, 2017). All potential sources of participant injury, including psychological harm, social harm and bodily harm, must be considered by researchers. Psychological injury could be caused by certain statements or questions made by the researcher that set off harmful emotions such as anxiety or distress (Fouche, Strydom, & Roestenburg, 2021). Social injury could be caused by stigmatisation and public humiliation that results from participation in the study. Physical harm could arise from any discomfort or injury caused by the study techniques. Dixon and Quirke (2017) confirm these definitions of psychological, social and physical harm.

In the current study, steps were taken to avoid all forms of harm to the participants. This included making it clear to participants that they were free not to answer any question they preferred not to answer, and the adoption of a sensitive, empathetic attitude by the researcher, who remained alert to the emotions that certain questions could have evoked. The researcher also made use of a quiet, private room for interviews to ensure that participants felt comfortable and that no members of the public could see who took part in the research study (Arifin, 2018).

1.11.3 Anonymity

According to Dougherty (2021), anonymity is respected when the participants' identities are kept anonymous, and their responses are not linked to any identifying information. The researcher is obligated not to disclose the names, photos, contact details or physical addresses of the research participants to anyone (Perera, 2017). Anonymity ensures that people who read the research study do not know who the participants of the study are, and cannot link any individual to any data. In this study, the researcher informed the participants that their identities and responses would not be disclosed. No identifying information was taken from the participants, such as full names, home addresses, or hospital file numbers. Pseudonyms were used to ensure anonymity and privacy. According to Kohlmayer, Lautenschlager and Prasser (2019), data pseudonyms are a research method used in which all true identifying information about research participants is replaced with numbers or fake names. In this study, the researcher used the terms Participant 1, Participant 2, etc, to identify the participants.

1.11.4 Confidentiality

According to Dougherty (2021), confidentiality refers to an agreement that is formed between the researcher and the participant. It also refers to keeping all information shared confidential, and not disclosing it to anyone else (Dougherty, 2021). Before scheduling interviews, the researcher assured participants of their anonymity in the study, and described the scope of it. This included making clear that, while the recordings would not be shared with anyone, including the university supervisor, written material would be sent to the supervisor, but that no identifiers would appear on the material. Confidentiality also entails being aware of the participants' identities and where to find them but abstaining from using that knowledge in accordance with the ethics of anonymous research (Dixon & Quirke, 2017).

1.11.5 Respect for privacy

Perera (2017) explains that privacy refers to the rights of participants to limit access by others to aspects of their personal lives. No participant in this study was coerced or persuaded to divulge any information that they did not wish to divulge. The researcher also conducted one-on-one interviews with each participant and none were aware of what the others had said. The room in the organisation where interviews were conducted was quiet and secluded. The researcher made sure that no one interrupted interviews and that no one outside the room could hear what was being said.

1.11.6 Deception of respondents

Ketefian (2015) states that researchers should not mislead their subjects; the information provided on the consent form should accurately reflect the purpose and nature of the study. Purposefully providing participants with false information regarding a study constitutes participant deception (Fouche, Strydom, & Roestenburg, 2021). Avoiding participant deception was achieved in this study by making no changes to the informed consent form or study objectives when the researcher's supervisor or the participants were not present. The study concentrated on the information sheet’s assertions and its primary goal, and adhered to the principles and procedures outlined to the participants at the start of the study.

1.11.7 Voluntarily participation

When researching with human participants, the principle of participant fee will must be upheld, in that each one should make their own decision about whether or not to participate (Newman, Guta, & Black, 2021). Research participants must not be forced, pressured, or manipulated to participate in the study (Newman, Guta, & Black, 2021). The researcher made it clear that participation was voluntary, that participants were not forced to participate, and that they could withdraw from the study at any time. Initially 25 participants chose to participate, but five later withdrew for various reasons, including work and family commitments. Participants should be given the freedom to withdraw from the study at any point without being made to feel bad (Anderson, Newman, & Matthews, 2017).

1.11.8 Debriefing respondents

According to Anderson, Newman and Matthews (2017), debriefing of participants refers to the opportunity given to respondents to give feedback at the end of the interview on how they felt about it. In this way, the researcher creates another opportunity to minimise any discomfort that the interview may have caused (Fouche, Strydom, & Roestenburg, 2021). The researcher encouraged the participants to talk about any emotions and thoughts that the interview may have evoked, which enabled her to ascertain whether any needed support after the interviews. The researcher referred two participants to social workers based at Itshudu Projects for emotional support. This was done through the organisation’s internal referral process.

1.11.9 Publication of findings

According to Newman, Guta, and Black (2021), the final research paper ought to accurately reflect the actual research findings. In keeping with this principle, the researcher did not invent or embellish any of the study's conclusions. The findings are presented by the researcher as they were expressed by the respondents. No data was created or modified with the explicit goal of misleading the scientific and social research community.

1.11.10 Protection of personal information

In working with the sample, the researcher took into consideration the Protection of Personal Information (POPI) Act. The Act sets out conditions and standards regarding collecting, receiving, recording, sharing and/or retrieving any personal information belonging to another individual (POPI Act, 2013). Section 13 of the Act states that one may collect personal information only for a specific, explicitly defined and lawful purpose and the subject must be aware of the purpose for which the information is being collected. The researcher explained and defined the purpose of the study and the reasons for the data collection to the gatekeeper. The Act emphasises gaining consent when one is intending to process the personal information of others. The Act also states that anybody who keeps the personal information of others must protect the information and keep it from being accessed by a third party (POPI Act, 2013). The researcher requested the gatekeeper of the organisation to identify prospective participants, speak to them about the study, and gain their consent to participate, as per the POPI Act. Once the organisation had confirmed that certain individuals were willing to participate, the researcher followed up by contacting each one, introducing herself and explaining the purpose of the study. During interviews and throughout the study process, the researcher used pseudonyms rather than the participants' names and took no identifying information, in order to protect the participants' privacy and the data, as obligated by the Act.

1.11 Conclusion

This chapter has provided background information on the research topic, a contextual understanding of the problem in the community in which the study took place, and the rationale and significance of the study. It has also presented the research questions, study objectives and assumptions, the study's limitations and a detailed explanation of ten key concepts that are central to the study. The chapter concluded with a discussion on the ethical aspects of research, both in general and in relation to the study. Chapter Two presents the literature review, which covers studies pertinent to the topic.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter discusses the findings of other researchers in relation to the topic, the theoretical frameworks and approaches that underpin the study (strength-based theory and systems theory) and the legislation and policy frameworks that are relevant to the study. The findings of other researchers are discussed below in relation to the four key objectives of the study, which are, broadly, to understand: the effects of hypertension on women; the impact of poverty on treatment adherence; women's experiences of accessing healthcare services; and women's coping strategies for managing hypertension and related conditions.

2.2 Review of the literature

Snyder (2019) describes a literature review as an examination of academic sources on a specific topic. A literature review is important as it analyzes, synthesizes, and critically evaluates the topic at hand to give a clear picture of knowledge (Snyder, 2019). Secondly, a literature review gives a researcher a chance to identify how their research addresses a gap and contributes to existing data (Snyder, 2019). This section aims to discuss the literature review relevant to the study.

2.2.1 The effects of hypertension and related conditions on women

It is known that a diagnosis of any chronic illnesses comes with changes that affects one's normal way of living. In a study conducted by Rosen et al. (2022) in the South of Sweden, a highly developed country, 12 persons who had been diagnosed with hypertension and were receiving treatment at a primary healthcare facility were interviewed in order to understand their experiences of having hypertension. All were over 20 years old and had received their hypertension diagnosis during the six months prior to the study. It was discovered that the participants felt a strong of being responsible for managing their condition, and were aware of what was expected of them in terms of eating a healthy diet, exercising, and abstaining from alcohol and smoking. Some participants had gone as far as purchasing blood pressure monitors to keep track of their blood pressure, which gave them a sense of being in charge of their own well-being (Rosen et al., 2022). It was also found that in the beginning, most had struggled to accept their diagnosis, experiencing feelings of anxiety and stress, and even denying the hypertension diagnosis. However, they had come to accept the condition and their fear of dying motivated them to continue with treatment.

Similarly, Shamsi, Nayeri and Esmaili (2017) investigated the experiences of 27 individuals diagnosed with hypertension, ranging in age from 28 to 74 in Iran, a middle-income country. The study found a similar sense of responsibility among participants as found in Rosen et al.'s (2022) study. The individuals admitted that, prior to their diagnosis, they had engaged in unhealthy eating habits, were physically inactive, smoked and drank, and had not undergone hypertension screenings.

Interestingly, some participants attributed their high blood pressure to their relatives, citing family genetics, unbalanced meals served in the home and family conflict, a source of stress (Shamsi, Naveri, & Esmaili, 2017). Family conflicts evoke feelings of anger, worry and anxiety, which can raise blood pressure and lead to hypertension and related conditions, including heart attacks and strokes.

In addition to personal and family factors, some participants blamed social factors. Social factors such as unemployment, crime, food insecurity, gender-based violence and child abuse can lead to hypertension and related conditions (Shamsi, Naveri, & Esmaili, 2017). These social issues have adverse psychological impacts on individuals and families, which may in turn put individuals at risk of developing hypertension.

2.2.2 The impact of poverty on treatment adherence

Once diagnosed with hypertension and related conditions, one will receive prescribed medication to manage the conditions to prevent long-term health effects. Therefore, it is important to understand how poverty influence adhere to treatment in order to enhance compliance to treatment. One of the most important ways to manage noncommunicable diseases is to attend outpatient clinics regularly, as recommended by the health professional concerned (Yan et al., 2020). This suggests that hypertension and related conditions can be managed through regular check-ups and monitoring. Yan et al. (2020) conducted a study on the impact of distance and poverty on outpatient visit adherence for noncommunicable diseases in rural Haiti, an impoverished community. While the study did not show a direct association between poverty and decreased clinic attendance, it did show a link between distance and lower adherence (Yan et al., 2020). One could argue that distance becomes a barrier to healthcare for those living in poverty. Poverty makes it difficult for patients to pay the costs of traveling to healthcare facilities, and therefore can lead to nonadherence to outpatient visits as required (Huot et al., 2019). This is an indication that poverty does have an impact on treatment adherence for hypertension and related conditions.

Terline et al. (2019) conducted a study on factors associated with poor adherence among hypertensive patients in low and middle-income sub-Saharan countries. According to Terline et al. (2019), nonadherence to hypertensive treatment is associated with the wealth index. Participants with a low wealth index reported lower adherence to treatment than participants with a high wealth index (Terline et al., 2019). In addition, the study showed that 27% of patients had stopped taking their hypertensive medication because of financial constraints. This factor was much higher among the lower-earning individuals than among the higher-earning individuals.

The above two studies confirm the relationship between poverty and nonadherence to treatment. It is also important to understand the aspects of poverty that directly impact adherence.

According to Men et al. (2019), poverty may cause food insecurity, which affects adherence to treatment. The prescribed hypertensive medication requires patients to take medication three times a day with meals, but if patients cannot afford to eat three meals a day, they may omit to take their medication (Men et al., 2019). Similarly, poverty makes it difficult to afford transportation to healthcare facilities, irrespective of the distance, while others walk to the facilities out of desperation (Andermann, 2016). Also, individuals living in poverty may spend their time looking for a means to an income, which can make it difficult for them to make time for regular outpatient visits. In other instances, those with informal employment are not granted time off by their employers, and so fail to adhere to regular clinic visits.

2.2.3 The experiences of women in accessing healthcare services

Different studies have shown different experiences of patients when visiting healthcare facilities. These experiences speak to the treatment from healthcare professionals and service delivery. Peltzer (2009) conducted a study on female and male patient experiences and the responsiveness of the South African healthcare system. The objective of the study was to compare the experiences of people using public and private services, and assess the responsiveness of the country's healthcare system. Peltzer (2009) found that consumers of both public and private healthcare services believed that medical personnel treated them badly. Social class and race were the two main categories of discrimination mentioned. Insufficient affordability and social class were also identified by Pullicino (2015) as significant causes of prejudice in both public and private institutions. It is noteworthy that people who used public health services were more likely to report experiences of racial and/or social discrimination than those who used private facilities (Peltzer, 2009).

Fernandes et al. (2020) also conducted a study on patient experiences in a public primary healthcare clinic. The study measured patient-reported experiences of care at Sibasa Clinic, Vhembe District, Limpopo Province, South Africa, finding an association between participants' sociodemographic characteristics and their experiences of care. According to Fernandes et al. (2020), men were more likely than women to report positive experiences of care, in that more men than women found nurses helpful and forthcoming with relevant information, and willing to answer questions. In addition, participants aged 35 to 64 years were more likely to report a positive experience of care, especially with regard to the duration of consultations, than participants aged 18 to 34 (Fernandes et al., 2020).

Elnaem et al. (2022) state that controlling and managing hypertension is a public health challenge, as it is influenced by multiple factors beyond the control of the individual patient. Elnaem et al.'s (2022) study examined disparities in the prevalence of hypertension and barriers to hypertension control in developing and developed countries. They found that a number of barriers applied: patient-related barriers, awareness-related barriers, lifestyle-related barriers, and pharmacotherapy-related barriers. According to Elnaaem (2022), patient-related barriers included age, gender, family background and socioeconomic status. Research has shown that the older the person, the higher the chances that they will have uncontrolled blood pressure, partly because of forgetfulness about taking medication and the inability to be physically active (Elnaem, 2022).

Medically, blood pressure also rises with age, as there are changes in the body; arteries become stiff and insulin resistance increases, which raises blood pressure. Sun (2014) describes this condition as follows:

> "*The walls of large conduit arteries, especially aorta, thicken and lose elasticity over time, and this process results in an increase in pulse wave velocity, an important and reliable measure of arterial stiffness. The increased arterial stiffness, whatever its underlying causes, would reduce the buffering function of the conduit arteries near the heart and increase pulse wave velocity, both of which increase systolic and pulse pressure*" (Sun, 2014: 2).

Socioeconomic status was another patient-related factor found by Elnaaem (2022) to affect access to treatment for hypertension. It was found that individuals with low educational attainment and those who were unemployed experienced challenges in accessing healthcare services for the management of their hypertension. This challenge included residing far from healthcare institutions, a lack of knowledge about the importance of treatment adherence, and religious beliefs (Elnaaem, 2022). The latter applied to individuals who did not believe in Western medicine and felt that conditions such as hypertension and related conditions were best managed through traditional medicine (Gagnon et al., 2017). These beliefs prevent individuals from seeking healthcare services and adhering to hypertension treatment; hence, they are identified as barriers to the management of hypertension.

Terline et al. (2019) define traditional medicine as any health-related practice outside the mainstream healthcare system or any alternative healthcare. These authors found that patients using traditional medicine reported lower adherence to antihypertensive medication. Liwa et al. (2014) conducted a study on traditional herbal medicine (THM) use among hypertensive patients in sub-Saharan Africa. According to the study, patients use THM to manage hypertension because of the costs of Western medicine, their cultural and herbal knowledge, the unwanted side-effects of Western medicine, lack of access to healthcare facilities, and family beliefs (Liwa et al., 2014). Terline et al. (2019) state that in developing countries, many rely on traditional medicine for their holistic well-being.

Studies on the different types of THM used by individuals to treat their hypertension are limited, although two Nigerian studies, conducted in 2007 and 2010, do explore the types of THM used to manage hypertension. Amira and Okubadejo (2007) investigated the frequency of complementary and alternative medicine use among hypertensive patients in Nigeria, while Osamor and Owumi (2010) explored complementary and alternative medicine usage for managing hypertension in an urban Nigerian community. Both studies discovered that the participants used the following THM to manage hypertension: herbs, aloe vera, bitter leaves, ginger and 'True Man's' capsule (Amira & Okubadejo, 2007; Osamor & Owumi, 2010, cited in Liwa et al., 2014). While some studies view the use of THM as a choice that negatively affects the management of hypertension, Kamyab et al. (2021) support the use of these remedies, arguing that some herbs contain vasodilatory properties, which decrease blood pressure.

With regard to lifestyle factors, Rahimi and Nkombua (2022) report on a number of personal habits that operate as a barrier to blood pressure regulation. These include a sedentary lifestyle, alcohol consumption, drug use (both legal and illicit), salt consumption and poor stress management. Awareness campaigns about hypertension have assisted, in that more people are aware of the importance of leading a healthy lifestyle than in the past, and awareness has also raised diagnosis figures, so that people are better equipped to deal with their conditions. However, some individuals remain reluctant to change their lifestyles, which makes it almost impossible to manage hypertension and increases their chance of developing hypertensionrelated conditions (Rahimi & Nkombua, 2022). Research has also shown that individuals leading an unhealthy lifestyle are at higher risk of morbidity, disability and mortality than those who watch their diet, exercise regularly and do not drink to excess or smoke (Abott, Ward & Bowe, 2021).

Lack of transport, lack of income, a lack of healthcare facility staff and a lack of knowledge about healthcare facilities have all been demonstrated in studies to be barriers to accessing healthcare. Driscoll et al. (2010) found the main reason for a lack of healthcare facility staff is the uneven distribution of healthcare professionals, with a higher number choosing to work in metropolitan regions than in rural regions.

A study by Huot et al. (2019) sought to pinpoint the unique difficulties that the Circumpolar North population faces in accessing and receiving healthcare services. Physical geography, healthcare-related hurdles, cultural and linguistic issues, and systemic variables were identified as the four main factors that imposed impediments on accessing healthcare services. The study discovered that individuals had to travel long distances to access healthcare services. Because of distances and a lack of available transportation options, participants who could not afford transportation did not use any of the healthcare services available (Huot et al., 2019). The study revealed that, in addition to the issue of distance, some individuals were unable to receive healthcare services because of extreme weather conditions (Huot et al., 2019).

Houet et al. (2019) also mention language and culture as important determinants of access to healthcare. The authors reported that since the majority of healthcare personnel did not speak the local language, language became a major barrier between patients and healthcare professionals (Hout et al., 2019). The quality of the examination, diagnosis, treatment and care are all compromised by the language barrier.

Alzubaidi et al. (2015) discovered further access constraints. Through a survey, they found that some people choose not to seek medical services because they are unaware of facilities nearby. The study also discovered that the influence of important persons, such as friends and family, affects access to healthcare. Alzubaidi et al. (2015) claim that patients involved their significant others when deciding whether or not to seek and use health services. According to these findings, loved ones may occasionally encourage people not to use healthcare services because of their own opinions or personal experiences.

A major barrier to accessing healthcare services is macro factors that lie beyond the control of the individual patient. Some of these have to do with the quality of service offered. "Part of ensuring access to essential healthcare services for vulnerable communities is ensuring that care is equitable and culturally competent" (Bhatt et al, 2018: 17). Healthcare organisations and policies must keep making efforts to eliminate healthcare disparities, which exist as a result of various racial, ethnic, class and cultural factors (Bhatt & Bhatija, 2018). Other studies indicate that addressing the social determinants of health is crucial for reducing health disparities.

There are various ways in which healthcare organisations can address the social determinants of health to reduce disparities and improve access. First, healthcare organisations can advocate for policy changes that promote the availability of transportation services in communities to address the barriers associated with transportation (Andermann, 2016). Second, healthcare organisations can formulate strategies to link patients with external resources to ensure holistic interventions. Third, healthcare organisations can raise awareness about the available healthcare services (Andermann, 2016).

2.2.4 How women cope with their diagnosis

Some of the challenges women face in living with hypertension have been mentioned in Chapter 1. Therefore, it is important to examine how women cope with these challenges. Boima et al. (2023) conducted a study on the resilience and coping strategies of patients living with hypertension in Ghana. They found that women mostly favoured spiritual coping strategies such as praying, meditating on the Bible and fasting. Interestingly, the study revealed that participants depended more on spiritual coping strategies the higher their blood pressure became (Boima et al., 2013).

Boima at al.'s (2023) study also found that social support helped patients cope well with their diagnosis. Participants who had three or more close friends experienced positive emotions more frequently and were more optimistic about the future than those who had weak support systems. Studies have shown that social support can prevent hypertension and related conditions, manage hypertension, and facilitate adherence to treatment (Osamor, 2015). Osamor (2015) investigated the relationship between social support and treatment adherence among hypertensive patients, finding that social support from acquaintances, colleagues, church, family members and friends was strongly linked to increased treatment compliance (Osamor, 2015). Osamor (2015) also found that while some individuals living with hypertension and related conditions relied on their faith and social support, some relied on professional help.

Boima at al. (2023) also found that during stressful times, participants living with hypertension relied on cognitive and emotional debriefing as coping strategies, including attending therapy (Boima et al., 2023). According to Boima et al. (2023), patients with controlled hypertension were patients who showed high levels of resilience and who implemented multiple positive coping strategies to cope with their hypertension and stressful situations. The study showed that treatments such as strength-based therapy and cognitive-behavioural therapy helped improve control of the condition and decreased the morbidity and mortality associated with hypertension and related conditions.

Pan et al. (2021) conducted a cross-sectional study that examined the effects of social support on treatment adherence for hypertension among 453 participants in China. The study found a positive relationship between a strong social support system and high levels of treatment adherence. "Treatment adherence of patients with hypertension was found to increase positively as their social support increased" (Pan et al, 2021:1). The social support came from families, friends, colleagues, church and community organisations, with connections of this promoting the health and wellbeing of the individual.

The studies have shown that social support and positive coping strategies are protective factors for individuals living with hypertension and related conditions. According to Crump et al. (2016), individual resilience and the presence of numerous coping strategies lower the risk of hypertension. Similarly, low stress resilience has been associated with the risk of hypertension and difficulties in managing it (Crump et., 2016). These findings suggest a need for the promotion of positive coping strategies and social support as a tool in the management of hypertension and related conditions.

2.3 Theoretical frameworks

A theoretical framework provides a roadmap for understanding the study at hand (Grant & Osanloo, 2014). A theoretical framework explains and predicts the research findings (Swanson, 2013). In this study, the strength-based approach and systems theory were used to understand the topic more fully.

2.3.1 The strength-based approach

According to Pulla (2017), the strength-based approach assumes that clients come for professional help already in possession of various resources and competencies (Pulla, 2017). The approach put the strengths and resources of individuals, families and communities at the centre of the professional relationship. The approach was designed to challenge approaches that see individuals as lacking any means to gain control over their problems (Pulla, 2017). Instead of looking at individuals as people with problems and limitations, healthcare providers and therapists following this approach view their patients or clients as individuals with resilience, resources and courage.

The approach emphasizes the strengths, capabilities and resources of individuals and holds the notion that individuals have strengths, resources and the ability to recover from difficulties (Smith, 2014). According to Pulla (2017), the strength-based approach seeks to develop clients' natural abilities and capabilities. Chapin (2017) adds that the strength-based approach is client led, in that professionals collaborate with the clients and help them identify and use their internal and external strengths. Internal strengths include patience and resilience, while external strengths may include tangible resources and social support. However, it is important to note that the approach does not overlook clients' challenges, traumas and stressors; instead, it sees them as steps towards change (Chapin, 2017).

In the current study, this theory applied in that it was assumed that the participants who thrived with their hypertension did so because of their resilience, ability to manage stress and social support.

2.3.2 Systems theory

Systems theory is based on the notion that behaviour is influenced by various factors that work together as a system (Schirmer & Michailakis, 2019). These systems include family, peers, school, work and the government, including various government institutions (Schirmer & Michailakis, 2019). Greene (2017) adds that when applying the systems approach, a researcher considers the individual's social environment with all its influences, seeking to understand how these systems affect the individual's mental health and well-being. The theory holds that an individual cannot be separated from their environment; behaviour cannot be fully understood without consideration of various environmental factors such as economic, social, political and familial (Kondrat, 2017).

This approach is relevant to the study as the study examined the experiences and challenges of women living with hypertension and related conditions in accessing healthcare services in the townships of Kwatsaduza. Kwatsaduza is a community affected by various systems, including those at the family or micro level (family relationships), the mezzo level (schools or workplaces) and the macro level (the larger community and society). The approach assumes that events and conditions happening in these systems influence the behaviour of the individual; in this case, women living in poverty with hypertension and related health conditions The theory shows that the experiences and challenges faced by these women cannot be understood without due consideration of their social and environmental factors. These include the social and structural issues that lead to poverty, stress, the onset of hypertension and difficulties in managing blood pressure.

2.4 Policy and legislation

The South African government has put in place a number policies and pieces of legislation to act as preventative measures for poor health and support for optimum health among the country's citizens. These policies include but are not limited to the National Adolescent and Youth Health Policy (2017), the National Development Plan (NDP) (2030) and the National Health Act 61 of 2003.

2.4.1 The National Adolescent and Youth Health Policy 2017

The National Adolescent and Youth Health Policy (NAYHP) was designed and is being implemented to promote the holistic health and well-being of young people aged between 10 and 24 years (NAYHP, 2017). The vision of the policy is "a long and healthy life for all South African adolescents and youth" and the mission is "to improve the health status of young people through the prevention of illness, the promotion of healthy lifestyles, and the improvement of the healthcare delivery system by focusing on the accessibility, efficiency, quality, and sustainability of adolescent and youth friendly health services" (NAYHP, 2017: 1). The prevention of illness refers to all kinds of illnesses, including hypertension and related conditions. Moreover, the promotion of healthy lifestyles, a priority of the policy, could prevent early-onset hypertension.

Many studies have shown that hypertension and related conditions can be prevented through the adoption a healthy lifestyle. A healthy lifestyle involves a healthy diet, regular exercise, limiting alcohol and cigarette intake, maintaining a healthy weight, and managing stress (Alefan et al., 2022). Overall, the main goal of the policy is to ensure that all national, provincial and local health departments and organisations respond to the health needs of young people. The focus is solely on the promotion of healthy lifestyles, the mitigation of risk factors, prevention, early detection, and early intervention for health conditions (NAYHP, 2017).

There are six objectives of the Adolescent and Youth Health Policy 2017, namely:

- Use innovative, youth-orientated programmes and technologies to promote the health and well-being of adolescents and youth.
- Provide comprehensive, integrated sexual and reproductive health services.
- Prevent, test and treat for HIV/Aids, tuberculosis and noncommunicable diseases.
- Reduce substance abuse and violence.
- Promote healthy nutrition and reduce obesity.
- Empower adolescents and youth to engage with policy and programming on youth health and be responsible for their health and well-being, leaving no one behind including youth with disability (National Adolescent and Youth Health Policy, 2017).

The implementation of this policy may help to reduce the number of young people who are diagnosed annually with hypertension and related conditions. It may also reduce the risks of developing hypertension and health-related conditions later in their lives. This observation is made on the basis that the policy stresses the promotion of good nutrition and a reduction in obesity.

2.4.2 National Health Act 61 of 2003

The National Health Act (NHA) 61 of 2003 is designed to provide a framework for delivering health services in the Republic of South Africa. The Act recognises the inequities of health services of the past and the current health disparities (NHA 61 of 2003), recognises the need to improve the quality of life of all citizens, and the need to close the gap caused by apartheid laws. The objectives of the Act are outlined to comply with section 7 (2) of the Constitution, which protects, promotes, and fulfil the rights enshrined in the Bill of Rights (NHA 61 of 2003). The objectives of the act are to:

- Establish a national health system which encompasses public and private providers of health services
- Setting out the rights and duties of health care providers and health users
- Protecting, respecting, promoting and fulling the rights of citizens and vulnerable groups such as women, children, older persons, and persons with disabilities

(National Health Act 61 of 2003).

The Act acknowledges that there are gaps in the South African Health System and these gaps affect the vulnerable groups, which includes women. Therefore, the policy is important in the study because it encourages the government to protect the rights of health users. According to the Act, every health user has a right to: emergency treatment, have full knowledge about their diagnosis, prognosis, and treatment; informed consent; participation in decision making; discharge reports; confidentiality; access to their health records; and free health services. Through this Act, women living with hypertension and related conditions can receive holistic health services irrespective of their socio-economic circumstances.

2.4.3 The National Development Plan (NDP) 2030

The NDP is a plan for South Africa to eliminate poverty and reduce inequality by 2030 (NDP, 2030). The framework aims to eliminate poverty and reduce inequality by 2030 through uniting South Africans, unleashing the energies of all its citizens, growing an inclusive economy, building capabilities, and enhancing the capability of the state and leaders in working together to solve complex problems (Fourie, 2018). The policy framework aims to ensure that all South Africans attain a decent standard of living through the elimination of poverty and the reduction of inequality. The core elements of a decent standard of living identified in the plan are housing, water, electricity and sanitation, quality healthcare, social protection, employment, social protection and adequate nutrition (NDP, 2030).

The plan proposes a range of measures to advance women's development and equality. This includes involving women leaders in all sectors of society and removing social, cultural, religious and educational barriers that hinder women from bettering their lives (NDP, 2030). This suggests that the NDP could help remove the social and structural barriers to healthcare services for women living with hypertension and related conditions.

This policy is relevant to the current study on women living with hypertension and related conditions, since poverty is a social issue that has been shown to increase the likelihood of developing hypertension, and is an effective barrier to the proper management of the condition (Fisher & Curfman, 2018). For instance, individuals living in poverty find it difficult to follow a healthy diet, access healthcare services, and seek treatment and adhere to it (Ridley et al., 2020). Therefore, the policy's proposal for the eradication of poverty may help to reduce the number of individuals diagnosed with hypertension and help those who have it to manage it better.

2.5 Conclusion

This chapter has a discussed the findings of numerous researchers in relation to the four key objectives of the study, which concern the effects of hypertension and related conditions; the impact of poverty on treatment adherence; women's experiences of accessing healthcare services for hypertension and related conditions; and coping strategies of women living with hypertension and related conditions.

The chapter has also discussed the two theoretical models underpinning the study, namely the strength-based theory and systems theory. In addition, the chapter has set out three of the major policies relevant to an understanding of hypertension and its management – National Adolescent and Youth Health Policy (2017), the National Development Plan (NDP) (2030) and the National Health Act 61 of 2003. The following chapter presents the research design and methodology used in the study.

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter discusses the methodology used in the study, that is, the research design, population and sampling strategy, the method of gaining consent from the participants, the research tool, the data-collection strategy, the methods used for data analysis, steps taken to ensure data verification, and the limitations of the study. The chapter concludes with a section on researcher flexibility and concluding remarks.

3.2 Research design

According to Jackson, Drummond and Camara (2007), a research design is a plan of how the researcher intends to conduct the study after a research problem has been formulated and the research objectives are clear. The study used a qualitative research design as a method of gathering data. According to Babbie and Mouton (2001), this approach focusses on participants' thoughts, feelings and experiences. Jackson, Drummond and Camara (2007) support this notion by stating that a qualitative research design is used to understand how people see and experience the world. The researcher is interested in the everyday experiences of human beings as told by them, which involves suspending the researcher's preconceived assumptions about the phenomenon (Cresswell & Poth, 2018). Instead of collecting numerical data, as in a quantitative study, a qualitative study asks open-ended questions such as the "how" and "why" questions. The qualitative research design is trusted for its ability to explain experiences and patterns of human behavior.

Different approaches to conducting qualitative research may be taken. These include the narrative research, the grounded theory approach, ethnographic research, case study research and phenomenological research (Teherani et al., 2015). This study adopted the phenomenological approach. According to Teherani et al. (2015), phenomenological research aims to describe the meaning of a particular experience in terms of what was experienced and how it was experienced. At its core, phenomenology aims to investigate and understand experiences from the perspective of the participant (Cresswell & Poth, 2018). Here, the focus is on the participant's beliefs about their experiences, why they experienced them, and how the experiences made them behave the way they do. In addition, the phenomenological approach involves interviewing and interacting with individuals, families and communities (Cresswell & Poth, 2018).

The qualitative research design was appropriate for this study as the researcher wanted to explore a phenomenon from the point of view of the participants, and thus to gain a deeper understanding of their lives in relation to the topic. Through the application of this design, the researcher acquired a greater understanding of the experiences of women living with hypertension in the townships of Kwatsaduza, Gauteng. The phenomenological approach was also pertinent because the study relied on the perspectives of the participants about their diagnosis.

The study is exploratory in nature. The phenomenological approach was therefore ideal, since it allowed the researcher explore and understand the lived experiences and challenges of women living with hypertension and related health conditions in Kwatsaduza, Gauteng. The qualitative design also provided an opportunity to deeply engage with the participants and obtain rich data.

3.3 Population and sample

The research population refers to a large collection of individuals who are the focus of a scientific query (Fouche, Strydom, & Roestenburg, 2021). The researcher's target population was every woman living in poverty with hypertension and related conditions, residing in Kwatsaduza, Gauteng Province. From this population, the researcher drew a small group of 20 women who were receiving supplementary and support services from an organisation named Itshudu Projects. (Fouche, Strydom, & Roestenburg, 2021) state that sampling is a process of selecting participants from the population. The focus of the study was women living with hypertension and related health conditions in Kwatsaduza, Gauteng. These were women who use public clinics and public hospitals and cannot afford private institutions. The relatively small sample enabled the researcher to engage deeply with participants and gain a quality of data that might not have been possible with a much larger sample.

3.3.1 Sampling technique

The researcher used a purposive sampling technique. Purposive sampling is a planned, intentional selection of participants based on their relevance and ability to provide detailed information on the topic being studied (Fouche, Strydom, & Roestenburg, 2021). The researcher chose the participants since the focus was only on women living with hypertension and related conditions; purposive sampling enabled the researcher to gather data only from women who met these criteria and could therefore help answer the research questions.

3.4 Data collection approach

The data collection method is a strategic process that the researcher follows to gather data from the respondents (Groenland & Dana, 2019). In this study, the researcher used one-on-one interviews to collect data. According to Lavrakas (2008), one-on-one interviews involve only the researcher and the individual respondent. The researcher was able to conduct face-to-face interviews, as the coronavirus (COVID-19) lockdown restrictions had been lifted. WHO (2023) defines COVID-19 as an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus. The virus was first detected in Wuhan, China, in November 2019, and quickly spread across the globe, since it is infectious and airborne. In March 2020, the virus was declared a pandemic by the World Health Organisation. South Africa recorded its first case of coronavirus in March 2020, after which the South African government implemented Covid-19 restrictions, which included the wearing of masks in public and the practice of social-distancing to reduce the spread of the virus. These restrictions were lifted in June 2022.

On 22 June 2022, the health minister of South Africa announced that citizens were no longer required to wear masks (Monama & McCain, 2022). Interviews were conducted at participants' homes, but COVID-19 protocols were still observed, in terms of social distancing and the use of sanitisers. The researcher also provided the participants with masks and wore one herself during the fieldwork. This was done in accordance with the beneficence research ethic which states that the researcher should protect participants from any form of harm or risk.

3.4.1 Data collection instrument

The study used a semi-structured interview schedule to collect data from the respondents. According to Harrell and Bradley (2009), a semi-structured interview schedule is a qualitative data collection instrument that consists of a pre-determined set of structured questions. Semi-structured interview schedules use open-ended questions to explore and probe for specific responses (Harrell & Bradley, 2009). An interview schedule was used in this study as a data collection tool to facilitate the interviews and ensure that all the research questions were consistent with the objectives of the study. This method allowed the researcher to facilitate the interviews smoothly, while still allowing for probing questions to be asked when the need arose.

Before the interviews began, the researcher cross-checked the questions in the interview schedule to determine the appropriateness of each, along with the phrasing, in order to ensure that they would be easy to understand and would yield the kinds of response sought. The researcher ensured that there were questions for each objective of the study. After compiling the interview schedule, the researcher submitted it to her research supervisor, and revisions were made where needed. Some questions deemed irrelevant to the focus of the study were removed and replaced with questions that were more relevant and would yield more helpful answers.

3.4.2 Data recording

The researcher used a mobile phone recorder as a recording tool for the face-to-face interviews conducted with the participants. According to Greeff (2005), an interview recording refers to an audio recording done on a tape recorder in order to gather and store information during an interview for research. Using a phone audio recorder allowed the researcher to focus on observing the participant's non-verbal cues and to listen actively instead of focusing on writing notes (McNamara, 2009).

3.5 Data analysis

Gathering qualitative data analysis is "a process which entails an effort to formally identify themes and to construct hypotheses as they are suggested by data, and attempt to demonstrate support for those themes and hypotheses" (De Vos, 2005: 333). The researcher used Tesch's (1990) eight-step model to analyse the data. These are as follows:

Step 1: The research data needs to be transformed from audio into written text before analysis can start. The written text is referred to as transcription. The researcher reads the entire transcript carefully to obtain a sense of the whole, jotting down some ideas.

Step 2: The researcher selects one case, asks, "What is this about?" and thinks about the underlying meaning in the information. The researcher's thoughts may be written in the margin. The important task here is unitizing the thoughts and feelings shared by participants

Step 3: The researcher makes a list of all the themes or topics that emerge from the data. Similar themes or topics are clustered together.

Step 4: The researcher applies the list of themes or topics to the data. The themes or topics are abbreviated as codes, which are written next to the appropriate segments of the transcripts. The researcher tries out this preliminary organising scheme to see whether new categories and codes emerge.

Step 5: The researcher finds the most descriptive wording for the themes or topics and categorises them. Lines are drawn between categories to show the relationships between ideas.

Step 6: The researcher makes a final decision on the abbreviation for each category and alphabetises the codes.

Step 7: The data material belonging to each category or theme is assembled and a preliminary analysis is performed.

Step 8: The researcher recodes existing material if necessary (De Vos, 1998: 343-344).

In applying Tesch's eight steps of data analysis, the researcher started by listening to the recorded interviews and reading all the transcriptions. This was done multiple times to get a detailed understanding of the data and its relevance to the research study, and to build an understanding of the data before it was analysed. The researcher then referred to the research objectives to develop four main themes and code and label the data. The researcher identified themes from the interview data. Four themes related to the four objectives of the study emerged during the process of data analysis. Each theme contained sub-themes and categories. Each category was discussed using relevant quotations from the participants' responses and supported by the literature.

3.6 Data verification

According to Morse et al. (2002), data verification refers to the process of ensuring that the instruments and methods used to gather research data are reliable and that the research is trustworthy. It is important to include such elements in a study, as they enhance the validity of the research data (Babbie & Mouton, 2012). According to Pool (2017), these elements are credibility, transferability, dependability, and confirmability.

3.6.1 Credibility

According to Korstjens and Moser (2018), credibility refers to the confidence that may be placed in the findings of a study. Credibility is a judgement made about whether the research findings are plausible and believable. For study credibility, the research instrument must measure what they are intended to measure (Babbie & Mouton, 2012). To ensure credibility for this study, all participants were asked the same main questions, and the researcher crosschecked the content of each interview with the research objective and the findings of the literature, as discussed in Chapter Two. In addition, the research data and interpretations were shared with the participants. This allowed the participants to correct any misinterpretations that were identified and add any further information that they wished to add to clarify their statements. The researcher did this to ensure that the findings of the study represented the participants' experiences. These steps ensured the accuracy, relevance, consistency and credibility of the findings.

3.6.2 Transferability

According to Korstjens and Moser (2018), transferability refers to the degree to which the results may be transferred to other contexts with different respondents. Korstjens and Moser (2018) add that transferability involves determining the similarities and differences between the current study and other contexts or studies. For this research, transferability was established through a thorough description of the research concepts, context and methodology, and through the use of purposive sampling, which led to the collection of specific information that aids transferability. In addition, the researcher's selected theoretical frameworks helped to determine how data collection and analysis took place.

The similarities between the findings of this study and the literature review findings in Chapter Two also help to prove that the study's findings could be applicable in other contexts with different participants and a different researcher.

3.6.3 Dependability

Babbie and Mouton (2007) state that dependability refers to the stability of the findings over time, should the research be repeated with the same respondents in the same context. According to Babbie and Mouton (2012), dependability is achieved when a research process is well documented and audited. This implies that dependability requires that the researcher provides evidence that if the same study were repeated by a different researcher, but with the same group of participants, in the same context, the findings would be consistent and similar. In this research, dependability was achieved through a dense description of the methodology and the use of semi-structured interview schedules. The researcher clearly outlined the objectives of the study, compiled a detailed and clear interview schedule based on the research objectives, and provided the methods and steps used to analyse the data. Babbie and Mouton (2012) state that when the objectives and methodology of the study are sufficiently detailed, dependability can be assured. Therefore, the researcher is confident that the research is dependable.

3.6.4 Confirmability

Confirmability refers to the neutrality of the study and the degree to which the findings of the research study could be confirmed by other researchers (Babbie, & Mouton, 2007). This means the interpretation of the study should not be based on the researcher's viewpoints but on the input of the participants; in other words, it should be grounded in data (Babbie & Mouton, 2012). In this research, confirmability was ensured through the use of an audit trail, in which the verbatim words of participants were reported. During the interviews, the researcher allowed the participants to express their views and share their experiences of living with hypertension and related health conditions in Kwatsaduza, Gauteng. The researcher did not influence the views of the participants in any way.

3.7 Limitations of the study

According to McNabb (2020), the limitations of a study refer to the constraints of the study. Clear descriptions of the limitations of a study show that the researcher has a holistic understanding of his or her study (McNabb, 2020). Anderson (2010) states that qualitative research is considered valuable, but it has its limitations. The limitations of the study include the design itself. The main limitation of the qualitative approach, according to Anderson (2010), is that the findings are subjective and cannot be used for wider populations with the same degree of certainty that a quantitative approach could be used. What one researcher might feel is important, another researcher might feel is not (Silverman, 2010). Thus, this study is limited by its design; it gathered data from the point of view of only 20 participants, and relied on the interpretation of the researcher. The findings are therefore not generalisable to a broader population. However, this limitation is compensated for by the fact that a qualitative design gathers in depth-data and yields a deeper, fuller understanding of the phenomenon under investigation than is possible in quantitative study. In this case, the researcher gained rich data on the experiences of women living with hypertension and related conditions in an impoverished community. Silverman (2010) adds that the method sometimes leaves out contextual considerations and focusses particularly on meanings and experiences. However, this research study is contextual. The study considered contextual understanding as it explained the topic in relation to poverty.

The smaller sample size also raises the issues of generalisability to the whole population. When the sample is small, findings are not generalisable to the broader population (Babbie, & Mouton, 2007). The researcher had the intention of interviewing 25 participants, but ended up with 20 participants. However, this did not affect the outcome or the credibility of the research data. The data for this study was collected from 20 participants who were deemed to be adequately representative of the wider population of women living with hypertension and related conditions in poor communities in South Africa. The researcher also had language as a limitation. The research objectives and questions were written in English and 3 of the participants could not fully comprehend them. The researcher managed to translate the objectives and questions in isiZulu with ease as she went to Zulu speaking schools. However, this was time assuming as the content had to be translated back to English.

3.8 Reflexivity

According to Korstjens and Moser (2018), reflexivity is the process of engaging in critical selfreflection about oneself as a researcher. This can be achieved through an examination of one's feelings, concerns, theoretical lens, assumptions and beliefs, and by reflecting on how these affected the research decisions made in all phases of the qualitative research.

The researcher worked as a social work volunteer in the Itshudu Projects organisation, where she also conducted her Master's first year study internship. The researcher currently works as a medical social worker in a hospital in Kwatsaduza, Gauteng, and consults with patients in the maternity ward, male and female medical wards, and the out-patient department. In her work in this hospital, the researcher has noticed that more women than men suffer from hypertension. Some develop the condition during pregnancy, and either lose their babies or die as a result. In addition, the researcher has encountered female patients admitted for parasuicide, and has noted that many were subject to stressors such as unemployment and gender-based violence.

In some cases, these stressors led to the onset of hypertension and health-related conditions.

In both the organisation and the hospital, the researcher also noticed that some women struggled to manage their conditions physically and emotionally, while others thrived with their condition. The researcher was interested in this phenomenon, and in what made some women thrive while others did not. The researcher was aware that Itshudu Projects offered supplementary and support services to women living with chronic health conditions, including hypertension. Hence, the organisation was chosen as the agency through which to access the relevant participants.

The researcher is a qualified and experienced social worker. In this study, the researcher needed to accept that the respondents were not her clients, and she was also not their social worker. This helped ensure a degree of objectivity and detachment in the process of gathering data.

It is also worth noting that the researcher grew up in Kwatsaduza, in Tsakane township. Having had some experience of the area, the researcher took care to bracket her own experiences, recollections and opinions for the duration of the research. She has a deep interest in the topic, and her engagement in this field was prompted by genuine concern for women in the area who suffer from stress-related conditions such as hypertension. It is hoped that the research will contribute to a better quality of service for women accessing supplementary health-related services.

3.9 Conclusion

This chapter has presented a detailed description of the research design and the methodology used to collect and analyse the data for this study. The chapter has presented a rationale for the use of a qualitative, phenomenological design, and has described the study population and sampling technique used, along with a rationale for its use. The data collection instrument and methods employed for data collection were provided. These included an interview schedule designed to cover all the research objectives. Aspects of data verification were discussed to show that the findings of the study are valid and trustworthy, and the study's limitations, mostly to do with the qualitative method and the fairly small sample, were also discussed. Lastly, the researcher reflected on her reasons for engaging in the study, and her personal involvement in the topic. The following chapter presents the research findings on the experiences of women living with hypertension and related conditions in Kwatsaduza, Gauteng Province in South Africa.

CHAPTER 4: RESEARCH FINDINGS

4.1 Introduction

This chapter presents and discusses the research findings in light of the findings of related studies. The chapter begins by re-stating the research question, aim and objectives; it then presents participants' profiles (Table 4.1) and the themes and sub-themes that emerged from the data (Table 4.2). The chapter goes on to discuss the findings in relation to the findings of similar studies and the relevant theories, strength-based theory and systems theory, as discussed in Section 2.3. The study seeks to contribute to a better understanding of the experiences and challenges of women living with hypertension and related conditions in impoverished communities.

Twenty women who were receiving supplementary support services from Itshudu Projects Organisation were interviewed in depth to explore their experiences of living in poverty with hypertension and related conditions in the townships of Kwatsaduza, Gauteng Province. Table 4.1 presents the participants' profiles.

Table 4.1: Participants' profiles

Participants (P)	**Age**	**Activity**	**Qualification**	**Gross Income**	**Family history of hypertension & related conditions.**	**Health Conditions**
1	19	Upgrading Matric	National Senior Certificate (NSC)	N/A	None	Hypertension
2	22	Selfemployed	NSC	R6 000	Maternal Family	Hypertension & anxiety
3	22	Unemployed	NSC	N/A	Maternal Family	Hypertension
4	27	Unemployed	Diploma	N/A	Maternal Family	Obesity & hypertension
5	30	Selfemployed	Undergraduate Degree	>R6 000	None	Hypertension & Diabetes
6	19	Student	NSC	N/A	None	Gestational hypertension

7	30	Unemployed	Diploma	N/A	Paternal Family	Hypertension & aneurysm
8	33	Unemployed	Higher Certificate	N/A	Maternal & Paternal Family	Hypertension
9	18	Grade 12	Grade 11	N/A	Paternal Family	Hypertension, hypertensive retinopathy & HIV
10	35	Unemployed	Undergraduate Degree	N/A	Maternal Family	Hypertension & diabetes
11	28	Employed	Undergraduate Degree	R15 000	None	Hypertension
12	30	Employed	Higher Certificate	R6 000	Paternal Family	Gestational hypertension
13	18	Student & Tutoring	Grade 12	>R6 000	Maternal & Paternal Family	Hypertension & HIV
14	35	Employed	Grade 12	>R6 000	Maternal & Paternal Family	Hypertension
15	28	Selfemployed	Grade 10	>R6 000	Maternal Family	Hypertension and diabetes
16	26	Unemployed & currency trading	Honor’s Degree	R3 000 – R6 000	Maternal Family	Hypertension
17	25	Unemployed	Higher Certificate	N/A	None	Hypertension
18	28	Employed	Undergraduate Degree	R15 000	Paternal Family	Hypertension & Hypertensive retinopathy
19	18	Upgrading Matric	NSC	N/A	None	Gestational hypertension
20	35	Unemployed	NSC	N/A	Paternal Family	Hypertension

4.2 Participants' profiles

Of the 20 participants interviewed, five were under the age of 20, eight were under the age of 30 and seven were above the age of 30. Eight were unemployed, four were formally employed, three were self-employed, two were upgrading their matric marks, two were university students, and one was completing her matric year. Only seven had tertiary qualifications. In total, 9 participants did not have a source of income.

All participants had been diagnosed with hypertension, and eight had comorbidities related to hypertension, including obesity, diabetes, anxiety, aneurysm and hypertensive retinopathy. Three of the participants reported having a history of hypertension in both their paternal and maternal families. Six of the participants reported a history of hypertension only on their maternal family's side and five reported a history of hypertension on their paternal family's side. Interestingly, five of the participants reported no history of hypertension in their families.

4.3 Presentation and discussion of the research data

Table 4.2 shows the themes, sub-themes and categories that emerged from the research data. The identification of these themes was guided by the objectives of the study. The themes that emanated were enlisted as follows:

Table 4.2: Framework for data analysis

Themes	**Sub-themes**	**Categories**
4.3.1 The effects of hypertension and related conditions on women living in Kwatsaduza	☐ Emotional	➢ Fear ➢ Stress ➢ Self-blame
	☐ Social	➢ Social isolation ➢ Lack of support
4.3.2 The impact of poverty on adherence to treatment for hypertension and related conditions.	☐ Food insecurity	
4.3.3 Experiences of accessing healthcare services by women living with	☐ Screening and diagnostic services	➢ Free testing stations
	☐ Support services	➢ Psychosocial support ➢ Nutritional support

hypertension and related conditions	Management services	➢ Regular check-ups ➢ Monthly treatment
	Staff attitude	➢ Negative attitude ➢ Positive attitude
	Patient confidentiality	
	Geographical location	➢ Distance ➢ Availability of transport
	Lack of information	
4.3.5 How women cope with their diagnosis	Social support	➢ Family ➢ Friends ➢ Romantic partners
	Personal abilities	➢ Resilience
	Professional help	➢ Social workers ➢ Psychologists

4.3.1 The effects of hypertension and related conditions on women living in Kwatsaduza

The effects of hypertension and related conditions on women living in poverty in Kwatsaduza included both emotional effects and social effects.

a) Emotional effects

The participants expressed that their diagnosis of hypertension and related conditions resulted in fear, stress and self-blame. Three who struggled with feelings of fear stated the following:

> *"I have heard so many stories about hypertension. I am scared, what if I die young?"* (P10).

> *"I heard that it can be genetic. Does this mean my children will also have it? The thought of this scares me"* (P12).

> *"I am scared I might not be able to have children because of the hypertension. I know a few people who have miscarried or had to abort due to uncontrollable hypertension"* (P20).

It would appear that these research participants believed hypertension to be genetic and deadly. The study findings were in line with Dillon et al. (2015) whose study findings found that newly diagnosed blood pressure patients experienced intense fear for their future and of measuring their blood pressure. This is consistent with the findings of this study, which revealed that the participants were worried that they might die young. Also, in the study, the fear of measuring blood pressure was observed in individuals who had stopped measuring their blood pressure after being diagnosed with hypertension.

Those who were stressed expressed themselves as follows:

> *"I am constantly stressed and worried about what hypertension might be doing to the rest of my body. I heard that it has adverse effects to one's overall health and body"* (P1).
>
> *"I find living with hypertension stressful. I need to be mindful of my diet, exercise more, a lot changes…"* (P5).
>
> *"I at times do not eat nor sleep because of my diagnosis. I sometimes feel stressed and depressed"* (P10).
>
> *"I stress and worry a lot about this hypertension, and I think I might be falling into depression"* (P15).

It is apparent that while the participants had accepted their hypertension diagnosis, they struggled emotionally to cope with it. Their fears about the condition caused constant worry and stress, which had led to depression for some. Other researchers support this finding as follows. Li et al. (2019) found that it is common to feel sad, worried and depressed after receiving a chronic illness diagnosis such as cancer, hypertension or diabetes. Similarly, a study by Kretchy, Owusu-Daaku and Danquach (2014) on the mental health of patients living with hypertension found that anxiety and stress were common among 57% of the hypertensive patients.

In addition, some participants felt that they could have done something to prevent hypertension, and engaged in self-blame. This is evident in the following remarks:

> *"I honestly blame myself for this, I should have followed a healthy diet …"* (P3).
>
> *"I stress a lot, even about the smallest things. I was warned about the long-term effects of stress, but I did not listen"* (P12).

It is evident that these participants experienced self-blame and guilt linked to their diagnoses, believing that they ought to have prevented the condition. Self-blame could be one of the contributing stressors for these participants. Jannati et al. (2020) conducted a systematic review study on the issue of self-blame among patients, finding that self-blame was a psychological concern in patients with various health conditions.

In addition, Callebaut, Molyneux and Alexander (2016) found that self-blame for a chronic illness is associated with increased emotional distress. Chronic illness is painful and stressful on its own, and adding self-blame simply adds another layer of stress to the suffering individual (Callebaut, Molyneux & Alexander, 2016). According to Jannati et al. (2020), psychological factors such as stress and self-blame have significant effects on the progression of any health condition and adherence to treatment.

b) Social effects

The participants expressed that their lives had been affected not only emotionally, but socially. It was discovered that many participants felt socially isolated and that they were not getting the support they needed from loved ones, such as friends, family and romantic partners. Those who felt isolated had this to say:

> *"I have lost a few friends since my diagnosis. They would tell me that I am now boring as I no longer consume alcohol and smoke as I used to"* (P2).
>
> *"I had to quit smoking and avoid spending time with friends and relatives to fight the temptation"* (P5).
>
> *"My relatives and friends think I have changed, and they are distancing themselves"* (P15).

The above remarks indicate that the condition had changed these individuals, and that the change had contributed to the loss of bonds with their friends and relatives. From their remarks, it would also appear that the participants' loved ones lacked understanding of their diagnosis and the requirements of managing it. An alternative possibility is that friends and family did know about the condition and its implications, but lacked empathy. Dillon et al. (2015) state that lifestyle changes that help control blood pressure can have social implications. This is evident in the current study, where some participants reported feeling isolated because of the lifestyle changes they had made to control their blood pressure.

On the other hand, some participants said that they still enjoyed good social relationships, stating that their condition did not have any effect on their relationships with friends, family and romantic partners. However, they did mention that they were not getting the support they needed.

> *"My family is not supportive. They always prepare foods that I am not supposed to be eating" (P17).*
>
> *"My friends always offer me alcohol. It seems like they are not supporting my lifestyle changes" (P20).*

The above remarks indicate that participants were not being supported in the way they wanted and needed to be. Specific ways in which family could be supportive include cooking healthy meals that would accommodate them, while friends could respect their lifestyle change and desist from pressurising them to smoke and consume alcohol. Studies have shown that individuals of low socio-economic status struggle to maintain a healthy lifestyle (Gillies et al., 2021). Because of their poverty, it is difficult for participants and their families to be consistent about eating a healthy and balanced diet. They could consult dieticians in the local hospital for guidelines on eating healthily on a budget. Moreover, the participants could create vegetable gardens at home, which would enable them to eat vegetables regularly.

The data further suggests that family and friends play an important role in the management and self-care practices of individuals living with hypertension. Chacko and Jeemon (2020) conducted a study to explore the role of family support and self-care practices on blood pressure control in individuals with hypertension. The authors found that 53.2% of men and 62.1% of women experienced minimal to mild family support for self-care activities. Self-care activities for individuals living with hypertension include eating a low-salt diet, no smoking, no alcohol, physical activity, and stress reduction (Melaku et al., 2022). Chacko and Jeemon (2020) state that family support is associated with increased lifestyle changes and adherence to treatment. The findings by Chacko and Jeemon (2020) suggest that healthcare providers should assess the availability or lack thereof of family support when managing individuals with hypertension.

The narratives on the social effects of hypertension and related conditions speak to the systems theory. The systems theory is based on the idea that behaviour is influenced by various factors including family, friends, society, politics and environmental. This implies that these factors influence the way an individual thinks, feels, and behaves. In this case, the participants were negatively influenced by their social systems, mainly, family and friends. The participants' families and friends did not support the participants, as a result, some of the participants felt isolated and not supported enough.

4.3.2 The impact of poverty on adherence to treatment

In exploring the impact of poverty on treatment adherence for hypertension and related conditions, it was established that some participants did not comply with their treatment requirements because of their socio-economic situation and food insecurity. The findings of the study showed several views which emanated from the participants as follows:

Participants who did not adhere to their treatment owing to food insecurity said:

> *"Food is expensive. I am unemployed and cannot afford to eat three times a day"* (P3).
>
> *"There are days when I do not eat at all. I do not take my medications on those days"* (P8).
>
> *"To save food, I only eat twice a day and save the rest for my kids. The stressful part is that I have to take some of my medication three times a day and I cannot take it without a meal"* (P10).
>
> *"I have to take some of my medication three times a day after meals, but I can only afford to eat twice and sometimes once a day"* (P16).

The extracts above clearly indicate that poverty has a negative impact on compliance with treatment for patients living with hypertension and related conditions. The researcher also noted that the issue of food insecurity was raised by participants who were unemployed. It is evident that the number of times participants are able to eat in a day and the number of times they are required to take medication do not align. Patients whose medication was supposed to be taken three times a day after meals reported that they defaulted on taking their medication when they had to skip a meal because off food insecurity. Wilder et al. (2021) conducted a study on the impact of the social determinants of health on medication adherence, finding that food insecurity was associated with poor medication adherence. Wilder et al. (2021) state that individuals can experience intense side effects when they take medications without food. This explains why participants opted not to take their medication when they did not have food.

Looking into the systems theory, Kondrat (2017) indicate that an individual cannot be understood without taking into consideration various environmental factors such as economic, social, political and familial. In this study, the researcher considered the participants' socioeconomic factors when exploring adherence and non-adherence to hypertension treatment. The study revealed that the economic factors, unemployment and food insecurity affected adherence to treatment. The study revealed that the participants were willing to adhere to treatment however, due to the economic factors that were not under their control, they could not adhere to treatment. This is evident that an individual's behaviour (non-adherence) cannot be understood without considering their environment.

4.3.3 Experiences of accessing healthcare services

The participants shared various experiences in relation to staff attitude, patient confidentiality, screening and diagnostic services, support and management services. Twelve participants highlighted their challenges and barriers in accessing healthcare services. The main barriers covered were physical geography and lack of information, discussed under f) and g) below.

a) Staff attitudes

The data shows that some participants had received poor treatment and others had received good treatment from the nurses and doctors in local clinics and the hospital in Kwatsaduza. The participants who felt that staff had bad attitudes said the following:

> *"The nursing staff is very rude. They treat us like nobodies" (P6).*
>
> *"The nurses are always in a bad mood. They shout at us when we ask questions" (9).*
>
> *"The doctors are mean. One once told me to stop wasting her time when I was asking questions about something I did not understand" (P12).*

> *"The doctors are inconsiderate. They make us wait for hours whilst they chit chat and be busy on their phones" (P16).*

The Department of Health emphasises the idea of serving patients with dignity, but the above comments are evident that there are still healthcare workers who do not abide to Batho Pele principles in the public sector. These principles were established by the South African Department of Health to guide the practice of all health professionals. These principles centre around consultation, service standards, courtesy, access, openness and transparency, redress, information sharing, and giving best value. Haskins et al. (2014) found that the reasons for nurses' negative attitudes towards patients include lack of passion for the profession, their high workload, short-staffing, non-appreciation by management, and long working hours. Negative attitudes by healthcare providers can affect treatment compliance and the quality of service rendered. A study by Haskins et al. (2014) support this idea, stating that poor attitudes by nurses and doctors result in poor patient care and poor outcomes for patients.

Some participants, on the other hand, praised the nursing staff of the clinics and the hospital in Kwatsaduza in the following manner:

> *"A few of the nurses are very friendly, especially the male nurses" (P2) "I always receive the best service when I go for my appointments, the doctors are very patient with us" (P4).*
>
> *"I like the fact that my doctor allows me to ask questions and she always provides detailed answers" (P18).*
>
> *"The nurses are kind. They sometimes give me taxi fare to go back home and to come for the next appointment" (P20).*

The comments above showed that while some healthcare workers do not abide to the principles of healthcare service delivery, others are doing so well, going above beyond the call of duty in some cases. It is important for healthcare workers to have positive and welcoming attitudes towards patients to assist with treatment adherence, foster trust between patients and healthcare providers, and enable improved outcomes for patients (Haskins et al., 2014).

b) Patient confidentiality

The study established that some participants reported that not only do some of the nurses and doctors have bad attitudes, they fail to uphold the principle of patient confidentiality. Some who felt that that their privacy had been violated had this to say:

> *"The nurses are loud. Everyone will know what you are there for" (P7).*
>
> *"One of the nurses is a family friend. She disclosed to my aunt that I have hypertension and HIV" (P9).*
>
> *"The nurse asked me about my hypertension and HIV treatment compliance in front of the administrators" (P13).*
>
> *"I hate that the nurses discuss our files in front of other patients and the administrators" (P20).*

It would seem that the nurses and doctors do not understand the principle of patient confidentiality and its importance. The principle of patient confidentiality prevents healthcare workers from disclosing patients' diagnosis, prognosis, and any information shared with them by their patients. In addition, upholding patient confidentiality builds and strengthens trust between the patient and the service provider. From participants' comments, it would appear that some healthcare service providers in Kwatsaduza have broken the bond of confidentiality and thus violated patients' privacy and dignity. The issue of confidentiality could be one of the reasons that some participants had defaulted on their treatment. When patients perceive that health services are not private and confidential, they are less likely to screen for health conditions and adhere to treatment where needed (Peterson, 2018).

Zucker et al. (2017) conducted a study on the experiences of youth with regard to confidentiality in their healthcare, examining how the principle of confidentiality affected their interactions with the healthcare system. The study found that youth worry about privacy and future discrimination, and as a result may lie about their risky behaviours or not seek medical care when there is a need to do so (Zucker et al., 2017). The same could be inferred from comments given in this study, indicating that health professionals did not honour the principle of patient confidentiality, and in so doing may be compromising the youth's trust in the public health system

c) Screening and diagnostic services

The study found that all the participants reported that they had found out that they had hypertension through the screening and diagnostic services offered by a clinic, mobile clinic or the hospital in Kwatsaduza. One had discovered her condition at a campaign conducted at a local shopping mall. The following views were shared by participants:

> *"I was at the clinic to get birth contraceptives. The nurses asked to test me for blood pressure, diabetes, and HIV. Upon checking my blood pressure, it was discovered that it is higher than it is supposed to be"* (P1).

> *"There was a health campaign at the mall. They provided information about blood pressure and diabetes, and offered to test us for free. This is how I found out that I have hypertension and diabetes"* (P10).

> *"I was at the hospital for my antenatal appointment. I was sent to triage to screen for hypertension and other conditions. The first time my blood pressure was normal. I went back when I was eight months pregnant and I was told I have hypertension that was caused by the pregnancy but could go away after giving birth"* (P12).

> *"They have always offered free screening at the hospital. I would screen every month. My blood pressure was normal in the first three months. It then started escalating until I was declared hypertensive" (P20).*

The quotations above were an indication that free screening in various settings alerted these women to their conditions. Some had deliberately asked to be screened, and others had been screened as part of the triage protocol in public health institutions. This suggests that for some, the discovery of their condition was coincidental, a result of seeking treatment or a check-up for something else, such as pregnancy and migraines. The quotes show that free screening and diagnostic services are helpful, as they ensure that people know their health status and get treatment where needed. According to Schmidt et al (2020), screening and diagnostic services help with the earl detection and management of hypertension and related conditions. Schmidt et al. (2020) state that early detection of hypertension helps identify high-risk groups, which results in timely treatment and management of hypertension and the prevention of comorbidities. Schmidt et al. (2020) add that early detection of hypertension can help reduce morbidity and mortality rates linked to the condition. Equally important, early detection of hypertension can help reduce health-related costs associated with hospitalisation for severe symptoms, risk factors and comorbidities linked to hypertension (Legorreta, et al., 2015).

d) Support services

Because of the many effects of hypertension and related conditions on participants, especially those living in poverty, clinics and hospitals offer free support services comprising psychosocial support and nutritional support. Those who were using psychosocial support services said the following:

> *"The doctor noticed that I was not dealing well with my diagnosis, and he referred me to a psychologist within the hospital"* (P4).
>
> *"I am receiving counselling from the hospital social workers"* (P15).
>
> *"I attend a support group once a month at the hospital"* (P17).

The above quotations suggest that the hospital in Kwatsaduza is providing holistic interventions in the treatment and management of hypertension. They further suggest that the services provided by hospital social workers and psychologists were helping the participants to cope better and reduce stress to control and manage their hypertension. The hospitals and clinics are providing psychosocial support services through individual counselling and group counselling provided by psychologists and social workers. According to Liu et al. (2017), counselling can help patients understand the effects of negative emotions such as anxiety, depression and fear on the development, treatment and rehabilitation of hypertension. Counselling may also encourage and improve treatment compliance. Shah et al. (2022) conducted a study of the effects of patient counselling on hypertension outpatients and found that it improved medication adherence. Similarly, Thomas et al. (2017) conducted a study on the impact of patient counselling on the knowledge, attitudes and actions of 105 hypertensive patients in a tertiary care hospital. According to the study, the knowledge of patients increased to 79% from 64%, positive attitudes increased to 82% from 73%, and treatment adherence increased to 86% from 77% after counselling (Thomas et al., 2017). These figures show that counselling is crucial for improving patients' knowledge of their condition, instilling positive attitudes, and fostering treatment adherence for the control and management of hypertension and related health conditions.

In addition to the psychosocial support services that participants received from the hospital and local clinics, they received nutritional support. Those who received nutritional support services stated the following:

> *"The social worker picked up that I default due to lack of food. She referred me to a vegetable garden project in the hospital where I get vegetables" (P5).*
>
> *"I get free vegetables from the hospital twice a month" (P3).*
>
> *"To help reduce my stressors, the dietician registered my new-born baby for monthly formula as I am not breastfeeding" (P7).*
>
> *"I used to get food parcels form the clinic during lockdown" (P10).*

The extracts above are proof that the healthcare institutions in Kwatsaduza are providing holistic interventions for the treatment and management of hypertension. They also indicate that the institutions are aware that some of their participants do not adhere to treatment because of food insecurity, and respond appropriately by providing nutritional support to address the issue.

e) Management services

The study discovered that all the participants reported that they used management services at the clinics and hospital. These are services offered by health facilities to help patients control blood pressure and reduce the risk of complications. The services include free regular check-ups and free prescribed medication.

> *"To ensure that my blood pressure is controlled, I attend monthly check-up sessions in the clinic" (P7).*
>
> *"I have my blood pressure checked every month" (P9).*

In addition to regular check-ups, the participants received free monthly medication:

> *"I collect my medication from the clinic every month" (P12).*
>
> *"To keep my blood pressure under control, the hospital gives me 3 -days medication'" (P15).*

> *"The monthly pills I get from the clinic help keep my blood pressure moderate" (P19).*

The World Health Organisation (WHO) states that countries should strive to reduce hypertension as a public health problem (Wilder et al., 2021). The research data shows that the South African public healthcare sector is making efforts to control and manage hypertension and related conditions. The quotations suggest that all the participants living with hypertension and related conditions are receiving the necessary assistance from the public healthcare sector to manage their conditions. They also suggest that the management help they receive is helping to prevent other serious conditions. Nguyen et al.'s (2010) study showed that controlling and managing hypertension and related conditions helps reduce the risk of heart disease, stroke and renal disease, to name a few related conditions.

The participants had different experiences in accessing the above healthcare services. Most commented on the attitudes of nurses and doctors in local clinics and the hospital, with some reporting negative attitudes among staff and others reporting positive attitudes. Some expressed concerns about the issue of patient confidentiality.

f) Geographical location

Geographical location was one of the main challenges faced by participants. Distances from their homes to the clinics and hospital was a challenge for participants when they needed to honour appointments, collect medications or receive vegetables from the nutritional support programme. Participants had few transport options:

> *"I live in Duduza and I need to take two taxis to get to the hospital and another two to go back home"* (P5).

> *"I miss some of my appointments and I know for sure I would never miss one if the hospital was closer to home"* (P8).

> *"I am required to attend my appointments at the hospital, and it is far"* (P16).

It appeared that for many, the problem was essentially lack of funds to pay taxi fares.

> *"I do not always have a taxi fare to go to the clinic, so I miss some of my check-up dates"* (P10).

> *"I have missed three counselling sessions due to not having money to go to the hospital"* (P15).

> *"I cannot always get vegetables from the hospital as I need R40 to get there and back home. I rather use the money to buy electricity and R10.00 vegetables nearby"* (P19).

The comments show that the participants had the desire to honour their appointments and to be consistent, but that poverty coupled with distances between homes and healthcare institutions prevented them from being consistent in their appointments. This finding supports that of Huot et al. (2019), whose study aimed at identifying barriers to healthcare services. These authors found that as a result of distances and the expense of public transport, patients often missed their appointments, defaulted on treatment, and developed other health conditions (Huot et al, 2019).

Sone participants could afford to get to the clinics and hospital, irrespective of the distance, but struggled to find public transport to the hospital.

> *"I live in Nigel, just the last section of Duduza. There are no taxis that go straight to the hospital. I have to get off at Extension 19, then uber to the hospital to make it on time" (P7).*

> *"There are no taxis that go straight to the hospital. I always have to pay someone to take me to the hospital, wait for me, then take me back home" (P14).*

> *"Getting to the hospital is always a mission. I sometimes must hitchhike as there are no public transports that go there" (P18).*

It was notable that none of the employed participants found the distance or expense prohibitive in itself – for them it was the fact that public transport was limited, making getting there and back difficult. Despite this challenge, the employed participants were able to remain consistent with their appointments, making plans to find alternative transportation such as e-hauling, hitchhiking and hiring a private car owner.

g) Lack of access to information

While all the participants were knowledgeable at the time of the study about the available healthcare services in Kwatsaduza for hypertensive women living in poverty, they reported that there was a point at which they did not have this information. They mentioned that lack of knowledge was one of the reasons their hypertension was not detected earlier. Some only began to receive counselling when there were on the verge of depression. It appeared that the necessary information about the full range of services available came to them incrementally.

> *"I have always needed counselling. I did not know that the hospital offers free counselling"* (P6).
>
> *"I missed medication for three months as there were days when I could not afford to have three meals a day. I did not know that the hospital had a vegetable project for people like me"* (P14).
>
> *"I could not collect my medication from the clinic. I only found out recently that I can ask to be moved to the hospital, as it is closer"* (P20).

While some participants learned about the available services shortly after their diagnosis, others learned about them only months after the diagnosis. As a result, some had defaulted on treatment and had delayed receiving psychosocial support from social workers and psychologists. A study by Alzubaidi et al. (2015) that explored barriers to healthcare service found that some patients do not use healthcare services because they are unaware of the full range of services available near to where they live.

4.3.4 How women cope with their diagnosis

Participants coped with their conditions through a combination of social support, personal abilities and professional help.

Those who thrived through social support said:

> *"I do not know what I would have done without the support of my family and friends. They are making this journey bearable for me" (P1).*
>
> *"My friends have been supportive from the day I was diagnosed with hypertension and diabetes. They remind me of my regular check-ups and accompany me to them when they are available" (P10).*
>
> *"Coming from a family with a history of hypertension, they have showed me great support and care since they discovered that I am hypertensive" (P13).*

> *"My boyfriend is my biggest strength. He always knows what to say and what to do when I start overthinking my diagnosis" (P16)*

It is clear that some participants drew strength from their friends, families and romantic partners. Their social support system allowed them to accept their diagnosis, adhere to treatment and adjust well to the required lifestyle changes. These findings are similar to those of Osamor (2015), who conducted a study on social support and the management of hypertension in south-west Nigeria. The study established that social support facilitates adherence to chronic disease management. Similarly, Lei et al. (2019) investigated the association between social support and blood pressure, concluding that support from family, friends, spouses and community-based organisations helped patients manage blood pressure.

Some participants lacked a good family support system, and relied on professional help to cope with their diagnosis. These participants stated:

> *"I started seeing a psychologist a month after being diagnosed with hypertension. She helped me cope with my stresses" (P3)*
>
> *"The doctor referred me to a psychologist and health social worker when I was eight months pregnant and diagnosed with hypertension. The psychologist and social worker supported me until I gave birth" (P12)*
>
> *"To be honest, I find my strength from the support groups facilitated by the social workers and psychologists in the hospital" (P15).*

Social support provided by family, friends, romantic partners, social workers and psychologists was augmented by participants' personal qualities. Two participants expressed:

> *"I cannot really say how I manage to cope with my diagnosis. But I have always been one strong woman. I can take up any situation. It was hard at first, though, but it got better" (P2).*
>
> *"At first, I was miserable and struggled to accept that I have high blood pressure and diabetes at such a young age. I bounced back and here I am now, stronger than before" (P15).*

The above comments show that some patients felt badly when they first receive their diagnosis, and struggle to accept it. However, owing to their personal strength and resilience, they come to accept the diagnosis and do what is required to manage it. These findings are similar to those of Boima at al. (2023), who explored coping strategies and resilience among patients with hypertension in Ghana. According to Boima et al. (2023), patients with positive coping strategies had controlled and well managed hypertension. Similarly, patients with uncontrolled hypertension were found to have low personal resilience. These findings are in line with the principles of strength-based perspective. Saleeby (2006) previously indicated that when applying the strength-based approach, professionals assume that the clients come for help already in possession of various resources and competencies. The above narratives are evident that the participants possess various resources and competencies. These resources included friends, family, and access to professional services. Moreover, the competencies possessed by the participants included personal strength and resilience.

4.4 Conclusion

This chapter presented a profile of the participants and discussed research findings in relation to specific objectives of the study. A comprehensive discussion of the research findings, according to themes, sub-themes and categories, was presented in relation to the research objectives of the study within the context of relevant literature. The study revealed that all the participants were diagnosed with hypertension and they all found it stressful to make lifestyle changes. Eight of the participants had hypertension and related conditions including obesity, retinopathy, diabetes, and aneurysm. The participants made use of various coping strategies to cope with their diagnosis of hypertension and related conditions. The health institutions in Kwatsaduza also provide supportive services to women living with hypertension and related conditions.

The following chapter presents the conclusions and recommendations of the study.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The aim of the study was to contribute to a better understanding of the experiences and challenges of women living with hypertension and related conditions in Kwatsaduza, an impoverished community. Twenty participants took part in the study. These women received healthcare services from public healthcare facilities in the community and supplementary services from Itshudu Projects Organisation.

It was established that living with hypertension had a number of implications for these women. The first finding was that their diagnosis had both emotional and social effects; emotional effects included fear, stress and self-blame, while social effects included social isolation and lack of support from families and friends. Second, the study found that some participants did not adhere to treatment owing to food insecurity caused by poverty, since medication for hypertension has to be taken in conjunction with food. Third, the study established that the participants received various services from public facilities, including screening and diagnostic services, support services and management services. Fourth, the women suffered a number of challenges in coping with their conditions. These included poor staff attitudes in the public healthcare facilities, lack of confidentiality, lack of information, and difficulties related to distances between homes and public healthcare facilities. Lastly, the study established that women living with hypertension and related conditions cope through a combination of social support from friends and family, personal resilience, and professional help from social workers and psychologists.

This chapter presents the conclusions and recommendations of the study, discussed in light of the objectives of the study.

5.2 Conclusions of the study

This section provides conclusions that derived from the findings of this study on the experiences of women living with hypertension and related conditions in Kwatsaduza, Gauteng province. The conclusions were based on the following objectives of the study:

5.2.1 The effects of hypertension and related conditions on women living in Kwatsaduza

The findings of the study showed that the participants experienced intense stress and fear following their diagnosis of hypertension and related conditions. Their stress was associated with mainly knowing about the diagnosis and the perceptions and beliefs they had about hypertension, with some believing that they would die young and that their children would inherit the condition from them. In addition, participants had lost friendships because of their condition, owing to the lifestyle changes they had made to better control and manage hypertension. Many participants were not receiving the support they needed from families and friends. Therefore, it can be concluded that women living in poverty and with hypertension and related conditions in Kwatsaduza are affected emotionally and socially.

It is important that policymakers and healthcare providers know and understand the effects that hypertension and related conditions have on women in impoverished communities. This understanding could help various role players, such as the Department of Health, health professionals and non-profit organisations to develop and implement strategies that reduce the extent of the effects. Appropriately designed strategies could reduce the women's stressors and enhance their strengths. As discussed in Section 2.3.1, strength-based theory maintains that focusing on individuals' strengths may help them overcome the challenges, which would help them thrive in difficult situations.

5.2.2 The impact of poverty on treatment adherence for hypertension and related conditions

The study found that poverty has a negative impact on hypertension and related conditions. This is evident in the fact that unemployed participants had quite different experiences from employed participants. Unemployed participants could not afford to eat three meals per day, as per treatment requirements. Hypertension medications have to be taken three times a day, after meals; the study found that many participants were forced to skip meals because of lack of food, and on such occasions, also skipped taking their medications. Employed participants were able to eat three meals per day and take their medication as per requirements. The study showed that unemployed participants were faced with the challenge of food insecurity, a social and health issue related to poverty. As a result of food insecurity, the management of their conditions was compromised. Participants who were employed at the time of the study did not report the challenge of food insecurity and were adhering to their treatment.

Fernandez-Lazaro et al. (2019) conducted a study on medication adherence and barriers among low-income patients. They found that low-income patients had the lowest percentage of treatment adherence among all their participants because these individuals had limited resources such as food. The findings of the current study also show that there is a relationship between poverty, food insecurity and non-adherence to treatment. This implies that addressing poverty will help fight food insecurity, which will increase the rate of treatment adherence amongst disadvantaged patients, and thus improve their health. These findings could inform poverty eradication strategies and programmes which assist with efforts to increase food insecurity. Recommendations in this regard are offered under Section 5.3.

5.2.3 Experiences of accessing healthcare services by women living with hypertension and related conditions in Kwatsaduza

The study revealed that all participants had access to various healthcare services provided by the clinics and hospital in Kwatsaduza. These included the key services of the South African public health system; namely, diagnostic and screening services, support services and management services. All the participants used at least two of these services, if not all. It was evident that the support services had a positive impact on the emotional and social wellbeing of the participants, and on their health.

To cope with the stress and fears that the participants were feeling, they relied upon their friends and family or, in some cases, solely on hospital counsellors, psychologists and social workers. Participants who were not supported by their friends and families attended support groups, where they felt understood and supported. Equally importantly, many participants collected vegetables from the hospital and food parcels from the local clinics to enhance their food security. It can be concluded that the support services offered are effective, as they address the emotional, social and socioeconomic issues experienced by participants, and enhance treatment adherence. However, the nutritional support services were inadequate in quantity, and could be seen as supplementary only. In theory, what they received was supposed to last a month, but in reality, most participants said they were insufficient to last a month.

Moreover, to prevent the development of serious conditions such as heart failure, the participants in the study also made use of hypertension management services. The clinics and hospitals are clearly providing a comprehensive suite of healthcare services to impoverished communities such as Kwatsaduza.

The research deemed it crucial to explore the healthcare services that are accessible and used by women living with hypertension and related conditions. This is important to know, as the information could help in evaluating the effectiveness of the services and the strengths and weaknesses of each service provided by healthcare institutions in impoverished communities.

The identification of gaps in healthcare service delivery could help improve the development and implementation of services according to the needs of society.

The findings revealed that some participants experienced negative attitudes from nurses and doctors in the clinics and hospital of Kwatsaduza. Nurses and doctors could be rude, disrespectful and impatient with the participants. Also, the findings show that participants had to wait several hours before they were attended to by either a nurse or a doctor. The literature shows that patients wait for a long time because healthcare workers are overworked and overwhelmed due to undertaffing; this may have been the case in the current study, but the participants' experiences were that healthcare workers were frequently on their phones or engaging in casual conversation amongst themselves. This gave the impression of a lack of seriousness about serving patients. This impression was reinforced by the fact that some nurses and doctors did not uphold the principle of confidentiality.

On the other hand, the study found that while some nurses and doctors were rude and unwelcoming, others were friendly, kind and patient with the participants. Therefore, it can be concluded that healthcare services are not consistent; some participants had negative experiences in accessing the healthcare services in Kwatsaduza, and others had positive experiences.

The study revealed that the experience of receiving treatment or managing hypertension and related conditions in health institutions influenced participants' decisions on whether or not to continue seeking treatment. Treatment by clinics and hospitals can either motivate patients to manage their hypertension and related conditions and screen for other health conditions, or deter and demotivate them.

These findings yield insight into the challenges patients face in using health institutions, the treatment they receive, and the attitudes and behaviours of healthcare professionals in public institutions.

Systems theory explains how people's environment and various structural factors affect their lives as a whole. This was clearly evident in the current study. The systems theory approach to the topic under review holds that patients' behaviour and adherence or non-adherence to treatment and their ability to thrive or not thrive in their situation cannot by understood without an examination of what takes place in health institutions. The theory suggests that the individual cannot be separated from their environment, and their behaviour cannot be fully understood without consideration of various environmental factors such as economic, social, political, structural and familial factors. All of these factors played a role in the current study. An understanding of how staff attitudes and poor service delivery affect the treatment and management of hypertension and related conditions could prompt Department of Health employees to be more aware of the effects of their attitudes and conduct. Better supervision could also ensure that all staff, not just some, adhere to standard work ethics for the health services profession, and implement the Batho Pele principles established for public servants. Batho Pele, which translates as ‘people first’, was launched to transform service delivery in the public sector. There are eight principles of Batho Pele: consultation, service standards, access, courtesy, information sharing, openness and transparency, redress and value.

The study found that unemployed participants had challenges in getting to the clinics and hospital owing to poverty; they frequently could not afford taxi fares and distances were too long to walk. Employed participants had different challenges; they could afford the taxi fare, but struggled to find public transport that went past the clinics or hospital. As a result, the participants had to get to the healthcare facilities by alternatives means such as e-hailing, hitchhiking, or hiring a private car owner to take them. Therefore, it can be concluded that all participants experienced challenges in accessing the healthcare facilities. While all the women in the current study were from poor backgrounds, the unemployed were particularly vulnerable. Their inability to affords transport costs caused them to miss appointments and thus default on treatment occasionally.

There have been a few studies that focus on barriers to healthcare in impoverished communities but none that focusses on barriers to healthcare services in Kwatsaduza. The findings revealed by this study could help the Department of Health, the Department of Social Development, businesses, organisations, and healthcare professionals to come up with strategies to eliminate these barriers. These include providing hospital or clinic transport for patients who cannot get to the institutions because of financial difficulties, and increasing the use of mobile clinics in areas that are far from healthcare facilities.

5.2.4 How women cope with their diagnosis

The study showed that women living with hypertension and related conditions in Kwatsaduza use a variety of strategies to cope with their diagnosis. Some found their social support system helped the most. These participants received support from their families, friends and romantic partners and spoke of how valuable their encouragement was to them. Equally important to the support of family and friends was the professional help they received from the healthcare facilities. Some participants received no support from families and friends and relied entirely on the professional help they received at the clinics and hospital. Some remarked that they could trust only professionals with their thoughts and feelings, and not their friends and families. The participants who relied on professional help used the free services of psychologists and social workers provided by the public healthcare facilities.

Another coping strategy identified was reliance on personal attributes such as resilience. It was notable some participants thrived with their diagnosis because of their personal resilience. These participants expressed that they had quickly adjusted after receiving the life-changing diagnosis of their condition. Their coping strategies align with strength-based theory, as described in Section 2.3.1. The theory assists professionals to focus on the strengths of the individual patient, and to encourage the individual to look at their assets and strengths rather than their challenges and weaknesses. The theory holds that personal resilience and strength are the key drivers to survival and positive change. The findings of the study are consistent with strength-based theory, in that some participants thrived through their personal resilience and strength.

5.3 Recommendations

The study had four objectives. Below, recommendations are given for the first three objectives, which were: to understand the effects of hypertension and related conditions on women living in poverty in Kwatsaduza; to explore the impact of poverty on treatment adherence for hypertension and related conditions; and to explore the experiences of accessing healthcare services by women living with hypertension and related conditions in Kwatsaduza. Each is discussed in turn.

5.3.1 Recommendations on the effects of hypertension and related conditions on women living in Kwatsaduza

Based on the findings and conclusions drawn on the effects of hypertension and related conditions, it is recommended that individuals be given pre-counselling before screening and being diagnosed with medical conditions. Pre-counselling should include information such as: What is hypertension, what it means to live with hypertension, the myths about hypertension, and the facts about hypertension and related conditions. Pre-counselling could reduce the stress and fears that prevail amongst hypertensive patients. This could be done by employing community health workers who not only screen communities for free but provide precounseling and, immediately after diagnosis, refer individuals to social workers and/or psychologists for further support and counselling, including treatment adherence counselling.

To foster family support and strengthen support systems, community healthcare workers should provide health education to families of individuals living with hypertension and related conditions. This would help families understand the condition, learn about the needs of the affected individual, and learn how they can best support them to ensure that their needs are met. This includes incorporating healthy meals and snacks, and adjusting their lifestyles to accommodate the individual and prevent the development of related illnesses. In addition, healthcare social workers could conduct family group counselling to explore the challenges faced by families in supporting loved ones living with hypertension and related conditions, and provide relevant interventions.

5.3.2 Recommendations on the impact of poverty on treatment adherence for hypertension and related conditions

Since food insecurity related to poverty was found to affect adherence to treatment, broad recommendations are given that have to do with both alleviating poverty and increasing access to food. These include job creation, the cultivation of church and home gardens, skills development, and social development interventions. Through church and home gardens, individuals and communities could provide vegetables and fruits to combat food insecurity. Some may be sold to generate an income. It is recommended that the national and local governments create job opportunities for individuals living with chronic illnesses and taking chronic medication, many of whom are excluded from jobs that require medical assessments as part of their screening process. A job roll-out scheme for those on chronic medication could include skills development training to increase their chances of securing employment.

The involvement of different stakeholders such as businesses, the Department of Social Development and the Department of Agriculture is encouraged. It is recommended that stakeholders sponsor and encourage young people to venture into vegetable, fruit and poultry farming. The support should include providing land, seeds, needed equipment and initial training. The youth could consume some of the produce, sell some, and donate some to disadvantaged families living with chronic illnesses. Moreover, it is recommended that once these emerging young farmers have secured land and started farming, they donate seedlings to churches and households to encourage healthy eating and fight food insecurity.

It is also recommended that the government increase its support of nutritional assistance programmes by funding more non-profit organisations that provide nutritional support to disadvantaged families. To ensure treatment adherence, government and the organisations concerned should prioritise families living with hypertension and related conditions.

Job creation, skills development, farming, home/church vegetable gardens and nutrition assistance programmes, as recommended above, would help to reduce food insecurity and hunger and, as a result, improve adherence to treatment for hypertension and related conditions.

5.3.3 Recommendations on access to healthcare services by women living with hypertension and related conditions in Kwatsaduza

The findings show that women living with hypertension and related conditions make use of the full range of healthcare services provided by the healthcare facilities, including psychosocial services. It is recommended that healthcare professionals and schools teach about the importance and benefits of therapy and counselling to combat stigma and myths about receiving therapy. This might increase the number of chronically ill individuals who attend therapy and finish their therapy sessions. This, in turn, could help reduce anxiety and depression among hypertensive patients, prevent their conditions from escalating and improve treatment adherence.

It is also recommended that healthcare professionals encourage patients with hypertension and related conditions to use the services of hospital dieticians. This would help individuals and families to understand how their diet affects their health, and how they can modify it. Dieticians can help individuals plan and cook healthy meals that accommodate their budget.

Since many participants spoke of having negative experiences in the healthcare facilities, including poor staff attitudes and long waiting hours, it is recommended that healthcare supervisors and management teams implements safe suggestion or complaints boxes to encourage patient feedback about services and staff attitudes. Complaints would be made anonymously to encourage honest patient feedback and reduce the fear of reporting. The researcher acknowledges that most healthcare institutions already have suggestion or complaints boxes; however, institutions do not always take action on complaints made. Obviously, it is recommended that along with providing suggestion or complaints boxes, institutions step up their responsiveness to complaints received.

The study concluded that physical geography, lack of funds and lack of information were the main challenges and barriers to accessing healthcare services. While each township that forms part of Kwatsaduza (Kwathema, Tsakane and Duduza) has at least one clinic, it is recommended that patients be allowed to choose where to receive their healthcare services. This recommendation is important in light of the findings that there were individuals who lived in Kwathema, for example, but were required to attend follow-up appointments in Tsakane. Allowing both in-patients or out-patients to select the health institution closest to their homes may reduce non-adherence to treatment and the rate of missed appointments.

Addressing the issue of lack of funds to get to hospital is challenging, since public healthcare institutions do not have petty cash to assist patients to travel to and from the clinic or hospital. However, social workers should advocate for the use of hospital transport to assist individuals who cannot collect their medication owing to lack of finances, and also strongly advocate for the greater use of mobile clinics. Mobile clinics could be used not only for screening and campaigns, but for the dispensing of medication and for medical appointments. Instead of traveling to clinics or hospitals, patients would be able to collect their medication and attend medical appointments at small mobile clinic closest to home. It is recommended that the Department of Health invest in more mobile clinics.

5.4 Recommendations for future studies

This section provides recommendations for future studies based on the conclusions and purpose of the study. Two recommendations are made for future research:

Firsty, the research was conducted in Kwatsaduza on a small sample of twenty women living with hypertension and related conditions between the ages of eighteen and thirty-five. Considering that the sample was small, there is a need for similar research to be conducted on a larger scale that would include women above the age of thirty-five. This would provide a broader and in-depth understanding of the experiences of women living with hypertension and related conditions, young and older women.

Secondly, it is recommended that the same research is conducted on an affluent community. This would provide a detailed insight on the experiences of upper-class women living with hypertension and related conditions. This is based on the need to explore the connection between social class and experiences of living with chronic conditions.

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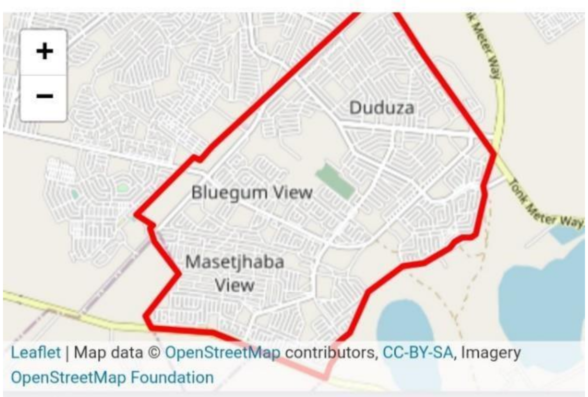
ANNEXURE A: MAPS

Map of Kwa Thema

Map of Tsakane

Map of Duduza



ANNEXURE B: Consent Form

UNIVERSITY OF CAPE TOWN

FACULTY OF HUMANITIES DEPARTMENT OF SOCIAL DEVELOPMENT

REQUEST FOR PARTICIPATION & CONSENT FORM

Date: September 2022
Name of Researcher: Cleopatra Mokone
Student number: MKNCLE005

This research forms part of the qualification for a Master of Social Development degree in the Department of Social Development at the University of Cape Town

Title of Study:

Accessing heath care in impoverished communities: The experiences of women living with hypertension and related conditions in the townships of Kwatsaduza, Gauteng province.

Objectives of the Study:

The study seeks to contribute to a better understanding of the experiences and challenges of women living with hypertension in impoverished communities. Therefore, the participants in this study were interviewed one-on-one in depth to fulfil the following objectives:

- to understand the effects of hypertension and related conditions on women living in poverty in Kwatsaduza:
- to explore the impact of poverty on treatment adherence for hypertension and related conditions;

- to explore the experiences of accessing healthcare services by women living with hypertension and related conditions in Kwatsaduza; and
- to examine how women cope with their diagnosis.

Please read the following and sign if you agree to participate in this study.

Research Procedures: I understand that I will be participating in an interview process to explore the experiences of women living with hypertension and related conditions in Kwatsaduza. The interview will last approximately one hour and will be recorded with your permission using a digital recorder or by taking notes. The recording will be transcribed and the notes, the recorded information and the transcripts will be kept in a secure place. Once the research has been completed, this material will be only be used for academic purposes and the transcripts will be destroyed.

Risks and Harm: There are no foreseen risks or harm in participating in this research. However, in the event of any emotional distress by a participant, the researcher will make a referral for appropriate assistance.

Benefits/Incentives: I understand that this research will not benefit me directly and that I will not be paid for agreeing to do this interview. However, through my participation, the information gathered will provide important information on the experiences of women living with hypertension and related conditions.

Participant's Rights: I understand that I am free to withdraw from participating in this study at any time, without giving any reason and that there are no consequences should I decide not to participate at any stage.

Confidentiality: I understand that the interview process will be kept strictly confidential and that information will be available to the researcher and the supervisor. Extracts from the interviews will be included in the final research report without anyone being able to link my quotes to my identity. The final report will be examined by an external examiner and the findings will be made available to participating agencies. Under no circumstances will my name be revealed in the report or any other publications related to this research.

I understand that if at any time I would like any additional information about this research, I can contact my research supervisor, Dr.Somaya Abdullah telephonically at 021 650-4219 or by email at somaya.abdullah@uct.ac.za

I confirm that I have read this consent form or the researcher has read it to me and that the study has been explained to me. I voluntarily participate in this study

Name of Participant

Signature of Participant Date (dd/mm/yyyy)

Signature of Researcher Date (dd/mm/yyyy)