CULTURAL CARE BELIEFS, VALUES AND ATTITUDES OF SHANGAANS IN RELATION TO HYPERTENSION

by

PATRONE REBECCA RISENGA

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SUPERVISOR: DR A BOTH

JOINT SUPERVISOR: MRS JE TJALLINKS

NOVEMBER 2002
DECLARATION

I declare that "CULTURAL CARE BELIEFS, VALUES AND ATTITUDES OF SHANGAANS IN RELATION TO HYPERTENSION" is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

SIGNATURE
(PR RISENGA)

DATE

NOVEMBER 2002
CULTURAL CARE BELIEFS, VALUES AND ATTITUDES OF SHANGAANS IN RELATION TO HYPERTENSION

STUDENT: PR RISENGA
DEGREE: MASTER OF ARTS IN NURSING SCIENCE
DEPARTMENT: ADVANCED NURSING SCIENCES, UNIVERSITY OF SOUTH AFRICA
SUPERVISOR: DR A BOTHA
JOINT SUPERVISOR: MRS JE TJALLINKS

Summary

The study explored the cultural care beliefs, values and attitudes among Shangaans relating to hypertension.

The study aimed to describe the cultural values, beliefs and practices such as taboos, rituals and religion within the world view of the Shangaan. The study was undertaken in the Mopani region of the Greater Giyani area, with the purpose of making recommendations on patient care.

Data collection was done by conducting focus group and individual interviews. The five themes that emerged were:

- Hypertension
- The traditional healer: the instrumental role
- Traditional medicine versus Western medicine
- Magico-religious healings
- Experiences of hypertensive patients with regard to traditional healers and hypertension

KEY CONCEPTS

Attitudes, cultural care beliefs, cultural sensitive nursing care, hypertension, professional health systems, Shangaans, values, world views.
Acknowledgements

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♦ Dr TVR and Mrs BN Ntsanwisi and their family, for their encouragement.
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Dedication

This study is dedicated in loving memory of my late parents, my mother, Ilherisa Maria Mamayila Chauke and my father, George Mkhacani Chauke
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The following abbreviations were used in this study:

ANC ancestors
B beliefs
HPE hypertensive patients' experiences
RA relationship with ancestors
REM- remedies negative
REM+ remedies positive
REM IND remedies indication
REMPIRE remedies prescription
REMPREP remedies preparations
SDA sources for diagnostic assistance/diagnostic methods
SS signs and symptoms
SYN synonyms for hypertension
T/F treatment feedback
TH traditional healer
TH con traditional healers' self-confidence
TWM traditional versus western medicine
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CHAPTER 1
INTRODUCTION AND OVERVIEW

1.1 INTRODUCTION

This study focused on the cultural care beliefs, values and attitudes relating to hypertension among Shangaans in the ¹Northern Province of South Africa. The most important aspect of the nursing profession is to render competent and culturally sensitive nursing care to all clients. Newman (1990: 199) stresses that a new generation of nurses with different cultural insights and a deeper appreciation of human life and values is developing sensitivity to culturally appropriate, individualised care.

Nurses should be knowledgeable about human diseases and the beliefs and customs of different cultural groups concerning these diseases. In addition, nurses should show respect, develop a non-judgmental acceptance of other cultures, and understand how culture influences health and illness in different ethnic groups. This is important because culture plays a significant role in the lifestyle of different ethnic groups. The major challenges that face the nursing profession are to provide culturally sensitive care and to move away from a narrowly biomedical type of care. This study will concentrate on these issues in relation to hypertension as a disease amongst the Shangaans as one of the ethnic groups in South Africa.

1.2 NATURE OF THE PROBLEM

Hypertension is an issue of great concern because of its rising incidence worldwide. According to the World Health Organization (WHO), hypertension, together with stroke, is ranked third as a cause of mortality under diseases of the circulatory system. According to the WHO, hypertension is increasing worldwide. Of course, improved technologies, better diet, the availability of medications for different diseases and increased hospital services cause people to live longer. An extended lifespan contributes to the incidence of many diseases such as hypertension (Boyle & Andrews 1995: 238; 417).

¹The name of the Northern Province of South Africa has now been changed to Limpopo Province. This change took place after this study was prepared, so the name Northern Province is used throughout.
Each ethnic group has its own values, beliefs and practices related to specific diseases/illnesses. This will affect the group response to a chronic condition. The study set out to investigate how the Shangaans, as the point of focus in the Northern Province, respond to hypertension on the basis of their own cultural values, beliefs and practices.

1.3 LOCATION OF THE SHANGAANS

The Shangaans are a Tsonga-speaking people occupying areas of the northern and eastern Lowveld of South Africa. The northern area, which includes Giyani and Malamulele, is bordered by the Kruger National Park to the east. The Ritavi district, situated approximately 10 km east of Tzaneen, lies to the west. Mhala district is a separate part in the south bordered by Timbavati Private Game Reserve to the north (Kriel & Hartman 1991:10). This is the former Gazankulu homeland area which at present falls mainly under the Northern Province. Part of it lies in the Mpumalanga Province.

Other ethnic groups living in the area include Venda and Sotho speaking people in minority groups. The researcher decided to choose the Shangaans as her target group. According to the investigations and the statistics the majority of hypertensive patients around the Mopani District in the Greater Giyani area are Shangaans. Identifying their problems would help the majority of people in the area.

The map depicting different areas mostly occupied by the Shangaans is attached as annexure B. Minority groups of Shangaans are also found in Gauteng Province due to urbanisation.

1.4 BACKGROUND TO THE PROBLEM

Hypertension is a serious health problem because its treatment poses complex nursing and medical problems. Because of the complexity of the problem of hypertension amongst the Shangaans, nurses need to increase and direct their efforts towards prevention, and towards helping clients to implement lifestyle alterations that will assist in controlling hypertension (Boyle & Andrews 1995:238; Nkhensani Hospital 1996:53).

The hospital in the Greater Giyani Lowveld region of the Northern Province has three health centres and the clinics, including mobile clinics, attached to it. The nearest clinic is about 10 km from the hospital, and the furthest clinic is about 55 km from the hospital. Hypertensive adults between the
ages of 40 and 65 are admitted to the hospital monthly due to collapse, stroke and high blood pressure. Other patients die before they reach the hospital.

These problems may be due to the difficulties patients experience in complying with long-term drug regimens and lifestyle changes that require major behavioural adaptations. Often, these behavioural changes may present challenges to cultural values, patterns and traditions involving dietary habits, daily activities and lifestyle.

The hospital in Greater Giyani has one adult medical ward with 70 beds to accommodate all medical patients, including hypertensive patients. This creates an accommodation problem for the hospital, and leads to some patients sleeping on the floor. Such a situation is not conducive to proper recovery, and rendering of correct nursing care becomes impossible. The hospital uses open days to examine hypertensive patients and to distribute treatments.

A common view of hypertension amongst the Shangaans in the Northern Province was expressed on the radio (Mungana Lonene) on 9 June 1997 at 19:00. Stanley Zitha, the SABC presenter, interviewed one patient suffering from hypertension. The patient said hypertension was caused by high salt intake and she was not sure about the treatment and effects of hypertension and its complications. From this interview it was clear that hypertensive patients were not well informed about their condition.

1.5 PROBLEM STATEMENT

During 1992-1993, the researcher worked as a professional nurse in different clinics in Greater Giyani, where she was responsible for providing primary health care. Many Shangaan patients were admitted to hospital due to complications of hypertension, specifically stroke. At one of the clinics in the Greater Giyani region, the researcher saw three hypertensive women brought to the clinic suffering from a stroke. They were immediately transferred to the hospital for further management and care.

One of the hypertensive patient in Hlaneki village collapsed while fetching water, and died on arrival at the clinic. This motivated the researcher to undertake research on the problem of hypertension among the Shangaans.
Statistics on hypertension indicate that hypertension is a major problem amongst the Shangaans in the Northern Province. Statistics for hypertensive patients from January to December 1996 at Nkhensani hospital are included (see Annexure A). Treatment facilities are available, but there is nevertheless proof of a high mortality rate amongst patients diagnosed as hypertensive. This suggests that there is a problem with either the health consumers or the providers.

On several different occasions, relatives of patients admitted to hospital with stroke came to the hospital with herbal medicine, requesting to be allowed to give it to the patients. These relatives were not allowed to give the herbal medicine to the patients.

An incident that happened in the operating theatre where the researcher was working in 1996, though not directly related to the problem of hypertension, illustrates the lack of cultural communication between the nurses and the Shangaan community. An old Shangaan female patient who was brought to theatre for surgery surprised the nurses and doctors. After the team in theatre had received the patient, the surgery nurse started preparing the theatre for surgical intervention on the patient. The old woman asked the scrub nurse not to do anything because it was already late for her *ripertile*, which means “sunset”. The nurse responded by telling the old woman the time. It was 14:00. She went on to say that it seemed late because they were in theatre and there was not enough sunlight. The poor old woman repeated her statement, but no one in the team responded appropriately because of their lack of understanding; they thought she was asking them to perform the operation quickly.

Later, when relating the incident to other senior nurses, they realised that the old woman was telling them that she was about to die, but because of their lack of cultural knowledge they had given an inappropriate response to her request. This incident challenged the researcher to explore human care knowledge that could guide nurses in the provision of culturally sensitive care. Such knowledge would also contribute much to the fundamental base of nursing knowledge. It would help nurses to avoid imposing their own culture-bound professional practices and ethics on patients. (Leininger 1991:39-42).

Such incidents highlighted a cultural gap between the medical staff at the hospital and the Shangaan patients. The question which therefore arose for investigation was: “What are the cultural care beliefs, values, and attitudes related to hypertension among Shangaans in selected areas of the Northern Province?”.
1.6 PURPOSE OF THE STUDY

The purpose of this study is to explore the cultural care beliefs, values and attitudes relating to hypertension among Shangaans in selected areas of the Northern Province. The study might throw light on the reason why many Shangaan patients are dying from hypertension and its complications although care facilities are available.

1.7 RESEARCH QUESTION

The research question for this study is: “What are the cultural care beliefs, values, and attitudes relating to hypertension among Shangaans in selected areas of the Northern Province?”.

1.8 RESEARCH OBJECTIVES

The objectives of this study are:

- to explore cultural values, beliefs and practices such as taboos, rituals and socio-cultural practices within the world view of health and disease, specifically in relation to hypertension, of selected Shangaans in the Mopani region in Greater Giyani in the Northern Province

- to make recommendations for health education in order to make it possible to provide culturally sensitive patient care

1.9 SIGNIFICANCE OF THE STUDY

It is important to know:

- how Shangaans view hypertension
- what Shangaans believe are the causes of hypertension
- the traditional treatment of hypertension

This knowledge would help nurses to deliver culturally sensitive nursing care which would be related to the cultural beliefs, values and practices of Shangaans. Any information gathered from patients would help to
enable nurses to render culturally sensitive care
enhance the body of nursing knowledge needed to render culturally sensitive care for these patients

1.10 DEFINITION OF TERMS

To facilitate communication and understanding by both researcher and the reader, the terms are defined as they are used in this study in order to avoid confusion in perceptions and interpretations.

- **Culture** is a view of the world and a set of beliefs [and] customs from the past to the present (traditions), used and transmitted from generation to generation, which provides a blueprint for determining one's values, beliefs and practices (Boyle & Andrews 1995:11).

- **Values** are personal perceptions of what is good or useful (Boyle & Andrews 1995:1). A world view is defined as a major paradigm, which is a way of viewing the world and the phenomena in it (Boyle & Andrews 1995:11).

- **Beliefs** are ideas which are considered true or trusted (Longman 1981:55).

- **Practice** is actual use or performance as compared with the idea and rules on which the action is based (Longman 1981:528).

- **Hypertension** is defined as persistent levels of blood pressure where the systolic pressure is above 140 mm Hg and the diastolic pressure is above 90 mm Hg (Brunner & Suddarth 1992:757).

- **Shangaans** are Tsonga-speaking persons who are Shangaans by birth and origin and have their own view of the world.

- **Cultural care** refers to subjectively and objectively learnt and transmitted values, beliefs, and patterned lifestyles that assist, support, facilitate or enable an individual or group to maintain their well-being [and] health, to improve their human condition and way of life, or to deal with illness, handicap, or death (Leininger 1991:47).
An attitude is a settled opinion or a way of thinking (Oxford Dictionary 1990:70).

1.11 RESEARCH METHODOLOGY

1.11.1 Research design

The researcher utilised a qualitative approach for this study. Qualitative research is conducted in order to generate knowledge concerned with meaning and discovery (Burns & Grove 1993:28).

An unspecified qualitative research design using an exploratory, descriptive and contextual approach was undertaken (Mouton & Marais 1998:102-103). This design was chosen because it provides data about the present and tells what people are thinking, doing, anticipating and planning in their natural environments, that is, the emphasis is on the natural world of humans (Polit & Hungler 1991:178). This is why the researcher identified this method as ideal for the study of the cultural care beliefs, values and attitudes relating to hypertension of Shangaans.

1.11.2 Population and sample

The population for the study was hypertensive patients and traditional healers who were Shangaans. Polit and Hungler (1995:230) describe accessible populations as those that conform to the eligibility criteria. For this study the accessible population was the portion of the target population to which the researcher had reasonable access, and consisted of hypertensive patients and traditional healers in Mopani Region in the Northern Province.

A sample refers to the subset of units or elements that compose the population (Polit & Hungler 1995:230). In this study the elements were named informants. Field and Morse (1990:138) describe an informant as one from whom the majority of information is obtained.

A non-probability, purposive sampling design was used to select informants. The informants met the eligibility criteria as outlined in Chapter 3 of this study. The informants were contacted and agreed to participate in the research, with informed consent (Streubert & Carpenter 1995:58). The sample included 30 hypertensive patients and 15 traditional healers.
1.11.3 Data collection approach

Focus group and individual interviews were used as data collection strategies. Both focus group and individual interviews were conducted in comfortable environments (Streubert & Carpenter 1995:23). Bracketing, intuiting and reflexivity were continuously reviewed to prevent bias of the researcher (Polit & Hungler 1995:636).

1.11.4 Data analysis

Data analysis was started immediately after data collection using content analysis and Tesch's stages of data analysis. Bracketing, intuiting and reflexivity were used to exclude preconceptions of the phenomenon in order to enter the world of the informants with an open mind.

1.11.5 Trustworthiness

The goal of qualitative research is to accurately represent the informants' experiences. Guba (1981:47) and Lincoln and Guba (1985:74) suggest four criteria to indicate trustworthiness. These criteria are credibility, dependability, confirmability and transferability. The criteria and strategies were used in the study to ensure trustworthiness.

1.12 ETHICAL CONSIDERATIONS

Ethical considerations were adhered to in order to prevent ethical problems. Permission from the Greater Giyani Municipality was obtained (Annexure C). Rights of informants were respected throughout the study. Confidentiality, anonymity and risk/benefit ratio were maintained throughout the study.

1.13 LIMITATIONS OF THE STUDY

Limitations applicable to this study included researcher's bias, data collection and analysis. The limitations are discussed in Chapter 5 of this study.
1.14 ORGANISATION OF THE REPORT

The dissertation is organised into five chapters.

- Chapter 1 introduces the reader to the problem studied. The purpose of the study was to investigate and describe the cultural care beliefs, values and attitudes of Shangaans in certain areas of the Northern Province relating to hypertension.

- Chapter 2 presents a literature review of selected literature pertaining to the culture of Shangaans, and literature on hypertension as a disease and its effects worldwide.

- Chapter 3 explains the study design, research setting, and data collection methods.

- Chapter 4 sets out the data analysis and presents the data.

- Chapter 5 presents the researcher's findings and recommendations.

1.15 CONCLUSION

This chapter described the context of the study. The importance of the study, its nature, purpose, research question and objectives were explained. Relevant concepts were defined and the organisation of the study outlined. A literature review follows in Chapter 2.
CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

An extensive literature review was undertaken using the Cinhall catalogue system. The chapter first gives a background to the study by outlining the world-view of the Shangaans as represented in the literature, their attitude to health and illness, and traditional healers. This is followed by a survey of their cultural and social structures as found in the literature. The chapter then presents an overview of hypertension internationally, nationally and regionally. Only limited sources were found regarding hypertension as an illness amongst different ethnic groups such as white, Asian and black people. Causes and incidence of hypertension, patho-physiology, signs and symptoms, and possible modes of treatment, including the magico-religious and biochemical treatments as well as complications, were explored. Aspects of Leininger’s sunrise model were utilised as a framework for structuring the literature review. A diagram of this model is depicted in Chapter 3 of this study.

Culture is defined in Chapter 1 of this research. From the previous definition, it can be inferred that culture is a set of guidelines which individuals inherit as the members of a particular society. These guidelines tell people in that society how to view the world and how to experience it emotionally and to behave in relation to other people. This includes their relation to supernatural forces and the natural environment, and this is promoted from one generation to another. This knowledge can be passed on in the form of beliefs, values and attitudes. Beliefs are ideas which are considered true or trusted within a particular culture group (Boyle & Andrews 1999:3-4; Helman 1994:2; Longman 1981:55).

An investigation was done on the Shangaan’s trusted ideas, their perceptions and their ways of thinking relating to hypertension as a disease. Although this study deals with only one of the ethnic groups in South Africa, reference is made to findings of research done on all black ethnic groups in South Africa. The focus of this study is on cultural care beliefs, values and attitudes among Shangaans relating to hypertension as a disease which causes high mortality amongst the Shangaans.
2.2 CULTURALLY SENSITIVE NURSING CARE

Culturally sensitive nursing care refers to those cognitively based assertive, supportive, facilitative or enabling acts or decisions that are tailor-made to fit in with individual, group, or institutional cultural values, beliefs, and ways of life in order to provide or support meaningful, beneficial, and satisfying health care, or well-being services (Leininger 1991:49). This type of nursing care can only happen when the cultural care values, expressions, or patterns are known and used appropriately and in meaningful ways by the nurse with the people.

2.3 WORLD VIEW OF THE SHANGAANS

A world view is a set of metaphysical beliefs used by a group of people to explain life's events (Boyle & Andrews 1995:17). A world view can also be defined as a major paradigm. A paradigm is a way of viewing the world and the phenomena in it. There are three major world views that dominate the explanations given for health and life events: the magico-religious, holistic and scientific paradigms. Aspects of each world view can be found in most cultures, though specific ones dominate. In the magico-religious paradigm the world is viewed as an arena dominated by supernatural forces. The fate of the world and those in it, including humans, depends on the actions of God, or the gods, or other supernatural forces for good and evil (Boyle & Andrews 1995:17).

According to the scientific or biomedical health paradigm, life is controlled by a series of physical and biochemical processes that can be studied and manipulated by humans. According to this paradigm the cause-effect relationship exists for all natural phenomena. This one dominates the medical field in Western societies (Boyle & Andrews 1995:18-28).

The holistic health paradigm is similar to the magico-religious paradigm except that the forces of nature itself are generally personified and must be kept in harmony. Human life is one of the aspects of nature and therefore nature must be balanced (Boyle & Andrews 1995:17-28).

The Shangaan's world view falls mainly within the magico-religious paradigm, an arena dominated by supernatural forces. They believe that there is a close relationship between creation (*Ntumbuluko*) and the supernatural power referred to as *tilo* by the Shangaans. They believe in actions of God as Creator, the gods, or other supernatural forces for good or evil (Kriel & Hartman 1991:29-31).
Shangaans believe in worshipping their ancestors, the spirits of dead people and wizards. Libation is practised as a way of speaking to the ancestors, in which traditional beer is prepared and a date for the function chosen (Hlengani 1998:70). Understanding the ways in which this kind of world view shapes the values, beliefs and practices of Shangaans will help nurses to appreciate the ways in which these people relate to the world around them and, in particular, to hypertension as a disease.

2.3.1 Health and illness

The World Health Organization has defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Boyle & Andrews 1995:21-22). Illness is defined as a state of perception, a subjective feeling in which a person may describe symptoms of disease or discomfort (Boyle & Andrews 1995:22).

Many Shangaans see health as a blessing from the ancestors because the person has respected aspects such as libation and is therefore protected by the ancestors. Presence of good health indicates that there is a balanced relationship between humankind, nature and the supernatural. They believe that negative physical or emotional symptoms may arise if this relationship with the ancestors is not in harmony. Other Shangaans who have converted to the Christian faith view health as a gift and as a sign of God’s blessing and good will. This makes them willing to resign themselves to God’s will, hence they believe that physical healing can be effected through prayer alone (Kriel & Hartman 1991:31).

Illness is viewed as a misfortune. There are, however, certain illnesses which are believed to simply appear. In such cases (for instance mumps), it is believed that the sick person will in time heal on his own. Illness is also viewed as God’s punishment (Kriel & Hartman 1991:32-35).

2.3.2 Causes of illness

Shangaans have many superstitions about disease, illness and its causes. They believe that illness and death are the result of spirits or mystic influences. Even if a person is involved in an accident resulting in death it will be ascribed to the same agency. They believe that the unfortunate victim was bewitched. Ancestral spirits that may feel neglected or wronged in some way may punish their descendants by sending illness or misfortune. There are different actions that may make the ancestors
angry, such as evil-doing and lack of respect for libations or the elders (Kriel & Hartman 1991:31). Another aspect that angers ancestors, according to Shangaan culture, is the violation of taboos (Hlengani 1998:11). Taboos are prohibitions or avoidance rules applied to particular persons, objects or phenomena.

Illness may also result from the malice of witches or sorcerers who use supernatural means to achieve their ends. The evil sorcerers are believed to use magic to cause the specific person whom they are against to be ill. There may also be family problems (Kriel & Hartman 1991:30-31). Beliefs concerning witchcraft and sorcery are especially common throughout South Africa. Many South African black peoples, such as the Zulu and Venda, frequently regard witchcraft and sorcery as causes of illness. Interestingly, a study conducted amongst African Americans has revealed that illness is frequently also ascribed to sorcery in this community (Helman 1994:79).

According to the Shangaan world-view, the treatment of illness should mainly involve the folk-health systems such as libation, the use of traditional healers such as herbalists (tin 'anga), diviners (vahlahlvi and vango nova) and faith/spiritual healers (vafundhi). Traditional healers play a vital role when different diseases and misfortunes occur (Kriel & Hartman 1991:30-31).

2.3.3 Traditional healers

_Tin'anga_ are traditional healers who usually have specialised knowledge of plant material and have medical compounds (mirhi), which they make available to individuals in return for payment. Normally these people are primarily diviners (vahlahlvi). Diviners are a very useful group of doctors in African communities. Diagnosis is their primary function. They are consulted to find out why something has gone wrong. In many South African societies, the diviner therefore interprets the will of the ancestors, and practises because of a call by the ancestor’s spirits. Diviners consult the ancestral spirits using their instruments such as a set of bones (tinhlolo or mavula) in order to reveal the cause of the client’s misfortune and to work out what action must be taken to correct it. Some 75 percent of the men and 65 percent of the women in the former Gazankulu homeland still make use of the services of _tin'anga_ (Kriel & Hartman 1991:30).
FIGURE 2.1 TINANGA
*Vangoma* are the second category of practitioner found among the Shangaans. These people also have magical powers but are distinguished from the *tin'anga* by the fact that they are possessed by an alien spirit or spirits and therefore train other possessed people as future healers. When *vangoma* practise their magic, they sometimes use a set of half seed pods (*hakoti*). *Vangoma* dispense information and healing while in a trance, which is characterised by the possessed person’s making unusual bodily movements, making unusual noises and speaking strange languages.

People who appear to be possessed by a spirit live with *mungoma* or *vangoma* for a period of training and are known as *mathwasana* during that time. Because the training period of *mungoma* costs a great deal, *vangoma* are held in high respect by Shangaans. The cost of the services of *vangoma* is usually considerable, more than those of *tin’anga*.

Some of the Shangaans – more women than men – belong to various Christian denominations. Men are mostly found in places where alcohol is sold, as they believe such places help them to share their views as men. The majority of people attending church are found in urban areas. Some of the churchgoers do attend services for ancestral spirits such as libation, where all family members are invited to attend. (Hlengani 1998:9; Kriel & Hartman 1991:32).

### 2.3.3.1 Methods of treatment by traditional healers

Traditional healers play a vital role in the treatment of different diseases and misfortune. Treatment used when a person is ill includes herbal medicines. If a disease were linked with ancestral spirits or issues of libation, an offering would be given to the ancestral spirits as a sign of respect and a means of communication with ancestors so that they would heal the sickness. If illness is believed to be caused by an evil sorcerer, the misfortune can be turned back on him with magic options, or the patient can be strengthened with certain medicines so that the evil influences cannot harm him further. This type of medicine, obtained upon request only from a *n’anga* or *mungoma*, is occasionally used as a proactive protective measure against the influence of evil sorcerers too.
FIGURE 2.2 MUNGOMA
2.3.3.2 Communication with ancestors

Libation is practised as a way of speaking to the ancestors. Shangaans believe in worshipping their ancestors. They believe in the power of the spirits of the dead and hence, when a person has a problem, the person is advised to report to the ancestors for help through libation (Hlengani 1998:36-37).

2.4 CULTURAL AND SOCIAL STRUCTURE DIMENSIONS

This refers to features of interrelated structural and organisational factors within a particular culture, including religious, kinship (social), political (and legal), economic, educational, technological and cultural values, and ethno-historical factors (Leininger 1991:47).

2.4.1 Technological factors

Technological aspects amongst the Shangaans are focused mainly on developments in specific areas. This study elaborates on developments made by the former Gazankulu homeland government where Shangaans are located, areas now falling under the Northern Province.

2.4.1.1 Mining development

Minerals were found in all magisterial districts of former Gazankulu, except the Mhala district, now called the Bushveld region. Gold was mined at Fumani and Union Gold Mine in the Malamulele district, now called Northern Region, and at Louis Moore Gold Mine in Giyani district, now called Mopani Region. This created many employment opportunities for the Shangaans from different areas of former Gazankulu because many men were employed there and helped to bring an income home. Men who did not like working in the mining industries went to Gauteng to seek employment and this often promoted the introduction of a high-fat diet. This might have increased the incidence of diseases such as hypertension (Kriel & Hartman 1991:56).

2.4.1.2 Agricultural development

In 1992, 71 percent of the population of Shangaans were directly, and 26 percent indirectly, involved
in agriculture. Only about 20 percent of agricultural production is market orientated. The other agricultural products are used locally. Community gardens are also run in order to provide the food needed by all communities. The most important crops cultivated are maize, nuts, peanuts, tropical fruits and sisal (Hartman 1991:103).

2.4.1.3 Development of business sector

Amongst the Shangaans, there are street vendors who enter the economy by selling produce from their gardens; though this is done at a very cheap price, this does help them to survive (Hartman 1991:104).

2.4.2 Religious and philosophical factors

2.4.2.1 Shangaans and Christian faith

Some of the Shangaan people belong to different Christian denominations (Dutch Reformed, Presbyterian, Roman Catholic and Zionist). The majority of the people attending the churches are women. Religion serves as a guide to their daily lives and interaction with other people. The church is perceived as the centre of social activities within the community. The Shangaan religious beliefs are expressed in their tendency to pray for everything. They also pray for the sick. They believe that prayer alone is enough to heal a person. People with chronic conditions such as hypertension are therefore advised to leave their medication and to pray for their healing to take place. Many of the Shangaans who are Christians have strong beliefs in their ancestors at the same time; they sometimes visit traditional healers during the night about serious matters affecting their families and bodies (Hlengani 1998:41).

2.4.2.2 Traditional beliefs

Some Shangaans do not belong to any church and do not believe in Christianity. They believe in their ancestors only. If one member of the family dies, according to Shangaan culture, that person’s spirit remains with them. They also believe that they must respect and worship the spirits to protect themselves from bad luck and to avoid curses from ancestors. According to Shangaan culture, ancestors are responsible for protecting their people and bringing good luck to all family members.
Communication with ancestors is achieved through the process of libation by family members (Hlengani 1998:41-42).

2.4.3 Kinship and social factors

Kinship refers to a social network of people who are related by common ancestors or origin, by marriage or by adoption. A family is defined as a relatively small domestic group of kin who function as a cooperative unit (Popenoe, Cunningham & Boul 1998:274-275). A nuclear family is a small family unit consisting of the father, mother and children (Bezuidenhout 1998:3). An extended family is a family consisting of three or more generations (Popenoe et al 1998:275).

As soon as the woman moves into her own hut and begins to use her own cooking area she, her husband and their children form an identifiable nuclear family. However, the Shangaan man may marry more than one woman so that a larger unit is formed consisting of different families with the same father as the head of each family.

When sons from an extended family eventually marry, a settlement develops consisting of a man, his wife or wives, their unmarried children and families of their married sons. The layout of a Shangaan settlement varies from area to area, but there are certain common characteristics. It is generally circular in shape with a cattle enclosure in the centre. The main entrance is situated on the eastern side; members of the settlement use other entrances. The principal wife's hut lies towards the centre of the settlement, with those of the other wives on either side. Each woman has her own cooking area and grain storage hut. The immature boys' hut is erected next to the main entrance. There is a similar hut for immature girls, but it is erected elsewhere in the complex. Open-air meetings are held just inside the main entrance. Ancestral spirit sacrifices are made at a special sacrificial area under a tree in the settlement. A special area is reserved inside or outside the settlement for men. Here no women are allowed; matters concerning the settlement and those living in it are discussed, and disputes are settled (Kriel & Hartman 1991:49).

According to Shangaans, marriage is not simply an agreement between two individuals. After transfer of marriage goods, a close bond with obligation on both sides is created between various family groups of the married couple (Kriel & Hartman 1991:49-50).
If a married woman happens to be infertile or dies before giving birth, the younger sister is chosen from the same family to bear children for the man. If the married man dies, his wife must be given to the man’s brother to allow her to bear children for that family and so that the relationship is not broken (Kriel & Hartman 1991:50-51).

When a woman gets married, she becomes part of the extended family of her husband, but retains membership of the male lineage and clan of her father. Some of the best-known clans amongst Shangaans are the Chaukes, Malulekes and the Nxumalos (Kriel & Hartman 1991:51).

2.4.4 The tribe

The tribe is a comprehensive group of people who recognise the authority of a joint tribal chief and live in a certain area. The core elements in such a tribe are usually members of the same clan, but a tribe may include members of other clans who have joined the core. The tribal chief is therefore usually the most senior member of the core group, and the foreign groups who have joined the core also recognise his authority. The names of many tribal groups in former Gazankulu in reality refer to the clan unit that makes up the core of that tribe (Kriel & Hartman 1991:28).

2.4.5 Cultural values and ways of life

A clear distinction is made between adults and children among the Shangaan. In earlier times, adult status was not obtained simply upon reaching a certain age or upon physical maturity. It was reached only by ceremonially undergoing certain initiation rites. Boys and girls are initiated in separate groups, and only after the prescribed rites have been successfully completed are they considered worthy of respect (Kriel & Hartman 1991:81).

The Shangaan people believe in respect for the elders. The word *ku xixima* is used amongst the Shangaans to demonstrate respect. Respect is demonstrated in different occasions or forms such as the following:

- Women kneel down when greeting the elders or when they give them something such as food.
- When greeting, they talk slowly and avoid eye contact as a symbol of respect.
Young males are expected to take off their hats and squat when greeting elders as a sign of respect.

Women are not expected to sit on a chair during the presence of elders.

Women are expected to be submissive to men.

Male dominance is highly valued.

When children are eating food from the same plate, the older brothers are supposed to take meat first and younger brothers take meat later.

After eating, the younger brother is expected to take the plates to the kitchen.

Any person who does not respect the elders is regarded as a person from a family where there is no respect. Shangaans believe if children grow up in a family where there is respect, such respect will be conveyed to outsiders as the child starts to socialise with others outside the family. Children are taught to respect elders at an early age and they are expected to conform (Hartman 1991:81).

2.4.6 Authority and legal factors

2.4.6.1 Authority within the family

Authority starts to be exercised in the nuclear family as the smallest unit within the tribe. Amongst the Shangaans, authority lies with the father. The man is regarded as the head of the family. The father lays down rules which govern the activities of the whole family. The man is treated with respect and is obeyed by his wife and children. Every member in the family is governed by certain rules of conduct, duties and obligations and has certain rights and privileges (Hlengani 1998:20).

2.4.6.2 Authority within the settlement

When sons get married, their wives and children become part of their father's settlement. The father has authority over everyone who lives in the settlement. The head of the settlement is not appointed. He just holds the position of his authority because of his seniority by descent. Problems which cannot be successfully solved by the head of the settlement are referred to the lineage head for help (Kriel & Hartman 1991:37).
2.4.7 Economic activities

Climatic and environmental conditions play an important role in the production of food amongst the Shangaans. The nature of their economic activities is determined largely by tradition. With the exception of upper- and middle-class people living in townships, the standard of living of all the members of the tribe is more or less the same. The same methods of food production are used and every one has the same type of housing, clothing and household articles (Kriel & Hartman 1991:32).

The economic life of the people and their social structure and organisation are closely related. The extended family functions as a self-sufficient producer and consumer unit and therefore there is less job specialisation. Differentiation between sexes forms the basis for division of labour (Kriel & Hartman 1991:32-33).

2.4.8 Educational factors

Both primary and secondary schools are available in the various areas where Shangaans are located. The majority of the children attend school. In remote areas, girls are not supposed to be educated and are therefore not allowed to attend school because, according to the elders, education promotes promiscuity. In some schools, there is a severe shortage of resources such as classrooms and books, to the extent that children are found receiving lessons under the trees. Pass rates are very low in some rural settlements of Greater Giyani because illiterate parents cannot give their children the support they need and this makes learning difficult (Hlengani 1998:57).

Classrooms in primary and secondary government schools are overcrowded. This also contributes to lack of interest by the teacher in educating learners, as the teacher does not have a chance to get to know all the pupils. The level of literacy is generally low in the rural settlement of Greater Giyani (Hlengani 1998:59).

2.4.9 Language

Shangaans speak the Tsonga language. During communication, there are specific expectations regarding the showing of respect. A period of silence during communication and avoiding eye contact are regarded as aspects of showing respect. Most of the younger generation of Shangaans speak
English. Reading, writing and the speaking of English are taught in all schools. Many Shangaans, mostly the elderly, speak little or no English. Some elderly males speak Afrikaans because of urbanisation (Hartman 1991:49).

2.4.10 Diet

The diet followed by the Shangaans consists of agricultural products; their food includes porridge, sorghum, *xichumbe* (small beans), samp, groundnuts and pumpkin. Fruits include *makwakwa*, *masala*, and *marhange*. Because they have many cattle they use milk with porridge as their staple food (Hlengani 1998:59).

2.5 KNOWN FACTS ABOUT SHANGAANS AND ELEVATED BLOOD PRESSURE

According to Hlengani (1998), Shangaans believe that hypertension or “high-blood”, as they call it, is related to or caused by excessive intake of salt and the habit of adding salt after cooking.

They believe that hypertension is also associated with the intake of sour porridge (*dini*). Sour porridge is prepared from mealie meal, which is mixed with water and is left in a container for three days for the fermentation to take place (Hlengani 1998:20).

Sometimes people who are diagnosed with hypertension are advised by family members to use lemon juice; others consult the traditional healer for treatment. Some of the Shangaans who belong to the Christian faith believe that prayer will cure them, hence treatment is not necessary. The Zion Christian Church (ZCC) members believe that the mode of treatment to be used is pricking the nostrils of a sufferer with a needle. The excess blood that causes the hypertension comes out, and this corrects the situation (Hlengani 1998:20-21).

Some patients with complications of hypertension go to the hospitals and clinics for treatment. This is revealed by the high hospital statistics for hypertension and high statistics of patients who suffer from complications and strokes. No research has ever been conducted amongst the Shangaans regarding the influence of cultural care beliefs, values and attitudes in relation to hypertension (Hlengani 1998:69).
2.5.1 Diverse health systems

According to Leininger (1991), the generic or folk system refers to culturally learned and transmitted indigenous (or traditional), folk (home-based) knowledge and skills used to provide assertive, supportive, enabling or facilitative acts towards or for another individual, group, or institution with evident or anticipated needs to improve a human way of life or health condition, or to deal with handicaps and death situations (Leininger 1991:48). Shangaans also have their folk system in relation to different illnesses and death.

This system consists of taboos, which are the prohibitions or avoidance rules applied to particular persons, objects or phenomena. Consequences of breaching the taboo may either follow automatically or be inflicted by some gods or spirits (Hlengani; 1998:89). According to Shangaans, the elders must care for the person with hypertension. They must also prepare the food to be given to this person, including unfermented soft porridge, porridge and low salt relish. The disease is detected by the throwing of bones and communicating with ancestors.

The elders are expected to report to the ancestors if there is a sick person in the family. After reporting to the ancestors, they can consult a traditional healer. The ancestors will bless the whole process to be followed throughout the treatment of this person until healing is effected because they have been informed.

The sick person is restricted from sexual activities because it is believed that these will delay the healing process and will prevent the herbal medicine from working effectively (Hlengani 1998:91-92).

2.6 THE PROFESSIONAL HEALTH SYSTEM AND HYPERTENSION

Both the folk system and professional system are consulted, but it is between these systems that conflicts often occur. The folk system and professional health care systems are both intended to influence the individual’s or group’s access to and quality of care (Leininger 1991:37).

These two major types of health system are capable of providing human care that is healthy, satisfying, beneficial and consistent with the client’s cultural values and needs. However, some professional health care practices might not always be consistent with the client’s folk care. This is
a challenge to health professionals, who might be willing to make appropriate changes towards providing culturally sensitive care.

Combining folk and professional care could lead to people like the Shangaans being willing to seek health care services and receive culturally sensitive care; fewer conflicts would then arise (Leininger 1991:37).

2.6.1 Definition of hypertension

McMahon (1990:81) defines hypertension as a disease state in which the arterial blood pressure exceeds established norms, producing an increasing mortality and morbidity. Materson (1991:40) defines hypertension as a disorder of arterial pressure elevation which includes systolic pressure of 160 mm Hg and above and diastolic of 115 mm Hg or above.

2.6.1.1 Contributory factors to hypertension

According to Lewis and Collier (1996:865-866), the following factors are likely to contribute towards the development of primary hypertension: increase in body weight, increased sodium intake, a sedentary lifestyle and increasing age. Men develop hypertension at an earlier age than women do. Other contributory factors include cigarette smoking, stress, low socio-economic status and low levels of education (Black & Matassarin-Jacobs 1993:1267; Lewis & Collier 1996:865-866).

2.6.1.2 Primary hypertension

Primary hypertension, also known as essential or idiopathic hypertension, makes up more than 90 percent of all cases of hypertension (Black & Matassarin-Jacobs 1993:1267; Lewis & Collier 1996:864). The cause of primary hypertension is in most cases not known. However, the following factors are believed to be involved:

- **Diet** Dietary factors that contribute to hypertension include high sodium, saturated fat, cholesterol intake and deficiencies in certain metal ions (K⁺, Ca²⁺, Mg²⁺).
Obesity Weight gain is associated with an increased tendency to hypertension. There is a high correlation between obesity and physical inactivity and hypertension (Lewis & Collier 1983:683).

Age Clinical signs of disease usually appear after age 40.

Race More black people than white people are hypertensive.

Heredity Hypertension runs in families. Children of hypertensive parents are twice as likely to develop hypertension than are children of normotensive parents.

Stress Stress results in increased sympathetic nervous system activity, leading to increased blood pressure (Lewis & Collier 1983:683).

2.6.1.3 Secondary hypertension

Secondary hypertension is elevated blood pressure with specific cause, usually corrected by surgery or medication, and it accounts for less than 10 percent of all hypertension patients.

2.6.1.4 Pathophysiology of hypertension

High blood pressure results from increased vasoconstrictor activity of the blood vessels, which leads to an increase in blood pressure. The vasomotor centre situated in the medulla of the brain has the sympathetic nervous system tracks emanating from it. The tracks go down the spinal column to meet sympathetic ganglia in the thorax and abdomen. Stimulation of the vasomotor centre sets in motion impulses that travel down through the sympathetic nervous system to the sympathetic ganglia. The preganglionic neurons release acetylcholine, which stimulates the postganglionic nerve fibres in the blood vessels, where the release of cathecholamines results in constriction of the vessels. Occurring concurrently with sympathetic nervous stimulation of the blood vessels is stimulation of the adrenal medulla, which secretes vasoconstrictors. Vasoconstriction impulses also result in schema of the kidney, causing the release of rennin. Rennin is converted to angiotensin, which stimulates secretion of aldosterone by the adrenal cortex. Aldosterone in turn increases the reabsorption of sodium by the kidneys, leading to water retention and an expansion of the intravascular volume, increasing the arterial blood pressure. If treatment is not effected, this could lead to death (Lewis & Collier 1996:866-867).
2.6.1.5 Causes of hypertension

The following are responsible for the occurrence of secondary hypertension:

- coercion or narrowing of aorta
- renal disease, for example, stenosis
- pheochromocytoma
- neuralgic disorders, for example, brain tumours and head injury
- sleep apnoea
- medication such as oestrogen replacement therapy or non-steroidal anti-inflammatory drugs
- pregnancy-induced hypertension, acute stress, burns, alcohol withdrawal and drugs (Black & Matassarin-Jacobs 1993:1268)

2.6.1.6 Complications

Lewis and Collier (1996) describe the complications of hypertension as follows:

- cerebrovascular disease resulting in stroke, with hypertension as the leading cause of stroke
- heart failure
- coronary artery disease
- retinal damage
- renal disease

2.6.2 Incidence

2.6.2.1 Global/international

International statistics indicate that hypertension is a serious problem worldwide. European statistics indicate that 20 percent of the adult population in Europe and the Western industrialised world generally suffers from hypertension. This means that more than 100 million people in Europe and the US suffer from this condition (Hypertension 1998:32-33). A study conducted by Shea, Misra, Ehrlich, Field and Francis (1992:125-140) points out that, despite the availability of a national
hypertension education programme in America, there is still a problem of uncontrollable hypertension amongst African Americans.

Information related to African Americans was explored in relation to hypertension and culture. According to Boyle and Andrews (1999:332), hypertension is a major risk factor for heart disease and stroke in this group. High blood pressure levels are said to be higher among African Americans than among European Americans. Boyle and Andrews (1999:331) stress the importance of control as the factor responsible for improvement, which has led to reduction of stroke mortality in black people by 50 percent.

A study conducted by Schoenberger (1997:174-181) shows that elderly African Americans believe that the high intake of certain foods and a genetic prediction could cause hypertension. African Americans prefer to use prescribed medicines. This further illustrates the importance of assessing the cultural beliefs, values and attitudes of people before imposing one's own (Boyle & Andrews 1999:198-199).

2.6.2.2 South Africa as a whole

A study conducted by Bradshaw (1996:28-29) on patterns of chronic disease indicates that hypertension is a problematic disease in different racial groups in South Africa. According to a national household survey of health inequalities in South Africa (South African Health Review 1996), hypertension is the highest-ranked condition in South Africa. People suffering from this condition range from the age of 15 years to 65 years and above.

2.6.2.3 Northern Province and Mopani region

The Mopani region contains 12 hospitals. Visits by hypertensive patients attending these hospitals amounted to 12 795 over 12 months. Amongst the 12 hospitals, Nkhensani hospital, which caters for the Shangaans in the Northern Province (Lowveld Region Annual Reports 1996-1997), has the highest number of hypertension patients (3943).
In the Northern Province, there are 19 clinics and two health centres (Dzumeri Health Centre and Giyani Health Centre). The region caters for all racial groups. Hospitals catering for Shangaans have the highest number of hypertension cases. Tintswalo hospital, for example, had 3,055 such patients in the period. In contrast, Duiwelskloof hospital, catering mainly for white patients, had only five hypertension patients (Lowveld Region Annual Reports 1996-1997).

Traditional healers and herbalists are available in the area and many patients consult them first before going to a hospital for treatment. The form of treatment used by herbalists/traditional healers will be described under magico-religious treatment of hypertension amongst the Shangaans.

2.6.3 Treatment

2.6.3.1 Medication

The general goals of medication management of hypertension are to reduce and maintain a diastolic blood pressure at less than 90 mm Hg and to limit uncomfortable or disabling side-effects to a minimum. The drugs currently available for treating hypertension are outlined in Table 2.1. These drugs include diuretics, adrenergic (sympathetic) inhibiting agents, vasodilators, angiotensin, converting enzyme, inhibiting agent and calcium channel blockers (antagonists) (Lewis & Collier 1996:871-875).
### Table 2.1: Antihypertensive drug therapy

<table>
<thead>
<tr>
<th>AGENT/DRUG</th>
<th>MECHANISM OF ACTION</th>
<th>SIDE EFFECTS AND EFFECT ADVERSE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIURETICS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Thiazides and related diuretics, for example, Diuril</td>
<td>Act on the ascending loop of Henle and distal tubule</td>
<td>Electrolyte imbalances including hypocalcaemia, hypokalemia, anorexia, vomiting, diarrhoea, dizziness, headache</td>
</tr>
<tr>
<td>- Loop diuretics, for example, Lasix (furosemide)</td>
<td>Act on the ascending loop of Henle to prevent the re-absorption of chloride and sodium; of shorter duration than thiazides</td>
<td>Fluid and electrolyte depletion, reversible hearing loss</td>
</tr>
<tr>
<td>- Potassium sparing diuretics, for example, Aldactone</td>
<td>Used mainly with thiazides diuretics to prevent or correct hypokalemia</td>
<td>Renal insufficiency, Urtercaria, Drug fever</td>
</tr>
<tr>
<td><strong>ADRENERGIC INHIBITORS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- B-Adrenergic blockers, for example, Propanolol (Inderal)</td>
<td>Reduce blood pressure, decreasing cardiac output, sympathetic stimulation and rennin secretion by kidney</td>
<td>Bronchospasm, heart failure, brachycardia depression, nightmares, insomnia</td>
</tr>
<tr>
<td>- Centrally acting as blockers, for example, Methyldopa (Aldomet)</td>
<td>Inhibits impulses through sympathetic nerve pathways</td>
<td>Dry mouth, sedation, impotence, constipation, dizziness, headache, fatigue, anxiety</td>
</tr>
<tr>
<td>- Peripheral-acting adrenergic antagonists, for example, Reserpine (Serpasil)</td>
<td>Acts both peripherally and centrally to deplete norepinephrine stores</td>
<td>Nasal congestion, drowsiness, mental depression, brachycardia</td>
</tr>
<tr>
<td><strong>ANGIOTENSIN CONVERTING ENZYME INHIBITORS</strong>, for example, Captopril (Capoten)</td>
<td>Inhibit angiotensin converting enzyme 9ACE) and lower the systemic vascular resistance (SVR)</td>
<td>Loss of taste, Cough, Tachycardia</td>
</tr>
<tr>
<td><strong>CALCIUM ANTAGONISTS</strong>, for example, Nifedipine (Isoptin)</td>
<td>Cause vasodilation of peripheral arterioles by blocking movement of extracellular calcium into cells, resulting in decreased SVR</td>
<td>Nausea, headache, hypertension, peripheral oedema and constipation</td>
</tr>
</tbody>
</table>

(Lewis & Collier 1996:871-875)
2.6.3.2 Diet

A diet for controlling hypertension should include the following guidelines:

- sodium restriction
- caloric and fat restriction (Lewis & Collier 1996:870)

2.6.3.3 Other measures of treatment

Lowering alcohol consumption reduces blood pressure (Lewis et al 1996:871).

- Regular exercise such as walking or swimming can help control blood pressure, promote relaxation and control body weight.
- Avoidance of cigarette smoking limits the incidence of developing hypertension (Lewis & Collier 1996:871).
- Stress management is recommended as it also lowers blood pressure (Lewis & Collier 1996:871).
- Clients are advised to limit coffee intake to two to three cups of coffee per day (Black & Matassarin-Jacobs 1993:1273).

2.7 CONCLUSION

The literature review first considered the background to the study: the definition of culture and the world view of the Shangaans. This included their attitude to illness and the role of traditional healers, and aspects of their cultural and social structure. The review then moved on to the attitude of the Shangaans to hypertension and gave an overview of the professional health system’s view of hypertension – its incidence, causes and treatment. Aspects from Leininger’s theory were used to guide this literature study.
CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The purpose of this chapter is to describe and justify a research design aimed at exploring the cultural care beliefs, values and attitudes among Shangaans relating to hypertension. Determining the appropriate design for research requires a process of decision making, data collection, data analysis, sampling and ensuring trustworthiness. These are referred to collectively as the research design (Botes 1995:17).

This chapter is organised according to the phases of research implemented to attain the objectives of the study.

3.2 RESEARCH OBJECTIVES

The objectives of this study were

- to explore the cultural values, beliefs and practices such as taboos, rituals, and socio-cultural practices which result from the world view of health and disease (specifically in relation to hypertension) among selected Shangaans in Greater Giyani
- to make recommendations to the professional health services with a view to their providing more culturally sensitive patient care among Shangaans in this area

3.3 RESEARCH DESIGN

Burns and Grove (1993:261) state that a research design is a blueprint of the method for conducting the study. It maximises control over factors that could interfere with the validity of the findings. It guides the researcher in the planning and implementation of the study.
An unspecified qualitative research design using an exploratory, descriptive (Wilson 1993:227) and contextual qualitative approach was undertaken (Mouton & Marais 1998: 43-44; 49-50). This design was chosen because such a design provides data about the present and tells what people are thinking, doing, anticipating and planning in their natural environments. The emphasis is on the natural world of humans (Polit & Hungler 1991:178).

The qualitative definition applied for this research is the one presented by Uys and Basson (1996); the study aimed to discover meanings and describe the cultural care beliefs, values and attitudes of Shangaans in relation to hypertension. Qualitative research is a way to gain insight through discovering meanings. Uys and Basson (1996:5) define qualitative research as the approach or methodology concentrating on human actions.

According to Schmid (1981:105), the purpose of qualitative research is to study the empirical world from the viewpoint of the person or group under study. During qualitative research, it is important to remember that the researcher is interested in the subjective meanings and perceptions of the informants. To critically assess the data obtained, the researcher has to remember that, besides being influenced by the physical, psychosocial and cultural environment, behaviour also goes beyond what is observed.

Kirk and Miller (1986:6) propose the following definition of qualitative research that reflects these concepts: “a particular tradition in social science that fundamentally depends on watching people in their own territory and interacting with them in their own language, on their terms”. Boyd, in LoBiondo-Wood and Haber (1994:254), defines qualitative research as “broadly stated questions about human experiences and realities, studies through sustained contact with people in their natural environment, generating rich, descriptive data that help us understand their experiences”.

According to Mouton and Marais (1998:43), the aim of exploratory research is to explore a relatively unknown research area to gain new insights into the phenomena under study, rather than collecting accurate and replicable data.

During this study, the researcher explored the literature and the natural settings of Shangaans and their experiences with hypertension. This was done in the context of Shangaans’ cultural care beliefs, values and attitudes regarding hypertension. The aim was to extend the theoretical knowledge
available about the Shangaans and their cultural practices.

In **descriptive research**, emphasis is placed on an in-depth description of a specific individual, situation, group, interaction or social object where applicable (Mouton & Marais 1998:43; Mouton 1996:133).

During this study, the cultural beliefs, values, and attitudes of Shangaans in relation to hypertension were described. This led to a more complete understanding of Shangaans and their culture in relation to hypertension.

According to Mouton (1996:50), the aim of **contextual research** is to give an extensive and in-depth description of the phenomenon, event or group within the context of the unique setting of the domain phenomenon.

This study is contextually bound to the unique time, space and value context of the specific villages where the study was conducted, and to their cultural care beliefs, values and attitudes. It is site specific and can only be relevant in those villages, namely Hlaneki, Dzumeri, Nkuri and Giyani. These findings are therefore only valid within the context of the specific communities in Greater Giyani.

### 3.4 PHASES OF THE RESEARCH PROCESS

#### 3.4.1 Phase 1

For the purposes of this study, the first phase dealt with the data gathering methods and the research questions and objectives. In this phase, the researcher elaborated on what would be looked at. The objectives and questions that guided the researcher were also defined. The research technique and format of data collection were decided on.

#### 3.4.2 Phase 2

The second phase dealt with population, sampling and data collection. Phase 2, Stage 1 consisted of focus groups for hypertensive patients. Stage 2 consisted of individual interviews with traditional healers. In Phase 2, the researcher gave a detailed explanation of how sampling was done and the
criteria and resources for choosing the target group. This phase formed the foundation for the third phase.

3.4.3 Phase 3

The last phase consists of the process of data analysis, and presents a summary of how analysis was done. Detailed information is presented on how trustworthiness was ensured and ethical considerations taken into account.

3.5 RESEARCH TECHNIQUE AND INSTRUMENTS

The research techniques employed in this study were focus groups and individual interviews. Research instrument topic guides were used (Wilson 1993:223). The interview schedule is included as Annexure G.

3.6 FRAMEWORK FOR THE LITERATURE REVIEW

Conceptual frameworks represent a less formal and less developed attempt at organising phenomena than theories (Polit & Hungler 1991:117). As the name implies, conceptual frameworks deal with abstractions (concepts) that are assembled by virtue of their relevance to a common theme.

A conceptual framework was not used in this study. However, concepts from Leininger's theory were used to guide the literature study. The research on cultural care beliefs, values and attitudes of Shangaans relating to hypertension was described using aspects of Leininger's view of care as essential for growth and survival of human beings. Leininger stresses that if cultural values, beliefs, expressions and forms of care are known, the health of people can be predicted. Leininger uses the world view, social structure, language, environmental context, genetic (folk) and professional systems to provide a comprehensive and holistic view of the cultural care and well-being of individuals, families, communities and institutions.
Figure 3.1
Phases of the research process
All levels were used in organising the literature reviewed in Chapter 2 of this study (Leininger 1991:335-337). Leininger’s Sunrise Model is depicted on page 38.

Together with the theoretical framework, the sunrise model is presented to help the reader of this research visualise different dimensions of the theory. This model is used to depict the influencing dimensions within the integrated view. The goal of the model is to discover and explain, interpret and predict cultural care knowledge and its influences, to understand and develop ways of providing culturally competent nursing care. The model consists of four levels.

Level 1 is the world view and social systems level, which includes religious, kinship, political, economical, technological and cultural factors. This level leads to the study of nature, meaning and attributes of care from three perspectives. This level was utilised in Chapter 2 of this study in organising information gathered during the literature review. The information gathered will assist the nurses and practitioners involved in the care of people from different cultural backgrounds to appreciate and understand the differences in meanings related to health and illness and, more specifically, hypertension (Wesley 1995:114).

Level 2 provides knowledge about individuals, families, groups and institutions in a diverse health system. It provides culturally specific meanings and expressions in relation to care and health. For this study, it involves the cultural care beliefs, values and attitudes of Shangaans in relation to hypertension. The study concentrated on the use of level 2 throughout the study. For this study, the focus was mainly on the cultural meanings and expressions of Shangaans in relation to hypertension, and hence the relevance of level 2 is justified (Wesley 1995:114).

Level 3 focuses on generic systems and nursing and professional systems, and allows for similarities and differences or cultural care diversity or universality in the information from the system. Level 3 was also used in this study to assist in organising the literature in Chapter 2. The generic system included all the knowledge available amongst the Shangaans with regard to hypertension, while the professional system involved all the scientific knowledge available with regard to hypertension (Wesley 1995:114).

Level 4 focuses on nursing care decisions and actions and involves cultural care preservation, cultural accommodation/negotiation and cultural care re-patterning/restructuring. Nursing care is delivered at this level.
Gu	ure Care
Social Struct  

Cultural values and lifeways
Kinship and social factors
Religious and philosophical factors
Technological factors

Influences
Care expressions
Patterns and practices
Holistic health (well being)

Cultural and Social Structure Dimensions

Cultural World view

Influencers
Directional Influencers

LEGEND

Figure 3.2
Leininger's Sunrise Model
(Adapted from Leininger 1991:106)
3.7 SETTING

The setting for this study was among the rural communities in the Mopani region in the Northern Province, specifically areas where Shangaans live, namely: Dzumeri, Hlaneki, Giyani, and Nkuri village (see the map in Annexure B).

3.8 POPULATION AND SAMPLING

*Population* refers to the entire set of individuals or elements that meet the sampling criteria. The target population for this study includes hypertensive Shangaan patients residing in the Northern Province. The *accessible population* is the portion of the target population to which the researcher has reasonable access (in this case, hypertensive patients and traditional healers in the Mopani Region of Northern Province).

3.8.1 Sampling design

Sampling involves selecting a group of people, events, behaviours, or other elements with which to conduct a study (Burns & Grove 1993:235). Non-probability sampling was used in this research. The method utilised was purposive sampling. According to Patton in Streubert and Carpenter (1995:43), purposive sampling provides information for an in-depth study with information-rich cases. Two groups of informants were selected, namely hypertensive patients and traditional healers.

3.8.1.1 Sampling of hypertensive patients

For phase 2, stage 1, hypertensive patients were sampled. These informants were selected because they were the people experiencing or making use of the care provided by the traditional healers (Bless & Higson-Smith 1995:95; Burns & Grove 1993:239-247).

The informants were included in the study on the basis of the following criteria:

- being Shangaan by birth and origin
- living in the rural areas in the Northern Province
- adhering to Shangaan tradition
• having first consulted a traditional healer about the problem of hypertension before going to hospital

3.8.1.2 Sampling of traditional healers

For phase 2, stage 2 of the research, samples were drawn of traditional healers. Informants were selected on the basis of their being known as good traditional healers in their communities (Bless & Higson-Smith 1995:95; Burns & Grove 1993:239-247; LoBiondo-Wood & Haber 1994:294; Treece & Treece; 1986:217; Wilson 1993:178-179). They were selected as experts with regard to cultural care beliefs, values and attitudes of Shangaans relating to hypertension.

The healers were included in the study on the basis of the following criteria:

• being Shangaan by birth and origin
• living in rural areas in the Northern Province
• having treated hypertension patients using traditional methods
• being a qualified traditional healer, having been trained by recognised traditional healers

3.8.2 Sample size and composition

The first group consisted of 30 hypertensive patients and the second group of 15 traditional healers. All participants gave their verbal consent to be included in the study. The hypertensive patients formed part of the focus group interview sessions. Four focus groups were held and included the following number of patients in each group: Hlaneki 7, Dzumeri 8, Nkuri 7, Giyani 8.

Traditional healers were interviewed individually and separately, as they did not wish to share information amongst themselves.

3.9 DATA COLLECTION

Data collection means precise, systematic gathering of information relevant to the research purpose or the specific objectives or questions of a study (Burns & Grove 1993:766).
The researcher conducted the study in four villages: Hlaneki, Dzumeri, Nkuri, Giyani. A vacant room was identified in the various clinics where the focus groups could be held.

The researcher translated the goal of this research into simpler language by saying, for example, “I am interested in your disease and would like to talk to you about your experiences with hypertension as a disease”. Later on, the researcher became more specific in her attempts to find out about the cultural care beliefs, values and attitudes of Shangaans in relation to hypertension.

The researcher explained to the informants that during the process of research she would like to record some information in writing. If the informants knew how to write, they were given a chance to write down their experiences. At times, data was tape recorded in order to yield a more permanent record. The researcher also obtained the informants’ permission to do the tape recording.

The researcher encouraged the informants to speak in Tsonga as they would be speaking to each other in their cultural context (Spradley 1979: 57).

The researcher asked informants to identify similarities and differences in the information collected. This helped the informants to understand the formal process (Spradley 1979: 59). The researcher gave the informants a detailed explanation of the research (Spradley 1979: 60).

Data collection was carried out in two stages: using focus groups and individual interviews. Methods are discussed below.

3.9.1 Phase 2: Stage 1

The researcher visited four areas, namely: Hlaneki, Dzumeri, Nkuri and Giyani to conduct focus group interviews with hypertensive patients, which included both males and females. Focus groups were conducted successfully in the four areas with the use of an interview schedule designed by the researcher after completing the literature review.

According to Wood (1988: 326), focus group interviews involve the collection of data from a group of four to ten participants who share their thoughts and experiences on a set of topics selected by the investigator. According to Polit and Hungler (1993: 437), a focused interview is a loosely structured
interview in which the researcher guides the informants through a set of questions using an interview schedule. (See interview schedule in Annexure G for questions used in this study.)

Focus group interviews were used because they allowed the researcher:

- more freedom to move from one topic to another in order to follow up on cues suggested by the informants (LoBiondo-Wood & Haber 1994:357; Wilson 1993:223)
- a great deal of freedom in exploring and discovering in-depth information and whatever appeared important to the researcher and informants in relation to hypertension and culture to clarify responses informants did not understand (LoBiondo-Wood & Haber 1994:357; Polit & Hungler 1993:205)
- to reword or rephrase questions so that they were more easily grasped by the informants (Burns & Grove 1987:33; Wilson 1993:225)
- to promote the likelihood that responses would be spontaneous, self-revealing and personal, which would aid insight into the study (Polit & Hungler 1991:231-232; Wilson 1993:225).

In all the four villages informants were comfortable with the focus group interviews and discussed information related to hypertension and culture freely.

3.9.1.1 Stages of data collection according to different villages

In all the four villages, reviewed literature was used as a guide for the interview schedule used as the basis of the interview. All the informants in the different areas were interviewed according to the same interview guide.

♦ Hlaneki village

Seven hypertensive patients were exposed to focus group interviews and all the discussions were tape recorded.
Dzumeri village

Eight hypertensive patients were involved in a focus group interview.

Nkuri village

Hypertensive patients exposed to focus group interviews were ten in number. Three patients declined to participate during the course of the discussion, indicating that they had other commitments.

Giyani

Eight hypertensive patients were involved in the focus group interview.

3.9.1.2 Dates of data collection

Hlaneki

The interview was conducted on 1 March 2001. The focus group interview lasted from 13:30 to 14:35. The researcher arrived at Hlaneki at 08:50 and all the informants were already seated outside the clinic in the shaded area provided for the patients. The researcher introduced the topic. All informants agreed to take part and accepted the issue of recording the discussion. Those who could read and write signed the consent form, while the others gave their oral consent.

The focus group interview with hypertensive patients was resumed in the vacant room in the clinic. The researcher used the interview schedule to structure the ensuing discussion in which informants were requested to share their knowledge with regard to hypertension as a disease amongst the Shangaans.

After the focus group interview, the researcher thanked all informants for participating in the study. Informants were invited to ask questions, which were answered, if possible, by the researcher. The discussion was completed at 15:00.
Dzumeri

The focus group interview with hypertension was conducted on 7 March 2001. The researcher arrived at Dzumeri Health Centre at 08:30 and the informants were comfortably accommodated. The researcher introduced the topic. Most informants seemed happy and excited about their participation in research after the purpose of the study had been explained to them. Signing of consent took place as in the first village. Hypertensive patients then took part in the focus group interview.

The focus group interview lasted from 12:00 to 12:55, after which all informants were thanked for their participation and their time. All informants were given a chance to ask questions and all were answered. The discussion was completed at 13:50.

Nkuri

Interviews were conducted on 8 March 2001. The researcher arrived at Nkuri clinic at 08:00 and some informants were already there, though others arrived together with the researcher. The introduction of the topic followed the same course as for the other villages. No complaints were raised by the informants with regard to participation in the research. After the explanation of the purpose of the study, consent forms were signed.

The focus group interview with hypertension patients lasted from 11:15 to 11:55. Informants were requested to ask questions and the researcher answered comprehensively. The researcher thanked all the participants for having spared their time to help her. The discussion was completed at 13:00.

Giyani

The interview was conducted in Giyani section E in the house of an informant who had volunteered to accommodate other informants, on 14 March 2001. The researcher arrived at Giyani Health Centre at 07:30. Most of the informants arrived at the same time as the researcher, and the topic was introduced as before.

Focus group interviews lasted from 10:00 to 10:55. The researcher expressed her appreciation for the participation of the informants. Informants were offered an opportunity to ask questions and they
were answered in detail.

3.9.2 Phase 2: Stage 2

An interview is defined as structured or unstructured verbal communication between the researcher and the subject, during which information is obtained for a study (Burns & Grove 1993:771).

The researcher also conducted interviews with traditional healers in the same villages. A focus group interview was not possible with traditional healers, as for cultural reasons they did not want to share their treatment practices with one another. They believed their ancestors had taught them their skills, which should be respected. Interview sessions were considered the best method to show respect for their cultural beliefs with regard to sharing information.

3.9.2.1 Stages of data collection according to different villages

In all the four villages the reviewed literature was used as a guide for structuring the questions put to informants.

✦ Hlaneki village

Five traditional healers were interviewed separately. Each interview with a traditional healer lasted for at least 40 minutes and all the information was recorded. For the interview schedule see Annexure G.

✦ Dzumeri village

Again five traditional healers were interviewed. Each interview lasted for at least 40 minutes and the information was recorded.

✦ Nkuri village

Three traditional healers were interviewed at Nkuri village. All interview information was recorded.
Two traditional healers were involved in interviews, which lasted for at least 40 minutes each. The discussions were recorded.

3.9.2.2 Dates of data collection

Hlaneki

The interview was conducted on 1 March 2001. The traditional healers were interviewed from 10:00 to 12h30.

A vacant room in the clinic was utilised for the interviews. Each traditional healer was interviewed separately. The researcher started the session by asking the traditional healer about cultural experiences and approaches regarding hypertension and its treatment.

The traditional healers felt free to express themselves, as they were talking to the researcher alone. The researcher took notes as the discussion was taking place. Questions asked by the researcher focused around the topic. Each interview session lasted for at least 40 minutes. All interviews were completed by 12:30. After each interview the researcher thanked the informants for participating in the study.

Dzumeri

The interview was conducted on 7 March 2001. Once again a vacant room was utilised to conduct interviews. The same questions as for the first interview were directed at traditional healers. The researcher recorded all the information during the discussion session. The interview session lasted for 40 minutes for each informant.

Nkuri

Interviews were conducted on 8 March 2001. Traditional healers were asked questions separately according to the interview schedule. Notes were taken and recorded throughout the discussion
process. Each interview lasted for at least 40 minutes. The researcher thanked all the participants.

Giyani

Two traditional healers were interviewed. Once again a vacant room was used to conduct the research interviews. The same questions were asked of traditional healers separately. All information was recorded during the discussion. The interview session lasted for at least 40 minutes per informant.

3.10 DATA ANALYSIS

Data analysis in qualitative research begins when data is collected and initial codes developed. Data analysis proceeds simultaneously with data collection, data interpretation and narrative reporting. The data collected by means of a tape recorder was transcribed verbatim and data collected in the field notes was organised into codes using cards. Data was then translated into English by the researcher, who is Shangaan, and given to two academic experts who are proficient in Tsonga and English. The first transcription was done within 24 hours. Data was coded again using cards; information was then studied for similarities and differences. Data was scrutinised to discover saturation of ideas. Major themes were abstracted and presented. Researcher findings and recommendations were presented (Tesch 1990: 113-129).

During data analysis, bracketing, intuiting and reflection were employed.

Bracketing is the process of identifying and setting aside any preconceived beliefs and opinions one might have about the phenomenon under investigation. It involves laying aside what is known (Brink 1999: 120). Fetterman, in Holloway and Wheeler (1996: 6), states that the researcher should enter the project with an open mind, though not an empty head. In this case the researcher suspended information known to her with regard to hypertension in order to avoid misinterpreting the phenomenon as experienced by the informants. Bracketing made it possible for the researcher to focus on informants’ experiences and to shape the data collection process according to them. The reason for bracketing was to reduce bias. The two aspects that led to the necessity of bracketing of any preconceived ideas were:
the literature study the researcher had done prior to the raw data collection
the researcher’s previous experience with hypertensive patients

**Intuiting** occurs when the researcher tries to develop an awareness of the lived experiences of the informants without employing prior expectations or knowledge in the process. The researcher reviewed the data again and again until there was common understanding (Brink 1999:120).

**Reflective** remarks reflected any thoughts, feelings, ideas, or insights the researcher wished to express. The researcher explored personal feelings and experiences that might influence the study and integrated that understanding into the study (Burns & Grove 1993:567). Abbott and Sapsford (1998:150) describe the importance of reflectivity throughout the researcher’s project.

The three reasons for reflectivity are:

- to help the researcher with self-monitoring, to spot when something is going wrong and to correct it
- to aid analysis of the data and finding the way through the mass of data
- to support self-justification and provide reasons why others should believe in the researcher’s interpretations

**Content analysis**, as described by Mouton (2001:165-166), was employed. Content refers to words, meanings, pictures, symbols, themes, or any message that can be communicated. Analysis was conducted as follows:

- selection of the unit of content to be analysed
- development of a category system for clarifying the units of content

### 3.10.1 The content analysis process

The process of content analysis involved the following:
• Selection of the unit of content to be analysed from data obtained during individual interviews with traditional healers and focus group interviews with hypertensive patients. The process was done separately for the two types of data. The units of analysis applied during this study were words and themes relating to hypertension. A phrase, sentence or paragraph may be identified as a theme (Polit & Hungler 1999: 199-200).

• Development of a category system for classifying the units of content.

  — Themes were developed from data units and classified into categories.
  — Categories derived from the framework developed through a literature review were supplemented with data from interviews. Nine categories were derived from interviews with traditional healers, and one category from the focus groups with hypertensive patients.
  — Each theme was divided into categories, which were also divided into subcategories depending on the data available in that theme, as the number of categories and subcategories are not the same in the themes.
  — A coding system was then developed for each category and subcategory. Each category and subcategory was based on guidelines as stated by Tesch (1990: 121-123).
  — The categories and subcategories as well as the coding were outlined in tables (provided in Chapter 4 of this study).

3.10.2 Data analysis process

No names appeared on tapes or transcripts, only coded identification. All tapes were transcribed verbatim. No attempt was made to correct the grammar of informants. The units of analysis were words and phrases. Thereafter the data, that is, the transcribed interviews, were coded by the researcher using cards. During data analysis the following process was followed:

✦ Phase 1

During the literature review bracketing, intuiting, and reflection, as described above in section 3.10, were applied.
Phase 2

During this phase, 15 individual interviews were transcribed. These transcriptions served as a permanent written record and a valuable reference point for the researcher during analysis and after the analysis process.

Before discussing the analysis process it is important to note that Shangaan-speaking informants were interviewed during this research. Thus, to maintain the exact meaning of what the Shangaan informants said and to combat loss of information, the interviews were transcribed by the researcher (Shangaan) into English and a quality control done by two expert academics who are both proficient in Shangaan and English.

Phase 3

Data obtained in the focus group interviews of hypertensive patients was transcribed verbatim by the researcher into English. Data was again coded by the researcher and verified by two Shangaan academics.

During the coding process, the actual coded transcripts and any new additions were transferred to the corresponding data under the formulated codes and related information which had been obtained from the literature review. Data obtained from both individual interviews with traditional healers and focus group with hypertensive patients were compared with information from the literature review to confirm the interpretation of the findings. The coded data were then given to two expert Shangaan academics proficient in Shangaan and English to verify the credibility of the transcripts and codes.

3.11 TRUSTWORTHINESS

The researcher used Guba’s Model of Trustworthiness for qualitative research during collection and analysis of data. Guba’s model was used because it is well developed conceptually and has been used by qualitative researchers, especially nurses and educators, for a number of years and provides structure and guidance to ensure trustworthiness (Krefting 1991:215).
Guba's model describes four criteria of trustworthiness, namely truth value, applicability, consistency and neutrality, which are relevant to the evaluation of the worth of the research. These four criteria are then described within the qualitative research perspective. Based on the philosophical differences between qualitative and quantitative approaches, several practical strategies for enhancing rigour are presented as a way for researchers to address the worthiness criteria (Guba 1981:80, 83; Krefting 1991:215, 217, 222).

Table 3.1: Guba's Model of trustworthiness of qualitative research

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>QUALITATIVE APPROACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Truth value</td>
<td>Credibility</td>
</tr>
<tr>
<td>Applicability</td>
<td>Transferability</td>
</tr>
<tr>
<td>Consistency</td>
<td>Dependability</td>
</tr>
<tr>
<td>Neutrality</td>
<td>Confirmability</td>
</tr>
</tbody>
</table>

3.11.1 Truth value

Truth value establishes how confident the researcher is of the truth of the findings based on the research design, informants and context. In qualitative studies truth is assessed by how well threats to the internal validity of the study and the instrument as a measure of the phenomenon under study have been managed. Internal validity is supported when changes in the dependent variable are accounted for by changes in the independent variable, that is, when the design minimises the effects of competing confounding variables by control or randomisation (Krefting 1991:215).

In qualitative research, truth value is obtained from the discovery of human experiences as they are lived and perceived by informants. Truth value is subject oriented and not defined by the researcher. Lincoln and Guba (Guba 1981:80) term this credibility. They agree that internal validity is based on the assumption that there is a single tangible reality to be measured. If this assumption is replaced by the idea of multiple realities, the researcher has to represent those multiple realities revealed by informants as adequately as possible. The researcher then focuses on testing findings against various groups from which the data was drawn, or persons who are familiar with the phenomenon under study (Krefting 1991:215).
Sandelowski (1986:30) suggests that a qualitative study is credible when it presents such accurate description of interpretation of human experience that people who also share that experience would immediately recognise the descriptions. Truth value is one of the most important criteria for the assessment of qualitative research, and a number of methodological strategies are required to ensure strong credibility (Krefting 1991:215-216). For this study credibility was attained as far as possible, as the information concerned cultural care beliefs, values and attitudes among Shangaans relating to hypertension was discovered through the use of interviews. This represented true, human experience as lived by the informants, which included both the traditional healers and hypertensive patients. The information obtained was not defined by the researcher but by the informants themselves. Informants, both traditional healers and hypertensive patients, were given a chance to describe their experiences while the researcher listened and recorded all the information.

3.11.2 Applicability

Applicability refers to the degree to which the findings can be applied to other contexts and settings or with other groups. It allows the researcher to generalise from the findings to larger populations. In qualitative studies, applicability refers to how well the threats to external validity have been managed (Sandelowki 1986:30). Payton, in Krefting (1991:216), defines external validity as the ability to generalise from the study sample to the larger population, and hence the importance of sampling technique is establishing external validity.

Sandelowki (1986:32) suggests that generalisation is irrelevant in many qualitative research studies. These studies are undertaken in naturalistic settings with few controlling variables. Each situation is unique and thus less amenable to generalisation. Generalisation is an illusion, as every research situation is made up of particular informants. Applicability is irrelevant to qualitative research as its purpose is to describe a particular phenomenon or experience, not to generalise to others.

Guba (1981:81) refers to transferability as the criterion against which applicability of qualitative data should be assessed. Qualitative research meets this criterion when the findings fit into contexts outside the study situation that are determined by the degree of similarity of fit between the two contexts.
Lincoln and Guba, in Krefting (1991:216) state that transferability is more the responsibility of the person wanting to transfer the findings to another situation or population than of the researcher of the original study. As long as the original researcher presents sufficient descriptive data to allow for comparison, he or she has addressed the problem of applicability. This study therefore addressed the issue of applicability in this study by providing sufficient descriptive data on the study to allow for transferability. This has been clearly presented in Chapter 4.

3.11.3 Consistency

Consistency refers to whether the findings would be consistent if the study were replicated with the same informants or in a similar context (Guba 1981:80). In contrast to the relatively controlled, structured experimental environment, the qualitative setting may be complicated by extraneous and unexpected variables leading to unstructured and often spontaneous settings (Duffy 1985:130). The instruments that are assessed for consistency in qualitative research are the researcher and the informants, both of whom vary greatly within the project.

Qualitative research expresses the uniqueness of the human situation, so that variation in experience, rather than identical repetition, is sought (Sandelowki 1986:33). Thus, variability is expected in qualitative research and consistency is defined in terms of dependability. Guba (1981:81) defines dependability as traceable variability, that is, variability that can be ascribed to identified sources. Explainable sources of variability may include increasing insight on the part of the researcher, informant fatigue or changes in the informant’s life situation, and the fact that qualitative research looks at the range of experience rather than the average experience. In qualitative terms, the outlying data need to be identified to describe the boundaries of the experience or phenomenon. Although a person might not be completely representative of a group, his or her experience is considered important (Krefting 1991:216). Since consistency is in this case defined in terms of dependability, this study ensured dependability of the study by providing a complete description of methodology, and coding of data by the researcher together with independent coders. Therefore, the study followed the requirements necessary to ensure consistency of the data obtained.

3.11.4 Neutrality

Neutrality refers to the degree to which the findings are a function solely of the informants and
conditions of the research and not of biases, motivations and perspectives. That is, it signifies freedom from bias in the research procedures and results (Krefting 1991:216).

During qualitative studies, the researcher tries to increase the worth of the findings by decreasing the distance between the researcher and informants, for example, by prolonged contact with informants or lengthy periods of observation. Lincoln and Guba (Krefting 1991:217) shift the emphasis of neutrality in qualitative research from the researcher to the data, so that data neutrality and not investigator neutrality is considered. They suggest that confirmability be the criterion of neutrality. This is achieved when truth value and applicability are established (Guba 1981:82). For this study, neutrality was achieved because truth value and applicability were explained and achieved by describing the informants' real experiences presented by informants themselves. This allows for applicability (transferability) of information to other areas. It was also achieved by doing a conformability audit, whereby data was given to independent coders from the University of Venda in the Northern Province for coding, together with the researcher.

3.11.5 Strategies for increasing the trustworthiness of qualitative research

Specific strategies for increasing the worth of qualitative studies were summarised and were described under each one of the four qualitative criteria for trustworthiness. Table 3.2 summarises the strategies for ensuring trustworthiness.

These strategies may be applied throughout the study, some during the study design stage, others during data collection and during and after data analysis. The strategies are defined under the criterion to which they are most frequently applied, but some strategies such as reflectivity are applicable to more than one criterion. As stated by Krefting (1991:217), it is important to remember that not all the strategies are appropriate to every qualitative study. Therefore, only those strategies applicable to this study will be discussed.
Table 3.2: Application of strategies for ensuring trustworthiness

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>CRITERIA</th>
<th>APPLICATION BY RESEARCHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>CREDIBILITY</td>
<td>Prolonged and varied field experience</td>
<td>Researcher spend nine years caring for hypertensive patient who are Shangaans.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Two years involved in study, 15 interviews, four focus group interviews and literature review.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Field notes were taken throughout the study.</td>
</tr>
<tr>
<td></td>
<td>Methodological</td>
<td>Literature review conducted to support findings.</td>
</tr>
<tr>
<td></td>
<td>Member checking</td>
<td>Follow-up interviews were conducted by the researcher with informants to clarify some concepts such as ku lumeka and healed.</td>
</tr>
<tr>
<td></td>
<td>Structural coherence</td>
<td>Concentrated on some concepts contained in Leininger's Sunrise Model.</td>
</tr>
<tr>
<td>TRANSFERABILITY</td>
<td>Nominated sample</td>
<td>Purposive sampling of informants obtained.</td>
</tr>
<tr>
<td></td>
<td>Dense description</td>
<td>Adequate database provided on informants, research content and setting.</td>
</tr>
<tr>
<td>DEPENDABILITY</td>
<td>Dense description</td>
<td>Complete description of methodology supplied.</td>
</tr>
<tr>
<td></td>
<td>Dependability audit</td>
<td>The researcher continuously examined the research process.</td>
</tr>
<tr>
<td></td>
<td>Code-recode procedure</td>
<td>Coded twice by researcher.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Independent coders discussed with researcher.</td>
</tr>
<tr>
<td></td>
<td>Peer review</td>
<td>Two colleagues in the nursing profession were given the document to check.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>As in credibility.</td>
</tr>
<tr>
<td>CONFIRMABILITY</td>
<td>Confirmability audit</td>
<td>Researcher examined the whole document upon completion of the study, as did one Master's student and a qualified M Cur colleague as independent co-coder.</td>
</tr>
<tr>
<td></td>
<td>Peer group discussion</td>
<td>Findings will be discussed with supervisor.</td>
</tr>
<tr>
<td>REFLECTIVITY</td>
<td>See credibility</td>
<td></td>
</tr>
</tbody>
</table>
3.11.5.1 Credibility strategies

Credibility was one of the strategies utilised to ensure trustworthiness of data. For this study, specific subheadings under credibility are presented to demonstrate how credibility was ensured.

♦ Prolonged and varied field experience

It is important to identify and document recurrent features such as pattern themes and values in qualitative research. This requires the researcher to spend adequate time with informants and to submerge herself in the research study. An important strategy is to spend an extended period of time, termed "the prolonged engagement", with informants, during which the researcher can check perspectives, allow informants to become accustomed to her presence, increase rapport, and through familiarity discover different and often more sensitive information than at the beginning. There is no limit to the length of time and frequency of encounters, it depends on the design and purpose of the study (Krefting 1991:217; Woods & Catanzaro 1988:453).

A threat to credibility is the preferred social response of the informant, that is, data is based on social desirability and not on personal experience. The extended time period (prolonged engagement) can be used to detect response sets, where informants consistently agree or disagree with questions, and to counteract them by using hypothetical cases and reframing questions to elicit more personal responses (Krefting 1991:218).

This study extended over a period of two years, in which the researcher had extensive and prolonged involvement with the informants and the data. The researcher has also been involved in rendering patient care to Shangaans and teaching of students for ten years.

♦ Reflectivity

Reflectivity refers to the assessment of the influence of the investigator's own background, perceptions and interests during the qualitative research process. It includes the effect of the researcher's personal history in qualitative research, as the researcher's background dictates the framework from which she will organise, study and analyse the findings (Krefting 1991:218).
It is important to remember that during data collection and analysis the qualitative researcher uses her own personality, bracketing and intuiting, which requires an open mind. Thus, she must relinquish sedimented views, that is, deconstruct, and reconstruct, form new ideas (Burns & Grove 1987:80). She must analyse herself in the context of the study. Therefore, during data collection and analysis the researcher compiled a contact summary after each interview and used the reflective remarks column on the transcript as a means of reflectivity during the study. While writing this personal information about the research process, the researcher became aware of biases and preconceived assumptions and altered the data collection and analysis approach to enhance credibility (Krefting 1991:218).

During the study, the researcher held numerous follow-up interviews and discussions with informants to check the interpretation of the analysed data. During data analysis the researcher held further follow-up interviews to confirm certain terms not clearly understood during interviews. These contacts occurred during and after data collection and analysis. A terminal member check was also done, after the study with informants had been completed.

Peer examination

Peer examination is based on the same principle as member checks, but involves the researcher's discussing the research process and findings with impartial colleagues who have experience with qualitative methods. Insights are discussed and problems presented as a form of debriefing.

Guba (Krefting 1991:219-220) suggests that this is one way of ensuring the researcher's honesty, while searching questions may contribute to deeper reflective analysis by the researcher. Colleagues can also increase credibility by checking categories developed out of data and by looking for disconfirming or negative cases. The researcher may also discuss with them the evolving design of the study. The availability of the informants' verbatim accounts, for example, in the form of tape recordings or transcripts of interviews, is helpful, as it allows the examiner to critically assess the interpretations from direct quotes.

During this study, two experts examined the interview schedule prior to, during and after the study. They also checked codes from tape recordings and verbatim transcripts, and performed a dependability and confirmability audit.
**Interview technique**

Applying the correct interview technique increases credibility. For instance, in order to avoid misunderstanding or to convey the exact meaning of a question, questions may be reframed, repeated or expanded to increase credibility. During this study, the researcher adhered to the principles of correct interviewing technique.

**Structural coherence**

Structural coherence is defined as the assurance that there are no unexplained inconsistencies between the data and their interpretation. Although data may conflict, credibility is increased if the interpretation can explain the apparent contradictions. Accounting for rival explanations or deviant cases here is important (Guba 1981:85; Krefting 1991:220).

During this study, the researcher obtained structural coherence by concentrating continuously on concepts contained in Leininger's Sunrise Model and integrating the masses of data in the research report to form a logical, holistic picture of the findings. The taped interviews were initially transcribed verbatim into Tsonga, and only after analysis were the findings translated into English. Two experts from the University of Venda in the Northern Province performed a dependability and confirmability audit.

**Establishing the authority of the researcher and referential adequacy**

The essence of the credibility issues is the unique authority of the researcher, the “I was there” element. To strengthen the idea of authority, viewing the researcher as a measurement tool has been proposed. Miles and Huberman (1984:233-234) identify four characteristics that are necessary to assess the trustworthiness of the human instrument, namely:

- the degree of familiarity with the phenomenon and the setting under study
- a strong interest in conceptual or theoretical knowledge
- the ability to conceptualise large amounts of qualitative data
- the ability to take a multi-disciplinary approach, that is, to look at the subject under investigation from a number of different theoretical perspectives
• good investigative skills, which are developed through literature reviews, course work and experience in qualitative research methods (Krefting 1991:220)

One way of assessing these investigative skills or technical competence is to examine the researcher’s background for any special training she has received that is relevant to the project, for example experience in interviewing. Additionally, any steps undertaken to enhance the skills of the researcher in the project, for example mock interviews, videotaping, analysis of the researcher’s interviewing skills and pilot interviews must be documented (Krefting 1991:220).

During this study, the researcher undertook a literature review focusing intensely on cultural care beliefs, values and attitudes of different ethnic groups as well as on hypertension as a disease and its impact on human beings. The researcher did not experience any difficulties with the taping of interviews and all the interviews passed off successfully without any problems.

3.11.6 Transferability strategies

3.11.6.1 Nominated sample

A key factor in the transferability of data is representativeness of the informants of the particular group under study (Krefting 1991:220). The researcher in this study ensured representativeness by the choice of criteria for selection of informants and by interviewing similar numbers in the two categories of informants.

3.11.6.2 Dense description

It is critical that the researcher provide dense background information about the informants and the research context and setting to allow others to assess how transferable the findings are to other studies. It is the duty of the researcher to provide an adequate database to allow transferability judgements to be made by others, and not to provide an index of transferability. Another way of enhancing transferability is to consider the data rather than the informants.

The researcher must determine if the content of, for example, the interviews, is typical or atypical of the phenomenon under study (Krefting 1991:220-221). During this study, the researcher gave a
sufficiently adequate description of the informants, research context and setting to enable transferability to be easily achieved by another researcher.

3.11.7 Dependability strategies

3.11.7.1 Dense description of research methods and dependability audit

Dependability relates to the consistency of findings, the exact methods of data collection, analysis and interpretation. This must be described to provide information as to how repeatable the study might be or how unique the situation is.

Guba (1981:87) uses the term auditable to describe the situation in which another researcher can clearly follow the decision trail used by the investigator in the study. Lincoln and Guba (Krefting 1991:221) suggest that a single audit of the research can enhance the dependability of the study.

During this study, the researcher described the research methodology in detail and continuously examined the research process. A dependability audit was also undertaken by two experts from the University of Venda, together with the researcher, as part of the whole process of auditing to ensure dependability.

3.11.8 Confirmability strategies

3.11.8.1 Confirmability audit

Guba (1981:87-88) views neutrality not as research objectivity, but as data and interpretational confirmability. Guba describes the audit strategy as the major technique for establishing confirmability. This strategy involves an external auditor attempting to follow through the natural history or progression of events in a project, to try to understand how and why decisions were made. Additionally, auditability suggests that another researcher could arrive at comparable conclusions given the same data and research context. The auditor considers the process of research, the product, data, findings, interpretations and recommendations.
According to Lincoln and Guba (Krefting 1991:221), six categories of records that may be included in the audit are:

- raw data (field notes, video and tape recordings)
- data reduction and analysis products (qualitative summaries, condensed notes)
- data reconstruction and synthesis products (interpretation)
- process notes (procedures and design strategies, trustworthiness notes)
- materials related to intention and dispositions (study proposal, field journal)
- instrument development information (pilot forms, survey format, schedules)

The audit should be a continuous process at the beginning of, during and after the study (Woods & Catanzaro 1988:456).

During this study the researcher audited:

- raw data (taped interviews)
- field notes
- data reduction and analysis products (15 verbatim interview transcripts and four focus group interviews)
- data reconstruction and synthesis products (themes, categories, subcategories and codes for use during data analysis)
- process notes (interview schedules formulated before undertaking the study)

### 3.12 ETHICAL CONSIDERATIONS AND HUMAN RIGHTS AND CONSENT

Ethical consideration includes the rights of informants where this research was conducted (Burns & Grove 1993:703).

Rights of informants were protected throughout the research.

#### 3.12.1 Permission

Permission to conduct the study was obtained from the municipal authority of Greater Giyani, which
is solely responsible for the communities in which the study was conducted (see Annexure C for letters of consent).

3.12.2 Respect for human dignity

The principle includes the right to free choice, which means that prospective informants should have the right to decide voluntarily whether or not to participate in the study. It also means that the informants have the right to terminate their participation, or to refuse to give information, or to ask for clarification about the purpose or any aspect of the study.

3.12.3 Informed consent

This principle was addressed by giving informants full information on the purpose of the study, its significance and data collection procedures before data was collected. This principle received priority consideration, since informants were patients and they might have perceived the researcher as having authority over them. They were informed that participation was strictly voluntary and a consent form was signed by informants (see Annexure D for agreement form by informants).

3.12.4 Confidentiality and anonymity

Confidentiality in this research was not easy to ensure, since precise quotations from transcripts had to be included in the collection of data. Informants were reassured that information gained would not be linked to their names.

Anonymity was provided by protection of the informants’ identities. They were assured that their names would not be used after data analysis had been completed. Anonymity was maintained during publication by omitting identifiable data and names.

3.12.5 Risk/benefit ratio

This principle means that the degree of risk taken by those participating should never exceed the potential humanitarian benefits of the knowledge to be gained. Qualitative research is considered usually non-invasive, depending on the topic under study. This study focused on a significant topic
that had a potential to improve the care of hypertensive patients.

3.13 CONCLUSION

This chapter dealt with the methodology applied in this research. The qualitative research method was described in detail and the phases of the research process, sampling design and method of data collection outlined, including the criteria used for inclusion of informants into the study. The method of data analysis was explained. The question of trustworthiness, and the extent to which the study fulfilled the requirements, was discussed at length. Ethical considerations were also dealt with. The next chapter will deal with analysis and interpretation of data.
CHAPTER 4
DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1 INTRODUCTION

This chapter deals with the analysis and presentation of the data obtained through the use of combined methods of data collection, namely, focus group interviews, field tests and narrative statements obtained through individual interviews. The purpose of this chapter is to present information obtained from informants and to assess them against the objectives of the study.

The objectives of this study are:

• to explore cultural values, beliefs and practices such as taboos, rituals and socio-cultural practices within the world view of health and disease, particularly with regard to hypertension, among Shangaans in selected areas of the Northern Province

• to make recommendations for the education of professional health-care providers to enable them to improve the culturally sensitive aspect of patient care

4.2 SUMMARY OF THE STRUCTURE OF THE DATA

The analysis of the data resulted in the emergence of five themes and ten categories. The major themes and categories are exhibited in Data Display 4.1. The summary serves as an overview of the data.
DATA DISPLAY 4.1
SUMMARY OF THE STRUCTURE OF THE DATA

Theme 1: Hypertension
Category 1.1: Synonyms for hypertension
Category 1.2: Signs and symptoms
Category 1.3: Remedies
Category 1.4: Treatment feedback

Theme 2: The traditional healer: the instrumental role
Category 2.1: Sources of diagnostic assistance
Category 2.2: Traditional healer self-confidence

Theme 3: Traditional medicine versus Western medicine
Category 3.1: Attitudes toward Western medicine

Theme 4: Magico-religious healing
Category 4.1: Relationship with ancestors
Category 4.2: Beliefs

Theme 5: Experiences of hypertensive patients with regard to traditional healers and hypertension
Category 5.1: Experiences of hypertensive patients

4.3 DATA ANALYSIS

Data was analysed using content analysis, which involved analysis of the words and phrases obtained from informants. There were two sets of data, each was analysed separately and all results were interpreted.
4.3.1 Data analysis of individual interviews

Field notes from different interviews with informants were partitioned into individual documents. All data was documented and transcribed verbatim from the tapes. Observations made by all informants during interviews were documented. The pages were numbered from the first interview in the first village to the last interview and this data put together according to the file-card system of Budge and Biklen (1982:169).

This data was then compared against the taped and documented data for accuracy. The researcher, using mnemonic codes to assist in remembering the categories, then coded the data. Data that belonged to one group was assembled in one place to assist further reading. Themes and categories were also formulated according to the data with the assistance of background information obtained during the literature review. Formulated themes for data obtained during individual interviews with traditional healers are as follows:

- Theme 1: Hypertension
- Theme 2: The traditional healer: the instrumental role
- Theme 3: Traditional medicine versus Western medicine
- Theme 4: Magico-religious healing
- Theme 5: Experiences of hypertensive patients with regard to traditional healers and hypertension

Data was critically checked to discover the themes from the data. Data was then organised according to themes and categories were developed.

4.3.1.1 Theme 1: Hypertension

According to informants' discussions, four categories emerged from the data. Each category was discussed separately and tables for each category were outlined to represent data units.

Category 1.1: Synonyms for hypertension

According to informants' own views and perceptions, no subcategory emerges, as only three names
are associated with hypertension in the Shangaan culture, namely *Ngatileyikulu, N’ombe* or "high blood". No informants presented any other terms. Table 4.1 displays data units pertaining to synonyms for hypertension.

**Table 4.1:** Category 1.1: Synonyms for hypertension

<table>
<thead>
<tr>
<th>CATEGORY 1.1: SYNONYMS FOR HYPERTENSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <em>N’ombe</em></td>
</tr>
<tr>
<td>“The disease hypertension is called <em>N’ombe</em> according to our Tsonga/Shangaan culture” (Informant 1).</td>
</tr>
<tr>
<td>• <em>Ngatileyikulu/N’ombe</em></td>
</tr>
<tr>
<td>“According to our Tsonga/Shangaan culture the disease is called <em>Ngatileyikulu</em> or <em>N’ombe</em>” (Informant 4).</td>
</tr>
<tr>
<td>• High blood, <em>Ngatileyikulu</em> or <em>N’ombe</em></td>
</tr>
<tr>
<td>“This disease was present long ago and it was called <em>N’ombe</em>; others call it “high blood”, or <em>Ngatileyikulu</em>” (Informant 5).</td>
</tr>
</tbody>
</table>

The informants indicated that hypertension was not something new; it had prevailed for years, so they were not surprised to hear about it.

The findings revealed that Shangaans assign synonyms to hypertension, which indicates that they are already familiar with hypertension in their culture. Blood pressure is associated with *Ngatileyikulu*: *ngati* simply means blood, *leyikulu* means something big or high. Therefore, the phrase “high blood” was included in their meanings. *N’ombe* is mainly associated with severe nose bleeding which was believed to be due to the excess blood in the body and hence classified under high blood.

A discussion was initiated with the Tsonga division of the Department of African Languages at the University of South Africa with regard to the meaning of the terms. They confirmed that *nombe* was said to be associated with nose bleeding which is assumed to be related to the blood which is in excess in the body. *Ngatileyikulu* was described as the condition where the blood is big or high in the body (R Mathye; SS Mukhari, personal communication, February 19, 2002). According to Lewis and Collier (1996:867), epistaxis (nose bleeding) may occur as a result of vascular complications secondary to hypertension, so the conclusion might be drawn that such a relationship may exist.
Interestingly, a study conducted by Snow (1974) about health beliefs of low-income African Americans in Arizona indicates that informants discussing body physiology described blood as being high or low, as blood is in a constant state of change (Boyle & Andrews 1995:248).

>> Conclusions and recommendations

As it has been shown that Shangaans are familiar with hypertension and have their own terms for the condition, it would be advisable for nurses in the professional health system to familiarise themselves with these terms as an aid to communication and cultural understanding.

♦ Category 1.2: Signs and symptoms

Table 4.2 outlines the data units related to the category.

Table 4.2: Category 1.2: Signs and symptoms

<table>
<thead>
<tr>
<th>CATEGORY 1.2: SIGNS AND SYMPTOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2.1  Headache</td>
</tr>
<tr>
<td>&quot;I felt my head pounding to the extent that I felt I wanted to take is off as part of my body, I tried to stand up but had difficulty until I saw darkness and then I could not tell what happened&quot; (Informant 16).</td>
</tr>
<tr>
<td>&quot;Hypertensive patients have a problem of headache&quot; (Informant 3.7).</td>
</tr>
<tr>
<td>1.2.2  Dizziness</td>
</tr>
<tr>
<td>&quot;They complain of dizziness&quot; (Informant 3, 6).</td>
</tr>
<tr>
<td>&quot;People with Ngatileyikulu (hypertension), you will recognise them by swelling, dizziness, failure to see properly and headache&quot; (Informant 3).</td>
</tr>
<tr>
<td>1.2.3  Nose bleeding</td>
</tr>
<tr>
<td>&quot;They usually complain about blood vessels which are protruding, painful body, tiredness, headache, nose bleeding, dizziness, collapse and fainting&quot; (Informant 6).</td>
</tr>
</tbody>
</table>

For this category, only three subcategories emerged, as the information was limited. Informants described the intensity of the headache experienced during the first attack, which was followed by headache as the most recurrent problem. Other signs and symptoms described included failure to see properly, generalised bodily pain, nose bleeding and protruding blood vessels.
The results revealed that the Shangaans realise that there are specific signs and symptoms related to high blood pressure. In their view, signs and symptoms include continuous headache, dizziness, generalised body pain, swelling, failure to see properly, protruding blood vessels, tiredness, nose bleeding, collapse and fainting.

It is evident from the above that similarities do exist between the signs and symptoms of what the Shangaans call ngatileyikulu and the signs and symptoms of hypertension. Lewis and Collier (1996:867) describe signs and symptoms of hypertension as including occipital headache, dizziness, palpitations and angina. Blurring of vision and nose bleeding occur as a result of vascular complications of secondary hypertension.

Conclusions and recommendations

The results reveal that Shangaans believe that all symptoms have cultural meaning. As they experience symptoms, they interpret them and react in ways related to their cultural norms. Therefore, nurses should become familiar with the terms that Shangaan patients use for their symptoms and the meanings they assign to the specific symptoms. The cultural meanings of the symptoms could then be restructured in a manner related to the nurse’s professional knowledge so that treatment can be decided upon and the treatment related to the patient in a culturally sensitive manner. In this way more effective communication and nursing care could be achieved.

Category 1.3: Remedies

Informants discussed many remedies for treatment of hypertension, including a variety of activities, from indications, prescriptions, positive remedies and negative remedies to preparation methods. Table 4.3 outlines data units in the category.
<table>
<thead>
<tr>
<th>1.3.1 Indications and remedies</th>
<th>“Herbal medicine is helpful to people who are having problems of tiredness and excessive sweating” (Informant 1).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Those with severe headache, I dry roots of herbal medicine, you will hear the headache go” (Informant 2).</td>
</tr>
<tr>
<td></td>
<td>“Herbal medicine poured in soft porridge is useful in headache” (Informant 3).</td>
</tr>
<tr>
<td></td>
<td>“Herbal medicine put on top of a red-hot ashes (piece of burnt coal or wood) is used for a person with nose bleeding in order to allow blood from the nose to fall on top of the hot ashes” (Informant 4).</td>
</tr>
<tr>
<td></td>
<td>“Burned moulds and herbal medicine are helpful for a person with hypertension, because the smoke will make the person’s blood to be loosened and the person will be healed” (Informant 5).</td>
</tr>
<tr>
<td></td>
<td>“Baso or smoke is allowed to enter the nostrils of the sick person and is believed to be very good for treatment of dizziness in a person with hypertension” (Informant 6).</td>
</tr>
<tr>
<td></td>
<td>“Herbal medicine is used to rub the affected side in a stroke to loosen the blood” (Informant 8).</td>
</tr>
<tr>
<td></td>
<td>“Herbal medicine is given to wash blood in phungula (steam inhalation)” (Informant 7).</td>
</tr>
</tbody>
</table>
Informants discussed many remedies for treatment of hypertension. The different treatments are presented in Table 4.3 above.
Subcategory 1.3.1: Indications and remedies

Informants presented various remedies for the treatment of Ngatileyikulu. Different remedies were prescribed for the different symptoms of hypertension. These were summarised.

Subcategory 1.3.2: Remedy preparation

Informants described methods of preparation of various remedies, as well as correct times for utilising such prescribed herbal medicine. These were summarised to ensure representation of all data.

Subcategory 1.3.3: Positive remedies

Informants described herbal and other remedies prescribed to yield positive results, given according to specific indications. Different routes for administration were explained by the various informants.

Subcategory 1.3.4: Negative remedies

Informants stated that there were certain remedies that were not supposed to be used for specific people due to their condition. For instance, an informant stated that blood letting from a vein should not be performed as this could cause collapse.

Subcategory 1.3.5: Preparation of remedies

Informants gave detailed descriptions of methods of preparation designed to yield positive results. These methods were summarised in Table 4.3.

Conclusions and recommendations

Informants’ comments revealed that the Shangaan people do have knowledge of remedies to be utilised for hypertension. Their herbal medicine provides for specific indications and prescriptions for hypertension. This includes positive remedies to be administered as well as negative remedies to be avoided; specific preparation methods are also used.
Some of the remedies described by the informants might need restructuring. The traditional healer might be persuaded to modify, reorder or change administration of remedies to ensure a more beneficial health pattern, while still respecting the client’s cultural values and beliefs.

*Ku lumeka*, for instance, involves cutting of the skin with a razor blade or scarification. A problem is that there is no certainty that the razor will be used for one person only. If the blade is used on more than one person there is a danger of patients’ contracting a disease such as HIV/AIDS; or a vessel might be cut and the patients might bleed to death. Such aspects of treatment would need restructuring in cooperation with the traditional healer.

*Ku lumeka* is also used by other South African black peoples such as the Zulu, who use the method of *ku lumeka* (cupping), and use a chain to draw some blood from the temple in cases of severe headache (Gumede 1990:89). This shows that the method might be applicable to many South African cultures, so the restructuring suggested might be generalised to other cases in South Africa as well.

**Category 1.4: Treatment feedback**

No subcategories emerged from the category. Some informants explained that after the sick person had taken the medication, they must come back to explain the results of herbal medicine in use. Table 4.4 displays data units associated with the category.

**Conclusions and recommendations**

Informants stated that patients with high blood pressure should report back to the traditional healer during the course of their treatment with regard to their progress while taking herbal medicine. This practice, according to Leininger’s modes of culture care, is to be recommended, in case there are complications from herbal medicine, so that medication can be stopped before another action is initiated. According to the informants, hypertension can be treated and cured, not only controlled.

On the other hand, professional Western medicine holds that the condition can only be controlled and that continuous treatment must be applied; stopping of treatment for hypertension could lead to complications such as stroke. These two opposing viewpoints need to be reconciled by means of discussion.
Table 4.4: Category 1.4: Treatment feedback

<table>
<thead>
<tr>
<th>CATEGORY 1.4: TREATMENT FEEDBACK</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Feedback to traditional healer</td>
</tr>
</tbody>
</table>

4.3.1.2 Theme 2: The traditional healer: the instrumental role

Informants described diagnostic methods followed by traditional healers during the treatment process. This explanation was accompanied by an expression of confidence in the procedures done. Two categories emerged from the data; each category is discussed separately to represent data units in each category.

Category 2.1: Sources of diagnostic assistance

Informants described diagnostic methods followed by traditional healers during the treatment process. This explanation was accompanied by an expression of confidence in the procedures done. Two categories emerged from the data; each category is discussed separately to represent data units in each category.

Category 2.1: Sources of diagnostic assistance

Table 4.5 displays data units evidencing the following subcategories.

Table 4.5: Category 2.1: Sources of diagnostic assistance

<table>
<thead>
<tr>
<th>CATEGORY 2.1: SOURCES OF DIAGNOSTIC ASSISTANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1 Procedures for throwing of bones</td>
</tr>
<tr>
<td>2.1.2 Throwing of bones</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>2.1.3 Interpretation of bones</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
CATEGORY 2.1: SOURCES OF DIAGNOSTIC ASSISTANCE

<table>
<thead>
<tr>
<th>2.1.4</th>
<th>Bones and ancestors</th>
<th>&quot;Throw the bones again to ask my ancestors the herbal medicine that is going to treat this person&quot; (Informant 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.5</td>
<td>Diagnosis and dreams</td>
<td>&quot;When I sleep my ancestors come to me in a dream to show me the things that are going to happen the following day, they show me that specific person, his disease and herbal medicines to be used in the treatment of such a person&quot; (Informant 11)</td>
</tr>
</tbody>
</table>

*Subcategory 2.1.1: Procedures for throwing of bones*

The next step in the procedure is the throwing of the bones.

According to seven informants, throwing of the bones is the most important diagnostic tool utilised. They believe if correct procedures are followed, the diagnosis can be easily made. From the discussions the following subcategories emerged.

*Subcategory 2.1.2: Throwing of bones*

Before people get to the treatment room, they are requested to take off their shoes. The informant explains that sick people are expected to pay a certain amount to ensure that the traditional healer unties the bag containing the bones. After payment, the traditional healer will untie the bag and request the sick person to blow into the bag containing the bones before throwing.

*Subcategory 2.1.3: Interpretation of bones*

Informants elaborated on the fact that the bones need to be analysed and interpreted while they are still scattered on the floor and that therefore not everyone could interpret them and diagnose a sick person using the bones.

*Subcategory 2.1.4: Bones and ancestors*

Informants explained that the ancestors assist them in diagnosis and even show them the medication to be utilised.
Subcategory 2.1.5: Diagnosis and dreams

Traditional healers explained that diagnosis could be made without bones being thrown, if the ancestors were with them. The ancestors are said to visit healers in a dream when asleep to show them the events which will occur the following day. In addition, this helps them in making a diagnosis.

The above information is supported by the data presented in Chapter 2 (Kriel & Hartman 1991:30-31) pointing out that traditional healers usually use bones to reveal the causes of illness or misfortune and action to be taken.

Conclusions and recommendations

According to informants, throwing of bones is the main source of diagnosis for hypertension as well as other diseases amongst the Shangaan people.

In Western medicine methods like measuring blood pressure with a Baumanometer and other such means are used for diagnosis of hypertension (Lewis & Collier 1996 868-869). Although both procedures have the same aim, of diagnosing what is wrong with the patient, the methods differ greatly and discussion between both branches of medicine needs to take place. Western doctors may fear that the diagnostic process of traditional healers could lead to wrong diagnosis and giving of wrong medication.

Category 2.2: Traditional healer self-confidence

Informants who were traditional healers displayed confidence in the herbal medicine used and its effects as well as the part played by the ancestors. From the discussions, the themes shown in Table 4.6 emerged.
| 2.2.1 Faith in oneself | “I treated many people suffering from hypertension successfully, and they are healed” (Informant 1). “I started treating people with hypertension while still working in Johannesburg, where I was treating the Zulu, Sotho, Venda and Tsonga speaking people. Even now I am no longer working in urban areas, I am still treating people with hypertension” (Informant 2). “I once treated a person with stroke which affected him both sides. Where family members refused to take him to hospital, I succeeded” (Informant 13). “I have never met any complications, whether in urban areas or here at home. I have just treated people who went home completely healed” (Informant 4). “I am sure that the person with Ngatileyiku will be healed and go back home, completely healed” (Informant 6). “I will be very pleased to see you come back again and we discuss further about the disease” (Informant 7). “I have never met any difficulties of any kind because I follow the instructions from my ancestors correctly. That is why they protect me” (Informant 1). “Yes, I know, I have treated even a White person from KwaZulu-Natal, and he was healed and went home completely cured, with the help of my ancestors” (Informant 10). |
| 2.2.2 Throwing of bones | “My herbal medicines are not such medicines that if I gave them to the person that person’s conditions will not improve and the person will have to go to hospital” (Informant 5). “I give herbal medicine to a sick person to drink with a cup three times a day, then the hypertension will be down, it can last for a month” (Informant 9). |
| 2.2.3 Trust in herbal medicine | |

*Subcategory 2.2.1: Faith in oneself*

Informants displayed the faith they have in themselves as traditional healers with regard to the treatment of hypertension.
Subcategory 2.2.2: Trust in the ancestors

Informants clearly demonstrated their trust in their ancestors in all the activities they are engaged in.

Subcategory 2.2.3: Diagnosis and dreams

The discussions given by informants clearly indicated that they completely trust the herbal medicine. Informants revealed that they have confidence in their work related to the treatment of high blood pressure. The results indicate that traditional healers have confidence in themselves, the ancestors and the herbal medicine used for the treatment of high blood pressure.

According to Gumede (1990), traditional healers or herbalists learn progressively more about the uses of plants and herbs for healing purposes. They acquire the art from others through serving an apprenticeship and may move up the ranks. After some time as an apprentice, the young traditional healer is confident enough to work alone as an herbalist and he or she is then equivalent to a general practitioner in Western medical terms (Gumede 1990:50).

Conclusion and recommendations

The above findings show that the knowledge of the traditional healers is acquired over many years and that they take pride in their work and trust themselves and their methods. Such knowledge needs to be respected and honoured and it would be advisable for health-care professionals to be open to new knowledge in mutual discussions.

4.3.1.3 Theme 3: Traditional medicine versus Western medicine

Informants displayed different attitudes towards traditional and Western medicine. Some informants displayed resentment towards it, others acceptance of Western medicine. Only one category with subcategories was developed. The subcategories outlined in Table 4.7 emerged from the discussions.

Category 3.1: Attitudes toward Western medicine
Table 4.7: Category 3.1: Attitudes toward Western medicine

<table>
<thead>
<tr>
<th>CATEGORY 3.1: ATTITUDES TOWARD WESTERN MEDICINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.1 Attitudes toward Western medicine by traditional healers</td>
</tr>
<tr>
<td>“People who come to me being very ill, I take them to the hospital for treatment. When they come back, they come for my herbal medicine. I also make them stop using tablets (hospital medicine)” (Informant 7).</td>
</tr>
<tr>
<td>“My grandfather, who was a traditional healer, told me that one of his clients with hypertension bled severely as the healer was pricking his nostril to reduce the blood which was in abundance and troubling the person, and that person fainted until he woke up again in hospital” (Informant 10).</td>
</tr>
<tr>
<td>“I allow them to go to hospital but if they come back, I do not allow them to mix hospital medicine and my medicine. They are supposed to stop hospital medicine if this is not yet completed and to start using my medicine until they finish” (Informant 1).</td>
</tr>
<tr>
<td>“Even myself I look for a car to take the person to the hospital if I see that the disease is getting worse, because in hospital there are some things that also help us, even me, as a traditional healer, if I am ill I go to hospital, so I cannot refuse to let them go” (Informant 11).</td>
</tr>
</tbody>
</table>

| 3.1.2 Feelings about Western medicine for hypertension |
| “We are just surprised to see the hospital making people to suffer by giving them tablets to take for the rest of their lives” (Informant 4). |
| “Invite the traditional healer to go to hospital to treat people with hypertension and that would be the best option of control” (Informant 2). |
| “The best message is to call the traditional healers to treat this disease so that people will stop swallowing tablets, do not forget this message” (Informant 3). |
| “Hospitals must invite traditional healers to go to hospital and treat this disease called hypertension and other disease troubling the hospitals” (Informant 5). |
| “I am requesting that you inform hospitals about my name in relation to the treatment of different diseases, because truly I know how to treat many diseases such as hypertension (Ngatileyikulu)” (Informant 6). |

* Subcategory 3.1.1: Attitudes toward Western medicine by traditional healers

Informants showed mixed feeling towards Western medicine. They explained that Western medicine could be utilised for serious complications (such as stroke) because the traditional healers do not have the necessary facilities to cater for complications. Yet informants mentioned that they did not allow
patients to continue with the tablets prescribed by the hospital but replaced them with their own remedies.

* Subcategory 3.1.2: Feelings about Western medicine for hypertension

Other informants blamed Western medicine for recommending prolonged use of medicines for treating hypertension.

* Subcategory 3.1.3: Recommendations by traditional healers

The informants recommended that the hospitals should invite the traditional healers into hospitals to assist with the treatment of hypertension and other diseases which the Western medicine is failing to provide a cure for. The results revealed that some of the traditional healers have a negative attitude towards Western medicine for failing to cure some diseases like hypertension and treating it as chronic. This means that people are supposed to live on medication for the rest of their lives, which the traditional healers do not approve of.

According to informants the best solution would be to invite the traditional healers to go to hospitals to assist the medical officers in the treatment of hypertension rather than giving people tablets for the rest of their lives.

> Conclusions and recommendations

In both traditional and Western medical systems, dealing with ill health involves first the diagnosis and then treatment. The difference lies in the purpose and methods of diagnostic procedure. In traditional systems, the purpose of diagnosis is usually to establish the ultimate cause of the illness and not the disease process causing the symptoms. The patient’s entire social and environmental circumstances are taken into account. The Western medical doctor attempts to establish what disease process is causing the symptoms. The concern is the patient, not the patient’s cultural environment, involving the influence of the ancestors.

The holistic approaches utilised or applied by traditional healers, on the other hand, include mental, psychological, social, physical and emotional aspects of the patient (Gumede 1990:90-92). Western medicine should try to accommodate the traditional healers in order to assess what they can offer with
regard to chronic diseases such as hypertension. It is very possible that they might be able to offer much of value.

### 4.3.1.4 Theme 4: Magico-religious healing

Informants expressed a belief in the presence of the ancestors throughout their lives, whether they were healthy or sick, and stressed that for things to go normally, proper communication must be maintained throughout. The belief in the presence of the ancestors forms part of the magico-religious aspects of the Shangaan's life view.

#### Category 4.1: Relationship with ancestors

Subcategories which emerged from the discussion with informants are presented in Table 4.8, which displays data units related to the category.

Table 4.8: Category 4.1: Relationship with ancestors

<table>
<thead>
<tr>
<th>CATEGORY 4.1: RELATIONSHIP WITH ANCESTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.1 Approval of ancestors</td>
</tr>
<tr>
<td>“If your ancestors are with you and happy, you treat people and get healed without any complication” (Informant 3).</td>
</tr>
<tr>
<td>“What I was trying to show you is that my ancestors are still with me and are happy” (Informant 6).</td>
</tr>
<tr>
<td>“My ancestors have never let me down. I have treated many people and they were healed” (Informant 2).</td>
</tr>
<tr>
<td>4.1.2 Communication with ancestors</td>
</tr>
<tr>
<td>“Firstly, I inform my ancestors that here is a sick person to let them bless the whole part to be followed in the treatment of this disease, because ancestors are helpful in treatment of this disease” (Informant 3).</td>
</tr>
<tr>
<td>“I use two methods shown to me by my ancestors” (Informant 4).</td>
</tr>
</tbody>
</table>

* Subcategory 4.1.1: Approval of ancestors

Informants in this study expressed the belief that there must always be peace between them and the ancestors. They trusted in the ancestors and felt that they had never let them down.
Subcategory 4.1.2: Communication with the ancestors

Informants stressed that it was necessary to ask the ancestors’ help before starting on a course of treatment.

Informants emphasised the belief that a happy relationship with the ancestors promoted health. They stressed that threatening the relationship or causing ancestors to be angry might bring ill-health. To resolve that problem, a ceremonial sacrifice should be performed. A study conducted by Cringe (1950:288) indicates that the Zulu people believe that the ancestors reveal themselves by seizing on a part of an individual’s body and causing illness. The South Sotho ascribe all illness to the ancestors because they believe the ancestors are jealous to people who are still alive (Hammond-Tooke 1974:331).

Generally, however, South African black people do not consider illness as an evil sent by the ancestors. They believe that a good relationship with the ancestors will promote one’s health. If one is ill, the traditional healer will provide the treatment for different diseases, including hypertension. To maintain the relationship there must be continuous communication between the ancestors and the people through the process of libation.

Conclusions and recommendations

Knowledge of the above information is important for the nurse and should be considered in providing culturally congruent care. Ignorance of this knowledge may lead to failure to adjust and cope with the chronic disease of hypertension. According to the three modes of Leininger’s Sunrise Model, culture care preservation or maintenance may be utilised in order to maintain balance and to promote coping with the disease (Leininger 1991:52).

Category 4.2: Beliefs

The category and subcategories that emerged from the discussions are shown in Table 4.9 which displays data units related to the category.
### CATEGORY 4.2: BELIEFS

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Description</th>
</tr>
</thead>
</table>
| 4.2.1 Causes of hypertension | “The cause is not known to anyone, but the disease is more likely to be found in specific families because of the anger of ancestors who punish the whole family” (Informant 3).  
“IT is caused by fatty foods eaten, making people to be fat” (Informant 4). |
| 4.2.2 Reporting to ancestors | “We believe when a person is ill, the family members are supposed to practise libation to inform ancestors that their child is not well and that they want to take the person to the traditional healer so they will clear the path” (Informant 4). |
| 4.2.3 Medication | “According to our culture life-long medication is not allowed at all” (Informant 3).  
“We do not believe that there are diseases which cannot be treated; even if you have been bewitched the person can be treated and become healed” (Informant 1). |
| 4.2.4 Cultural care of a hypertensive patient | “We as the Tsonga speaking people believe that a person with hypertension must be nursed by the elderly people inside the house. The sick person is not allowed to do household chores until the condition improves, because the person is having a problem of dizziness and can fall and sustain injuries” (Informant 5). |
| 4.2.5 Prognosis | “We, the Tsonga people, believe that hypertension is curable” (Informant 2). |

**Subcategory 4.2.1: Causes of hypertension**

Informants explained that there are several aspects responsible for causing hypertension, though some seemed to be beyond their control.

**Subcategory 4.2.2: Reporting to ancestors**

The informants stressed that all the events occurring in the family must be reported to the ancestors, including illness in the family.
Subcategory 4.2.3: Medication

Informants expressed their belief that there is no need for a person to live on lifelong medication, because hypertension is curable.

Subcategory 4.2.4: Cultural care of a hypertensive patient

Informants stated that there is a belief that there are specific people who are allowed to look after the hypertensive patient when ill.

Subcategory 4.2.5: Prognosis

Informants believed that people with hypertension could be treated successfully without any need for prolonged drug treatment.

Discussions with informants revealed that the Shangaans did not know what caused hypertension, but they believed the ancestors might be responsible as the disease occurs in specific families. Therefore, ancestors might be punishing the family. Others believed certain types of food such as fats might be responsible.

A study conducted by Snow (1974) indicated that African Americans believe that diet is responsible for increasing or decreasing someone's blood. They also believe other factors may be responsible for high blood pressure, such as diet (too much salt, fat, meat and sweets), mental status, the person's relationship with God or the devil, or being bewitched by an enemy. Such beliefs might be largely responsible for the lack of acceptance of the chronicity of hypertension.

This study has revealed that the Shangaans believe that everything happening in the family must be reported to the ancestors. If one of the family members has hypertension or "high blood", they must report this to the ancestors, who will open the path for the person to be healed from that disease. However, reporting the condition to the ancestors might delay their seeking help, as sacrificial ceremonies are expensive. Like African Americans (Snow 1974), the informants believe that most illnesses are curable: "If every illness has its cure, then what one must do is to find it." This belief might contribute to people seeking help from different health systems. It also leads to their regarding
long-term medication as a negative practice which is only controlling the condition and not curing it.

Conclusions and recommendations.

It is clear from the results that the beliefs relating to the causes, cultural care, medication and prognosis of the hypertensive patient, as well as the need to report the condition to the ancestors, are deeply ingrained and strongly held beliefs in the Shangaan people. Failure to recognise or consider how these cultural beliefs might apply to the care of culturally diverse clients may lead to inappropriate nursing actions.

4.3.2 Analysis of focus group interviews

Raw data was documented and transcribed verbatim from tapes by the researcher. Raw data, which was in Xitsonga, was then translated into English by the researcher. Two Shangaan academic experts who are proficient in Xitsonga and English checked the data to ensure credibility. Data was then checked against recorded data for accuracy.

Selection of units from content was done. A category with five subcategories was developed from the data. And informants were requested to respond to the interview schedule already formulated.

4.3.2.1 Theme 5: Experiences of hypertensive patients with regard to traditional healers and hypertension

The informants described many aspects of their experiences. From the descriptions the following category and subcategories emerged.

Category 5.1: Experiences of hypertensive patients
<table>
<thead>
<tr>
<th>CATEGORY 5.1: EXPERIENCES OF HYPERTENSIVE PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.1.1 Experiences of signs and symptoms</strong></td>
</tr>
<tr>
<td>“I felt my head pounding to the extent that I thought of taking it off as part of my body” (Informant H1).</td>
</tr>
<tr>
<td>“After feeling that, I am having a severe headache which did not respond to anything. I was advised to visit the traditional healer by my grandmother. I went to the traditional healer; on arrival I explained that I was not well. The traditional healer had to throw bones to assist him in detecting my condition. The traditional healer told me I am having Ngatleyikulu. After trying to find out more about the disease he told me I have more blood in my body and therefore I must receive treatment in order to make my headache to stop and then I agreed” (Informant H4).</td>
</tr>
<tr>
<td>“I was bleeding through the nose, dizzy and having headache, I could not even see properly” (Informant H5).</td>
</tr>
<tr>
<td>“I visited the traditional healer after experiencing severe headaches. On arrival he threw bones to ask his ancestors my problem and they showed him that I have Ngatleyikulu. After that I was subject to his treatment of kulumeke where I was cut by a razor blade on both sides of my face”.</td>
</tr>
<tr>
<td><strong>5.1.2 Patients’ beliefs about causes of hypertension</strong></td>
</tr>
<tr>
<td>“Hypertension is caused by high salt intake added with food has been cooked a while ago” (Informant D7).</td>
</tr>
<tr>
<td>“It is also caused by eating food containing more salt and fat” (Informant H2).</td>
</tr>
<tr>
<td>“It is caused by bad luck from angry ancestors, if you fail to obey their instructions” (Informant H3).</td>
</tr>
<tr>
<td>“When ancestors are angry they can send you an illness such as hypertension” (Informant D4).</td>
</tr>
<tr>
<td><strong>5.1.3 Experiences of diagnostic methods</strong></td>
</tr>
<tr>
<td>“The traditional healer throws the bones when visited by the sick person and he will tell you your problem” (Informant N2).</td>
</tr>
<tr>
<td>“I was told to pay R250.00 for treatment option by my traditional healer” (Informant H3).</td>
</tr>
<tr>
<td>“As Shangaans, if there is something wrong we usually go to the traditional healers to find out if the ancestors are angry or if we have been sent an illness from sorcerers, that is where you re going to discover your disease” (Informant N5).</td>
</tr>
</tbody>
</table>
5.1.4 Experiences of remedies

"The traditional healer applied herbal medicine on my cheeks and two balls were placed to pull blood from those areas. I am really fearful to talk about it even today as I nearly bled to death. I just saw myself in hospital, not knowing how I got there" (Informant N2).

"Usually we visit many resources such as pastors, hospitals and traditional healers, depending on the belief system of that specific family, if we have problems" (Informant G5).

* Subcategory 5.1.1: Experiences of signs and symptoms

Informants tried to indicate the intensity of the headache experienced on the first attack, which was followed by dizziness. Headaches were the most recurrent symptom. Nose-bleeds were also mentioned. Patients described their experience of treatments by the traditional healer.

* Subcategory 5.1.2: Patients' beliefs about causes of hypertension

Informants believed various factors could cause hypertension: too much salt and the anger of ancestors were mentioned.

* Subcategory 5.1.3: Experiences of diagnostic methods

Informants reported that they were expected to pay a specific amount of money before the diagnosis could be made. They described the throwing of the bones.

* Subcategory 5.1.4: Experiences of remedies

Informants described fear and pain related to some methods utilised as remedies.

The discussions indicated that informants' experiences of the symptoms and treatment of hypertension differed. Some described discomfort and pain during their treatment.
Conclusion and recommendations

According to Wilson (1983), many black patients seek care from both traditional healer and physicians, leading to a practice known as “dual uses” of care providers.

From the above discussion of findings, it is evident that clients need to be taught carefully about the chronic nature of hypertension and told why they are expected to take tablets to control the high blood pressure on a continuous basis. Not all members of the Shangaan culture will seek alternative treatment outside the professional system, but many clients from all cultures do. The decision to seek alternative care is an individual one and must be elicited carefully during the assessment process. People who suffer from chronic diseases such as hypertension seem particularly prone to seeking alternative care if professionals cannot offer a cure. Knowledge of patients’ beliefs is helpful in planning for proper nursing interventions which will also promote the patients’ participation.

4.4 CONCLUSION

This chapter dealt with the analysis and interpretation of data. Results of the study revealed many cultural aspects of the Shangaan life view relating to hypertension as a condition.

The next chapter will summarise and comment on the findings and recommend actions according to the researcher’s perception. Limitations of the study and recommendations for future research will be outlined.
CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In Chapter 4, data was analysed and findings described and interpreted. The findings revealed the extent of the Shangaans' knowledge about hypertension, and the initial cultural diagnosis, treatment and care of the condition.

This chapter focuses on the study and summary of the findings. Conclusions are drawn and general recommendations made. The strengths and limitations of the study are discussed.

5.2 SUMMARY OF THE STUDY

To arrive at the research question and objectives, the researcher first conducted a literature review to gain information regarding the phenomenon. The informants, who were drawn from the population using a non-probability purposive sampling technique, consisted of an expert sample of 45 informants (30 hypertensive patients and 15 traditional healers). During data analysis reflectivity, bracketing and intuiting were implemented as basis for analysis. Lincoln and Guba’s Model of Trustworthiness of qualitative research was used to ensure that all data obtained was trustworthy. From data analysis, five themes with categories and subcategories and guidelines were formulated to facilitate more understanding of the findings.

Data was analysed using the Tesch stages of qualitative analysis and content analysis. Tape recordings and field notes were transcribed verbatim into English by the researcher and checked by two academic experts. Categorised data was then studied to identify saturation of information and recurrent patterns of similar and different meanings. Interpretation was then finalised, major categories developed and presented.
The research objectives of this study have been attained:

- The study has explored the cultural values, beliefs and practices such as taboos, rituals, and socio-cultural practices within the world view of health and disease, specifically relating to hypertension, among selected Shangaans in the Mopani region of Greater Giyani in the Northern Province of South Africa.

- Recommendations have been made on the education of health care professionals with a view to providing more culturally sensitive patient care.

The findings are briefly described below. These are centred on the research question and objectives and the responses of the 45 informants.

5.3 FINDINGS

The research objectives were integrated into research findings and the five themes after data analysis to describe the research question. As explained in Chapter 4 of the study, the five themes are interrelated. The findings are summarised below according to the themes and the categories. Please refer to Chapter 4 for specific recommendations under each subcategory.

THEME 1: HYPERTENSION

Category 1.1: Synonyms for hypertension

Findings revealed that the Shangaans do use synonyms for hypertension such as *Ngatileyikulu*, *N’ombe* and “high blood” and are therefore evidently aware of the condition.

Category 1.2: Signs and symptoms

Information obtained in the study indicates that the Shangaans recognise specific signs and symptoms associated with the disease they call *Ngatileyikulu* (hypertension).
Category 1.3: Remedies

It emerged from the study that specific remedies related to hypertension are applied by Shangaans.

Category 1.4: Treatment feedback

Informants stated that hypertensive patients who are treated by traditional healers must go back to them to report on the effectiveness of the medication.

THEME 2: THE TRADITIONAL HEALER: THE INSTRUMENTAL ROLE

Category 2.1: Sources of diagnostic methods

According to informants certain methods are employed for diagnosing hypertension (*Ngatileyikulu*) and include bone throwing and dreams from ancestors.

Category 2.2: Traditional healer self-confidence

It emerged from the study that traditional healers have faith in themselves and their herbal medicine and faith in the intervention of the ancestors for the treatment of hypertension.

THEME 3: TRADITIONAL MEDICINE VERSUS WESTERN MEDICINE

Category 3.1: Attitudes towards Western Medicine

The study uncovered varying feelings and opinions among traditional healers relating to Western medicine’s mode of treatment for hypertension.
THEME 4: MAGICO-RELIGIOUS HEALING

Category 4.1: Relationship with ancestors

Informants revealed a belief that a positive relationship must be maintained with ancestors throughout one’s life-span, through specified communication processes. If this relationship is not respected the individual might experience bad luck as well as illnesses.

Category 4.2: Beliefs

The views and cultural beliefs of the Shangaan people related to the causes, medication, experience of remedies and prognosis were fully expressed. The discussion further included the manner of reporting illnesses like hypertension to the ancestors.

THEME 5: EXPERIENCES OF HYPERTENSIVE PATIENTS WITH REGARD TO TRADITIONAL HEALERS AND HYPERTENSION

Category 5.1: Experiences of hypertensive patients

Informants in the study discussed their experiences as hypertensive patients with reference to signs and symptoms, causes, diagnostic methods and cultural care and prognosis.

5.4 CONCLUSION

This study has shown that Shangaans have their own perceptions of hypertension and this is influenced by their world views and cultural perceptions and their experiences in their own culture.

As discussed specifically under each subcategory in Chapter 4, failure by nurses and other health personnel who are rendering health care to recognise these beliefs, values and attitudes might lead to many complications.
5.5 GENERAL RECOMMENDATIONS

Based on the above conclusions and the specific recommendations in Chapter 4, the following recommendations may be made:

- Health professionals should develop a positive relationship with traditional healers.
- Closer collaboration should be developed between Western medicine and traditional healers.
- Workshops involving both health professionals and traditional healers should be held.
- Further research should be undertaken regarding the provision of more culturally sensitive care in hospitals.

5.5.1 Development of a positive relationship with the traditional healer

Health professionals should try to develop a positive attitude towards the traditional healer. Once this attitude is established, it will promote a good working relationship, with each party helping the other. This is very important, because both traditional healers and medical practitioners have one common goal, to help the patient get well. Both are patient-orientated.

Winning the confidence of the traditional healers is vital. Once the traditional healers are satisfied that they are being consulted as equals in their own right, mistrust will be dispelled and negotiations between the traditional healers and the health professionals can take place in an atmosphere of mutual respect.

Gumedze (1990: 230) reports that a study conducted by Oberholzer through a community-orientated programme, consulting the Dingaka council (a local traditional healer council), made important observations. It was found, for instance, that the traditional healers felt the Western doctors wanted to subjugate them and manipulate them into working under the supervision of medical practitioners. The traditional healers, however, wanted to implement a liaison.

The nursing profession needs to avoid stereotyping of herbal medicine. Nurses should rather take time to learn something about the practice of the traditional healer; this will enable them to view it within a cultural context (Leininger 1991:39).
5.5.2 Closer collaboration between Western medicine and the traditional healer

Development of a positive attitudes towards the traditional healers will draw them closer to the health professionals and promote closer collaboration.

"Western healers need to come out of the temples of learning on the hilltops and come down to the valleys where the people are" (Gumede 1990:235). This statement clearly supports and promotes the issue of collaboration in health systems. The issue is no longer one of either formal or informal health care; both Western and traditional healing should be welcomed. A Chinese poet, quoted in Gumede (1990:235) writes in support of the issue of going to the people in order to meet their needs: “Go to the people, live among them, start with what they know and build on what they have”.

The World Health Organization, as described in Gumede (1990:235-237), set a target to achieve health for all by the year 2000, and it was stated clearly that this could not be done on the Western model alone; other alternatives would have to be found. The traditional healers, according to their representatives in this study, seemed to be willing and ready to talk. Health professionals must make it their task to address the problem and to start a system of proper collaboration (Gumede 1990:235-237).

5.5.3 Workshops with traditional healers

Health professionals, including nurses and medical practitioners, should organise workshops for traditional healers to give them more information in relation to hypertension.

During the workshop, the traditional healers need to be given an opportunity to present their point of view. Thorough assessment of their information should be done by the health personnel. At the end, the three modes of Leininger’s sunrise model should be adopted. Good practices will help the Shangaan to retain and preserve relevant cultural values, maintain their well-being and recover from illness related to hypertension.
5.5.4 Recommendations regarding further research

- Similar research should be conducted amongst other Shangaans, covering a wider area. Research relating to the Shangaans and other diseases than hypertension should be conducted.
- Similar research should be conducted amongst people of other ethnic groups such as the Zulu, Sotho, Venda and Ndebele people.

5.5.5 Other recommendations

Other recommendations relate to the following topics:

- Organising workshops for hypertensive patients about hypertension, its signs and symptoms, and in particular the importance of continuing with the intake of medicines for hypertension on a long-term basis.
- In-service training for nurses and other health personnel about hypertension and culture.
- Workshops with Shangaans other than hypertensives and traditional healers with regard to explanation of the disease, early recognition and the importance of continuous medication.
- Inclusion of culture-related aspects in the basic curriculum of student nurses. (Specific cultures relevant to an area must be emphasised.)
- Training of nurse administrators in particular in the importance of cultural care. (As they are in charge of the hospital their positive attitude will filter through to the nurses in their charge as well.)
- Education of the Shangaan community at large on hypertension and its cultural implications.

5.6 STRENGTHS OF THE STUDY

Strengths of the study include the following:

- The qualitative approach and unstructured interviews allowed the informants to speak for themselves.
- This was not a laboratory-orientated study, but was implemented in the field. The researcher was open to any experience in order to produce fresh and direct data.
• The researcher was conversant with the situation and was more accessible to the traditional healers due to her familiarity with the context in which the study was conducted. Because the researcher was an employee of the hospital and within the same culture as the clients, she could have more insight into the experiences of the informants.

• The findings have made a contribution to the knowledge of management of hypertension amongst the Shangaans. The findings increase the knowledge of the phenomenon and establish an understanding of Shangaan culture and hypertension. The knowledge is important and significant to the health care profession.

5.7 LIMITATIONS OF THE STUDY

• Limitations of this study include the possibility of researcher’s bias in data collection, as well as data analysis. The researcher’s bias involved in this research could include aspects such as the researcher’s prior knowledge of hypertension, which indicates that the researcher entered the study with some knowledge, though bracketing was done.

• This is a contextual study and the findings of this study cannot be generalised.

5.8 CONCLUSION

Cultural care beliefs, values and attitudes form part of the world view of the Shangaan and other cultural groups.

Shangaans have their own perceptions of high blood pressure/\textit{Ngatileyikulu}/hypertension, and these are influenced by their world view, cultural perceptions and experiences of their own culture.

Failure to recognise these beliefs, values and attitudes by nurses and other health-care personnel might lead to many problems, such as the failure of Shangaans who are hypertensive to cope with the chronic nature of their condition, and their failure to adjust to lifestyle changes necessitated by the condition.

Delivery of culturally sensitive health care requires that nurses develop positive attitudes towards people from different cultural backgrounds. Nurses need to acquire more knowledge about the different cultural groups in the South African population and the way culture influences the way in
which people react to health and illness (specifically hypertension as the focus of this study). Only after recognising cultural knowledge and providing culturally sensitive care will health-care professionals be able to minimise problems of incongruence between folk health systems and professional health systems.
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Annexure A

Nkhensani hospital statistics
Hypertension statistics for January 1996 – December 1996 at Nkhensani Hospital
Annexure B

Map of former Gazankulu
Annexure C

Letters of consent
Sir

REQUEST TO CONDUCT RESEARCH IN THE VILLAGES

I am a student at the University of South Africa. As a requirement for my Master's degree, I am expected to submit a dissertation for my study.

My research activity is to explore the cultural care beliefs, values and attitudes among Shangaans relating to hypertension.

The target population for this study is hypertensive patients and traditional healers.

I therefore request permission to conduct the study in the following villages:

• Hlaneki,
• Dxumeri
• Nkuri and
• Giyani Township

Thanking you in anticipation.

Yours faithfully

PR RISENGA

Cell: 083 416 0713
Tel: 015 812-3251 X2020
Fax: 015 812-2461

Work address: Nkhensani Hospital
Private Bag 9581
GIYANI
0826
REF: 15/8

Enquiries M.T. Shiviti

Mrs P. R RISENGA
BOX 655
GIYANI
0826

Dear Madam

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH IN GREATER GIYANI


You are informed that you have been granted permission to conduct research in Greater Giyani for the purpose mentioned in your application.

Kind regard

MUNICIPAL MANAGER
Annexure D

Agreement form
Agreement

Student number 762-649-5

I, .................................................................................... on this ................................................... day
of ............................................................................. 2001

hereby consent to:

1 Being interviewed by PR RISENGA on the topic CULTURAL CARE BELIEFS, VALUES AND ATTITUDES OF SHANGAANS IN RELATION TO HYPERTENSION.

2 Follow-up interviews, if necessary.

3 The interviews being audio-taped.

4 The use of data derived from these interviews by the interviewer to the research report as she deems appropriate.

I also understand that:

1 I am free to terminate my involvement or to recall my consent to participate in this research at any time I feel like it.

2 Information given up to the point of my termination of participation could, however, still be used by the researcher.

3 Anonymity will be maintained by the researcher and that will under no circumstances be reported in such a way as to reveal my identity.

4 More than one interview may be necessary.

5 The researcher will make no reimbursement for information given or participation in this project.

6 I may refrain from answering questions should I feel these are an invasion of my privacy.

7 By signing this agreement I undertake to give honest answers to reasonable questions and not to mislead the researcher.

8 I will be given the original copy of this agreement on signing it.

INFORMANT RESEARCHER DATE
Annexure E

Example of a focus group discussion
EXAMPLE OF A FOCUS GROUP DISCUSSION

DATA COLLECTION
HLANEKI VILLAGE
FOCUS GROUP INTERVIEW
SEVEN INFORMANTS (HYPERTENSION PATIENTS)
ALL FEMALES

R I am interested in your disease and I would like to talk to you as a group about your experiences with regard to hypertension according to Western culture in relation to what you call it, according to Tsonga culture.

H1 The Tsonga people call this disease Ngatileyikulu or N'ombe but now dominantly the young generation talk about it as high blood.

R What causes hypertension in your view?

H2 It is also caused by eating food containing more salt and fat.

H3 It is caused by bad luck from angry ancestors if you fail to obey their instructions.

R How can one know that one is suffering from hypertension?

H4 After feeling that I am having severe headache which was not responding to anything. I was advised to visit the traditional healer by my grandmother. I went to the traditional healer; on arrival I explained that I was not well. The traditional healer had to throw bones to assist him in detecting my condition. The traditional healer told me I am having Ngatileyikulu. After trying to find out more about the disease he told me I have more blood in my body and therefore I must receive treatment in order to make my headache to stop and then I agreed.

H1 I felt my head pounding to an extent where I thought of taking it away as part of my body.

H5 I was bleeding through the nose, dizzy and having headache I could not even see properly.

R Did you visit the traditional healer? Is so, explain.

H7 I usually visit the traditional healer for several problems. After experiencing the problem of my disease of high blood I went to the traditional healer for help. The traditional healer told me the disease which I was suffering from. So I was exposed to phungula with the aim of washing my blood.
R So what happened?

H7 In phungula a person is covered with a blanket with a tin of boiling water and herbal medicine, burned stones are poured into the tin and others would be supporting the blanket outside so that you do not go out before the traditional healer recommends that the treatment is over. Thereafter you will be allowed to go out and be given water to wash and after that I felt much better.

R Do yo visit the hospital sometimes because of your disease? If yes, please explain.

H3 We are really forced to visit the hospital, because not everyone who visits the traditional healer gets healed after receiving the medication. Only those whose ancestors are with them do get healed. But if your ancestors are not with you, you can go to the traditional healer and nothing happens and hence you have to visit other places such as the hospital for help, or go to pastors for prayer. I was told to pay R250,00 for the treatment option by the traditional healer. So imagine that amount, whereas in hospital we far less and the pastor’s prayers are free.

R Do you receive medication in hospital? If so, please explain.

H7 I am not receiving medication in hospital, because the treatment given to me by the traditional healer healed me completely.

H3 I receive medication from the clinic, I collect tablets every month. I can show them to you when you come back.

H4 I have been treated by a traditional healer, a famous woman at Xikundu village, and since then I have never experienced the problems again, that is why I am not receiving any medication from the clinic.

H1 I used to collect tables every month from the clinic previously but now I have stopped because taking treatment every day is a problem. But now I cope well though at times I have headache but after resting the headache tops. And I am not the only one who has stopped using tables, the majority of us do.

R What are the cultural beliefs, values and attitudes of Shangaans in relation to hypertension?

H5 Shangaans do not believe in diseases which are said to be incurable, because for every disease there is reason for its occurrence, so once the reason is solved than a person is free from that disease.

R What are the measures to be used to control hypertension?

H7 The hospital must work together with the traditional healers, this can help many people.
R Thank you. If there is anything else relating to hypertension and you believe we can talk about it, then you are welcome to explain.

H2 We are happy also to have had a chance of sharing with you our experiences.
Annexure F

Example of an individual interview with a traditional healer
I would like to talk to you about your cultural experiences with regard to hypertension according to Western culture in relation to what you call it according to Tsonga culture.

This disease hypertension is called *N'ombe* according to our Tsonga/Shangaan culture.

In your view, what causes this disease?

Eating too much fat and failure to communicate with the ancestors.

How do you tell that the person who comes to you is troubled by the disease called hypertension (*Ngatileyikulu*)?

Hmmmm, well the bones will tell me what is troubling the person.

Do you know how to treat this disease of hypertension?

Yes, I have treated many people with hypertension successfully and they become healed.

Since you state that you know how to treat people with this disease, how do you treat them?

I will not manage to explain the details of the treatment methods because my ancestors can be very angry with me. Herbal medicine is too helpful to people who are having problems of tiredness and excessive sweating.

I take the herbal medicine that is wet and grind it, after grinding, I place it inside the water in the clay pot to stay overnight. The following day I strain the herbal medicine, I use the cloth to remove the remaining sediments from the herbal medicine.

After I pour the herbal medicine in the bottle of one litre, I do not do *lumeka* (blood letting) because the people can collapse.
R How many people have you treated and healed after exposing them to your treatment?

I I have treated many, many people.

R Have you ever met any difficulties when treating people with this disease of hypertension?

I I have never met any difficulties of any kind because I follow the instructions from my ancestors correctly, that is why they protect me.

R Do you allow your clients to go to hospital if there is something troubling them?

I I allow them to go to hospital but if they come back, I do not allow them to mix hospital medicine and my medicine. They are supposed to sop the hospital medicine if not yet completed, and start using my medicine until they finish. The sick person must come back to explain how is the herbal medicine working.

R What are the thing that the Tsonga/Shangaan people believe in, in relation to hypertension (the disease called Ngatileyikulu according to your Tsonga culture)?

I We don't believe that there are diseases which cannot be treated. Even if you have been bewitched the person is treated and becomes healed.

R Do you see how hypertension can be controlled?

I I invite the traditional healers to hospital to treat this disease.

R I am very thankful for our talk about this topic, I will come back. If you have something more to explain in relation to hypertension, please do.

I I don't have anything, I will see you when you come back.
Annexure G

Interview schedule
INTERVIEW SCHEDULE FOR FOCUS GROUP

What is hypertension, according to Tsonga culture?

What, in your view, causes hypertension?

How can one know if one is suffering from hypertension?

Do you visit traditional healers? If so, can you go into more detail?

Do you visit the hospital because of your condition? If so, please give more detail.

Do you receive medication in hospital? If so, please go into more detail.

What are the cultural beliefs, values and attitudes of Shangaans relating to hypertension?

What are the traditional measures used to control hypertension?

Thank you. If you would like to add anything else about hypertension, please feel free to discuss it.
INTERVIEW SCHEDULE FOR INDIVIDUAL INTERVIEWS

What is hypertension, according to Tsonga culture?

What do you think causes the disease?

How do you tell whether the person who consults you is suffering from hypertension?

Do you know how to treat hypertension? If so, could you please explain your methods?

How many clients have you successfully treated for hypertension – i.e., clients who recovered after treatment?

Have you ever encountered difficulties in treating clients with this condition?

Do you allow your clients to go to hospital if there is something troubling them?

What are the beliefs of the Tsonga people in relation to hypertension?

How can hypertension be controlled?

Thank you. If you would like to add anything about hypertension please could we discuss it.