

**UNIVERSITY OF KWAZULU-NATAL**  
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**A QUALITATIVE STUDY FOCUSING ON COPING MECHANISMS FOR BLACK  
DIABETIC WOMEN BETWEEN THE AGES OF 40-50 YEARS**

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.....  
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Anthropology

## **DECLARATION**

I, Yonela Scina, declare that this work. All citations, references and borrowed ideas have been appropriately acknowledged. I hereby confirm that an external editor was used to proof read and correct spelling and grammar errors.

Signed .....

Date .....

## **DEDICATION**

This study is dedicated to my late grandmother Nondumiso Muriel Scina, my mother Thembakazi Scina, Njabulo Mlungiseleli Dlamini, Chulumanco 'Joy' Bhengu and my little angel Liyema Phakade Dlamini.

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- To the participants this study would not have been a success without you. A special and sincere thank you to all of you.

## ABSTRACT

This is a study on black diabetic women in Durban, Umlazi N Section in South Africa. The study seeks to explore the cultural meanings that are attached to diabetes as well as examine the coping mechanisms that the women in the study used to manage diabetes. The study further investigates the existence of social networks within the community where diabetic women live and how these networks enable women to cope with their condition. This study also discusses how women receive information at the clinic on how to manage their diabetes.

The study adopts a qualitative research design. The research techniques that are used in the study are in-depth interviews and semi-structured interviews. Participant observation techniques were also adopted in this study. Interactions with the women took place at the clinic, their homes, and during the group meetings that they hold every month with Diabetes South Africa at the clinic. Participant observation managed to shed light of the diabetic women's lived experiences.

Two theoretical perspectives were adopted in this study. These namely the social network theory and social capital theory. The women's background, family life experiences and networks all contributed to a rich understanding of issues and diabetic women's experiences. This study demonstrated the important role culture plays in the lives of the participants. Cultural background influenced a lot of decisions that the diabetic women made with regards to their health seeking behavior. Cultural forces included religious and traditional beliefs' influences. The education that the women got at the clinic was good and it enabled them to manage their diabetes and to understand that diabetes is not *umeqo* or *idliso*.

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# CHAPTER ONE

## INTRODUCTION

### 1.1 Background and significance of the study

Liburd (2010:21) defines diabetes as “a group of metabolic disorders that share the phenotype of hyperglycemia”. It is one of the leading chronic diseases in the world. Shaw, Sicree and Zimmet (2010:4) “Diabetes mellitus is one of the most common chronic diseases in nearly all countries, and continues to increase in numbers and significance, as changing lifestyles lead to reduced physical activity, and increased obesity”. Diabetes mellitus is a challenge to public health as more people are developing the condition. Somersall, Madill and Summers (2011:854) state that “recent studies estimate predict that more than 300 million people will have the condition by the year 2025”. The greatest increase in diabetes is shown to be in developing countries. This is influenced by the lifestyle changes due to globalisation (Kolb & Mandrup-Poulsen, 2010; Zimmet *et al.*, cited in Somersall, Madill and Summers 201: 854). They explain that “the rapid increase of diabetes has coincided with the changes in environment and lifestyle associated with advanced industrialisation and globalisation, including more sedentary jobs, aging populations, and increased availability of sugary drinks and foods with high fat and salt content”. Due to lifestyle changes the greatest increase in diabetes is in type 2, which is also known as adult onset diabetes. Somersall, Madill and Summers (2011:854) predicted that the greatest increase in type 2 diabetes is likely to occur in developing countries as they become industrialized and are subjected to the influences of globalization”. Diabetes is affecting all cultures and races Jamison *et al.*, (2006:2) point out that “the highest prevalence of diabetes is found among populations of

Indian descent, urban populations, and those with a family history of diabetes, obesity or physical inactivity”.

Diabetes mellitus is divided into two types Ngamlana (2006:8) explains that “DM is divided into type 1, formally referred to as insulin-dependent diabetes mellitus (IDDM), and type 2, formally referred to as non-insulin-dependent diabetes mellitus (NIDDM)”. Ingram, Gallegos and Elens (2005:7) stress that “diabetes can be fairly described as a “whole life” disease, in that few areas of one’s life is not either influenced by, or implicated in, the manifestation and control of the diabetes”. Yet diabetes was never a common problem in South Africa’s past, so what happened to change that? Mulberg, Silber and Van den Anker (2009:350) state that “industrialization and stressful lifestyles brought new diseases. For example, lifestyle diseases, of special importance for pediatric populations, include obesity, diabetes, hypertension, heart disease, and diseases associated with smoking, alcohol and drug abuse”. South Africa is a developing country. The new lifestyle encourages the susceptibility of diabetes because of its unhealthy nature. One of the consequences, therefore, of increased globalisation is that it leads to changes in lifestyle, such as eating new foods and embracing a more fast-paced existence and this situation has exposed more individuals to diabetes. “The conservative South African estimate is that 6,5% of adults aged between 20-79 years have diabetes, but age-adjusted prevalences of up to 13% have been described in urban populations as far as 1994” Amod *et al* (2012:4). A similar study by Jamison *et al.* (2006:2) confirms that “Three million people in Sub-Saharan Africa were afflicted with type 2 diabetes as of 1994, but that number is projected to increase by two or threefold by 2010”. Many Africans – and South Africans in particular – have changed their eating habits, abandoning cultural foods for fast foods that are high in carbohydrates, sugar and fat. These new foods are a danger to the body, in that they can lead to excessive weight gain and obesity, which, in turn,

lead to health complications such as an increased susceptibility to diabetes, cancer and heart diseases. As South Africa is a developing country a fast-paced lifestyle has been adopted by many, abandoning healthy, active lifestyles. People have less time to cook and opt for take a ways instead, fast foods instead. These are not healthy as they are high in fat, sugar and carbohydrates, which are all substances that are not to be consumed excessively. People have less time to exercise because of the demands made by their jobs. Instead of walking people now have cars.

This situation should sound warning bells, not only to health practitioners and the government but also to citizens. In 2008, 2.6% of men and 4.1% of women died as a result of diabetes in South Africa alone (Stats S.A 2009: 189). These statistics seem to prove that more women die from diabetes than do men. This state of affairs motivated me to find out more about the coping mechanisms of diabetic women.

In dealing with, and looking at, the situation of women, it is interesting and worthwhile to note specific cultural attachments that diabetes has been given. Part of the coping mechanism is medication, so the following questions will be asked: how are black diabetic women coping and managing the disease? What sort of medication are they using? Are they receiving adequate support from their families to maintain and manage the disease? In summary, the present paper will investigate black women's attitudes towards diabetes and how they cope with having the disease.

Diabetes is a disease that affects both males and females, but recent research has shown that it is more problematic in the female. Liburd (2010:27) sums up: "Generally, diabetes is diagnosed more often in women than in men, its frequency increases with age, and levels off in those aged

80 years and older”. Women therefore have to make sure that they try to take care of themselves by managing their diabetes well, more so because of the daily challenges and duties that they have to perform for their families. “Universally, sickness and death are stressful events with potentially serious physical, emotional, social or economic consequences for sufferers, their relatives and other members of their community” (De Villiers and Tjale, 2004:136). Having the responsibility of looking after one’s family and/or having a full-time job and then also being diabetic, can become extremely stressful. This led to my interest in finding out how black women cope with diabetes. I want to find out if diabetic women receive any form of help from their families and also if their families are well-informed and educated concerning what to do if the ‘patient’ becomes ill.

Helman 2001:50, cited in Dein 2006:16, states “Anthropologists have pointed out that any society’s health care system cannot be studied in isolation from other aspects of that society, especially its social, religious, political and economic organization”. Culture is a pattern of learned beliefs, values and behaviour that are shared within a group; it includes language, styles of communication, practices, customs and views on roles and relationships (Joseph, 2006). Explanations of sickness and healing differ from community to community and tend to depend upon one’s cultural background. In a country like South Africa, where there are many diverse cultures, it becomes difficult to define and treat a disease using the biomedical approach alone, since one’s “ culture plays a large role in shaping health-related values, beliefs, and behaviour” (Joseph, 2006). People attach their culture and cultural belief to illnesses, so it is often difficult for doctors to address health issues when their patients attach cultural beliefs to every illness and disease and thus treat or deal with the disease the way that they feel is best and not necessarily according to the instructions of the doctor. “Patients and their health care providers may view

causes of illness and management strategies differently, often to the frustration of both parties” (Clark Vincent, Zimmer and Sanchez, 2009:383).

Kalowinsky (2008) postulates that “these differences in disease understanding are not innate or due to the black box of “culture,” but can be understood as the result of shared historical experiences that shape current cultural practices”. Diabetes is a disease that is affected by cultural change, which includes the adoption of new eating habits and ways of everyday living. The economy has a great influence on our health; diabetes used to be regarded as a disease of the affluent, because generally it was only the wealthy who had access to an abundant supply of unhealthy foods. Today diabetes also affects the poor and is becoming a growing problem for the lower levels of society. Poor people tend not to have a balanced diet; in fact, most of their meals consist of starch, unhealthy oils and sugars, all of which are dangerous to the body because they promote weight gain. What we eat and do depends upon our culture. Hence diabetes is a disease that is, at times, perpetuated by what we eat and the life-style we lead. It would appear that we now live on foods that cost us our health. We no longer exercise, walk or do any form of exercise that keeps our bodies healthy.

After being diagnosed with diabetes, the diabetic individual has to change his/her eating habits and adopt a new way of eating. “For persons diagnosed with type 2 diabetes, complex negotiations of judgements of taste inscribed by the past, present, and future associations with food and eating: this is food as lived in their daily lives” (Ferzacca, 2004:44). The change in diet tends to be difficult, as the individual has to now start eating foods that have a different taste from usual and most of us only like the foods to which we are accustomed. But diet is an important aspect in the diabetic’s life, as it can help to control glucose levels.

This study was conducted in Durban KwaZulu Natal in Umlazi N section clinic. This is a public clinic that attends to the N section community; it is run by qualified nurses and a doctor comes in during the week. Selection of participants took place at the clinic due to their commitment for attendance for both clinic check-ups and Diabetes South Africa support groups. Umlazi is a township in which mainly black people reside. A portion of the population is unemployed due to poor educational backgrounds. Coovadia, Jewks, Barron, Sanders and McIntyre (2009:823) point out that “unemployment has been worsened by low educational attainment and a dysfunctional education system is a persistent legacy”. Those who are unemployed have part time jobs and some are self-employed: they sell fruit and vegetables, wash and iron clothes for people and clean people’s houses.

Poverty is a trend in some people’s lives in this area, as some depend on grant money allocated for their children; this money is not enough for big families. Ingram, Gallegos and Elens (2005:6) state that “the hardest hit by diabetes are often those who also face health disparities”. The monthly income for some families is far lower than the responsibilities; housing systems are not good, as some share a house with 11 other people. This situation is not conducive for someone who is afflicted with a disease. Coodavia, Jewks, Barron, Sanders and McIntyre (2009:823) stress that “overcrowding, inadequate sanitation, malnutrition and stress causes the health of the black population to deteriorate”. A study carried out by Schneider, Bradshaw, Styen, Norman and Laubscher (2009:177) found that “In addition to socioeconomic differentials, the South African population has a rich ethnic diversity that influences the distribution of life-style and risk factors for non-communicable diseases”. Poverty has a negative role in the lives of those that are afflicted by disease, as it makes it difficult for them to manage their disease to the best of their ability. A study carried out by Seligman and Schillinger (2010:7) showed that

“adults with diabetes are 40% more likely to have poor glycemic control if they have inadequate money for food than if they can afford a healthful diet. Their odds of having frequent and severe hypoglycemia are almost twice as high, most likely a consequence of food inadequacy in association with medication regimens that lower blood sugar”. They add that “the strikingly elevated risk of hypoglycemia almost certainly contributes to the fact that adults with diabetes who cannot afford adequate food have five more physician encounters per year than their counterparts who can afford adequate food” Seligman and Schillinger (2010:7). Ngamlana (2006:12) continues “Not only does poverty have an influence on the development and management of DM, but it is evident that DM also has serious economic consequences. When this disease affects the breadwinner in a poor family, it frequently has severe implications for the economically dependent children”.

The question the researcher seeks to address is what strategies black diabetic women have in place to cope with their diabetes.

## **1.2 Rationale/motivation for the study**

This study was motivated first of all by the loss of two close family members who were diabetic, as well as by the increasing prevalence of diabetes amongst young South African adults. “Another, older term for type 2 diabetes mellitus was adult-onset diabetes” (Kardori, 2010). Diabetes used to be a disease that came with age, but today one’s age is no longer such a determining factor. Currently, with children becoming more and more inactive and there being an obesity epidemic as a result, type 2 diabetes mellitus is increasingly occurring in the young. The death of my two family members made me realise how uninformed and uneducated families are with regard assisting diabetics. Khan, Glaser, Fox and Peterson (2011: 213) feel that

“Diabetes educators play a vital role in training patients to manage diabetes, thereby reducing patients’ risk of diabetes complications and hospitalizations”. The education of the patients is very important for a diabetic patient and the family. Through proper and thorough education they are able to learn new ways of managing their diabetes. This can save the lives of the afflicted. Education of family members should be emphasized more strongly by nurses or other diabetic educators, so that they thoroughly understand how the patient should be living. It becomes difficult for the afflicted individual to maintain and manage diabetes alone, as there are too many aspects to the management of the disease. A study carried out by Ingram, Gallegos, Elens in (2005:1) proved that, with thorough education, patients and families are able to manage diabetes properly. They state that “participant attitude toward diabetes changed from ignorance and fear to acceptance and control, which seemed pivotal in improving their emotional well-being, regardless of self-management practices”.

### **1.3 The statement of the research problem**

The study seeks to explore the cultural meanings that are attached to diabetes as well as examine the coping mechanisms that the women in the present study use to manage diabetes.

### **1.4 Key research questions**

The key research questions of the study are:

- 1) What are some of the cultural meanings that are attached to diabetes?
- 2) Do these women get sufficient information at the clinic on how to manage the diabetes?

- 3) What coping mechanisms do these women have in place for dealing with diabetes and managing it?
- 4) Do the family and community form part of a support system for the women?

### **1.5 Objectives of the study**

The objectives of this study are to:

- 1) To find out the cultural meanings that are attached to diabetes;
- 2) To examine whether or not women receive enough information at the clinic on how to manage their diabetes;
- 3) To discuss the coping mechanisms are that these women use to manage their diabetes; and
- 4) To investigate the existence of social networks within the community that help these women manage their condition.

### **1.6 Overview of literature on the subject**

There is little literature that has focused on diabetes and the cultural aspect in South Africa, culture is very important for understanding and dealing with diseases, as it has an influence on the types of health-seeking behaviours that different cultures have. In the case of South Africa, where there is such diversity, it becomes an important issue to try to bring about awareness and appropriate means of medication and health-seeking behaviour in times of illness. This study will add to the meagre literature that is available in South Africa concerning how culture affects decisions taken by people when they are sick. It will show the different types of belief that black diabetic women have attached to diabetes and the meanings that diabetes have been given. It will

help health practitioners of different cultures to understand the power that culture has on people and the options that they choose for treating their illnesses.

### **1.7 Theoretical framework**

This study will be guided by the following two social science theories:

#### *Social network theory*

In general terms, the concept of a network refers to patterned relationships among individuals, groups or organisations (Dubini and Aldrich, 1991). Networks provide social capital for people when they have to adapt to a new living arrangement that involves diabetes. Newly diagnosed diabetics have to learn new ways and skills of living. The social network theory will enable me to find out how black diabetic woman use their family and social networks to understand and better manage their disease. The theory will also help me understand how these women position themselves within the community after being diagnosed with disease. Do black female diabetics have people that they can rely on for help? Do they come together and talk about the challenges that they face? Do they feel that they find solutions to their situation? Do they help each other, for instance by empowering each other through sharing their own coping strategies, the medicines that they use and the doctors that they know? Clark, Vincent, Zimmer and Sanchez (2009:383) have stressed: "Support from the family can increase one's determination to adhere to the lifestyle changes necessary to manage diabetes successfully." I will also ask the women whether or not health practitioners have been helpfully educating them about their disease and how to better manage it.

#### *Social capital theory*

The social network theory “views social relationships in terms of nodes and ties. Nodes are the individual actors within the networks, and ties are the relationships between the actors” (Lin, Cook and Burt, 2008). Culture is a form of social capital that people have. Social capital is a form of capital that people possess for understanding and making sense of their everyday lives. Culture forms the basis of how people define and deal with illness. It is through culture and learned experiences that people shape their behaviours towards illness. Networks can be used to determine the social capital of individuals. Social capital is “the fruit of social relations, and consists of the expectative benefits derived from the preferential treatment and cooperation between individuals and groups” (Bowles and Gintis, 2002). Research has found that the presence of social capital through social networks and communities has a protective quality on health. Bolin (2003) reasons that social capital “affects health risk behavior in the sense that individuals who are embedded in a network or community rich in support, social trust, information, and norms, have resources that help achieve health goals”. For example, a person who is sick with cancer may receive the information, money and/or moral support that he or she needs to endure the medical treatment and recover from it. Social capital also encourages social trust and membership, which, in turn, tend to discourage individuals from engaging in risky health behaviours such as smoking and binge drinking.

### **1. 8 Organization of thesis**

This thesis is divided into six chapters. The first chapter introduces the research. It gives a guideline to what the dissertation will be focusing on and to the points of discussion. The introduction includes the background of the study and its significance, the rationale and motivation behind the study, the statement of the research problem, key research questions, the study objectives, an overview of the literature on the subject and the theoretical framework.

Chapter Two will be the literature review, which will concentrate on literature based on coping mechanisms of black diabetic women, some of the cultural meanings that they have given to diabetes, the importance of networks and how the networks assist them with managing their diabetes and the relevance of the information that they get from the clinic. Chapter Three will discuss on the research methodology, how the research was carried out, where it was conducted, how it was conducted and the tools used in the research. Chapter Four will present the results and analysis of the findings of the study. Chapter Five will discuss the findings and Chapter Six will conclude the thesis.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

Chapter Two will discuss and examine the literature which deals with the approaches and management mechanisms that black diabetic women use to manage their diabetes. This literature review is divided into six subsections that highlight each objective and link the objective to the daily lives of diabetic black women and how they manage diabetes. People with diabetes, irrespective of race and gender, need all the assistance that they can get in order to manage and keep their blood glucose levels at recommended levels. To properly manage diabetes patients need to conform to a culture of appropriate medication habits. Families are the closest network to diabetic patients and have a very close-knit relationship with them; they have great influence on the choices of medication and even the type of healer. For proper diabetes management patients need to be properly educated by selected healers on how to best manage their condition.

The first section will discuss the different cultural meanings that have been attached to diabetes by black diabetic women; it will give a more meaningful insight into how they view diabetes and the meanings that they have attached to the health condition, concerning diabetes. The second section will discuss issues regarding access to information on how to better manage and control diabetes; it will focus mainly on the clinic and the nurses since they are the primary source of information for these women. Section number three will discuss the different types of coping mechanisms that black diabetic women of Umlazi N section have in place to deal with and manage their diabetes. Section four explores whether black diabetic women understand the importance of exercise for a diabetic patient and whether they exercise or not. Section five

focuses on the information that black diabetic women have on the diabetes. Do they understand what it is and the effects that it has on the body, can they use glucometers and are they able to read them. Section six will discuss the different types of networks that are available to these women and how these networks can assist women to deal with and better understand their diabetes.

## **2.2 Cultural meanings attached to diabetes**

Every illness in every society, belief and culture is dealt with in a manner that is closely related to the beliefs that they have with regards to that particular illness. Belief systems and culture influence many decisions that are taken in health-seeking; similarly, patients with diabetes mellitus may have their own definition and understanding of the disease. Cerkoney and Hart 1980, cited in Mann, Ponieman, Leventhal and Halm 2009:279, stress that “Understanding how patients’ beliefs about their disease and its treatment affect health behaviors such as medication adherence represent important opportunities for improving diabetes medication adherence”. A study carried out by Barnes *et al.*, 2004, cited in Mann, Ponieman, Leventhal and Halm 2009:279, “of diabetes beliefs among Tongan compared to Europeans with diabetes in New Zealand showed that Tongans perceived their disease to be acute and cyclical in nature, uncontrollable with less perceived need for medications, all of which were associated with lower adherence to diet and medication taking” (Mann, Ponieman, Leventhal and Halm 2009:279). Beliefs concerning diabetes and the causes of it differ in every culture and ideology system. These beliefs have a great influence on medication adherence and the type of medication that the patients decide to use. Diabetes has become a medical challenge in southern Africa. More black people are becoming diabetic and this is due to many factors, such as culture and lifestyle change. South Africa on its own is a very diverse country, with different cultures and beliefs

systems. Diabetes affects people from all the different races and cultures. Each has different ways of dealing with and managing diabetes. This becomes a major problem for health care professionals. Surbone, Kagawara-Singer, Terret, Baider (2006:636) explain that “Culture provides each person with a reference framework to interpret the external world and to relate to it. Each person relies on her culture when trying to make sense of what is happening to her, especially at difficult or traumatic times in life, such as during the course of a serious illness”.

Diabetes is viewed in different ways by different people; the causation of diabetes is also interpreted in different ways by different people and different cultures. Mbanya, Motala, Sobngwi, Assah and Enoru (2010:2262) state that “in most rural and some urban African settings, health beliefs, knowledge, lay perceptions, and health behaviour interact strongly”. Others link diabetes to culture and sorcery and therefore opt to be treated by a traditional healer. An incident was recorded by Kum Awa and Phillimore in 2008: found that “The scene is a small rural hospital in north-west Cameroon. A few night staff remain on duty after their more senior colleagues have left. During the evening an indigenous healer arrives, invited by members of the family of a very ill diabetic patient. Nursing staff allow him in, and he proceeds to perform a ritual to diagnose the ‘true’ causes of this particular case of diabetes”. According to Kum Awa and Phillimore (2008:475), some believe that diabetes can be caused by a shock. If someone hears or sees something that shocks them they believe that the diabetes starts. Some Mexicans believe that their diabetes is triggered by *susto* meaning. Seligman, Fernandez and Jacobs (2010:228) add that “acute stressors were often linked to *sutso* (frightful experiences) in diabetes causal explanations. One respondent said, “The cause of my diabetes must be the fright . . . My house burned down and it frightened me”. Some believe that God has brought the diabetes into

the life of the diabetic for purposes that only He knows. Fleming and Gillbrand (2009:148-149) found that “a significant number of Muslim participants believe they developed diabetes due to Allah’s will; they also recognize a religious obligation and personal desire to exert agency and control over diabetes self-management”. When the belief is that God has brought the diabetes into one’s life, some patients will also believe that God will take the disease away. Some people refuse to take medication because of the belief that God is a higher authority that controls everything on earth, even the doctors and the medicines that are prescribed by them. This is an obstacle to medication compliance, as patients with diabetes will not take medicine. People who believe that their diabetes is as a result of sorcery have preferred options for dealing with and managing their illness. In most cases they consult traditional doctors and use traditional medicines. This results in lack of proper medication compliance; they do not regard medicines given at the clinic as being as important as the medicines that they get from the traditional healers.

### **2.3 Information received by black diabetic women at the clinic**

Van Zyl (2003; 14) emphasised that diabetes is a significant problem, which needs for preventative measures to counteract and delay complications which lead to enormous morbidity (with the loss of quality of life) and mortality. I believe that clinics should be structured to support healthcare, with sets of rules for healthcare and education so that diabetic woman can acquire the information that they need to manage their diabetes and to keep healthy. According to Hoey 2004:25, cited in Ngamlana 2006; 113, when it comes to diabetes care the principal objective is to improve the patient’s health and to ensure the total well-being of the patient through education. Van Zyl (2003; 14) points out that there is very little information available on the quality of care in clinics in South Africa. The impression is that it is poorer than advised in

the current guidelines. He adds that in South Africa an audit of primary diabetes care in the public sector of Cape Town showed a poor quality of care, together with a high prevalence of suboptimal glycaemic and blood pressure control. Diabetic complications remained largely unrecorded. While collecting data I observed that during the clinic visits with the Diabetes South Africa (DSA) team, clinic nurses as health professionals were not very involved when it came to educating the patients about diabetes and how to manage it. The DSA team had to explain everything to the women, from knowing the difference between when their blood sugar levels were high or low, explaining to them how they should eat and prepare what they are eating and why they should eat like that. The team even showed the women the types of exercises they can do that do not require them to engage in strenuous exercise, firstly because of their age and secondly because of their cultural background. The team brought their own glucometers, which they gave to the women for free; they also showed them how to use them. These women looked very excited, as it was the first time that they had been given a means of participating in managing their diabetes; it made them more active and eager to come back to the clinic (Ngamlana 2006). Effective DM management not only reduces complications, but is also associated with an improved quality of life.

Campbell *et al.*, cited in Van Zyl (2003; 14), studied 60 general practices in England, in an attempt to identify predictors of high quality of care of chronic diseases. High quality of care was strongly related to the duration of routine consultations, the size of the practice (large practices tend to deliver better diabetes care) and location of the practice (prevention care was worse in low socio-economic areas). Practices with a good team climate delivered a high level of care. This study indicates that the quality of care for people with chronic diseases tends to be related to the frequency of the patients' visits to the clinic. This might be due to the fact that after some

time the patient becomes familiar with the health practitioners and a relationship is created between the practitioner and the patient. Van de Wiel and Wijnberg-William (2004:19), cited in Ngamlana 2006 state that healthcare workers who are committed to providing quality diabetic care must be prepared to spend time mediating intense interactions with DM patients. To achieve this, healthcare workers require improved communication skills and adequate psychological knowledge. This will assist healthcare providers when dealing with patients; they will be able to communicate with them in a manner that is appropriate for their condition. The psychological aspect will assist in understanding the patients inside the healthcare boundaries and when they are outside, at home. This will improve communication skills and a better understanding of what the patient feels is best for managing the diabetes.

One of the most important coping mechanisms in dealing with any disease is compliance with treatment. “The most important way of assisting patients in coping with DM is by giving them information about their disease in order to improve their self-care” (Ngamlana 2006; 139). The patient needs to take the medication as instructed at the clinic. In a study carried out by Ngamlana in 2006, most patients verbalised that good treatment compliance is helpful in the management of their condition. Nam *et al.* (2010: 4) stated that “most of the published literature related to diabetes self-management focuses exclusively on patients, rather than clinicians or patient–clinician interactions”.

In order to better manage and control diabetes, diabetic patients need to be properly educated on management skills. Healthcare providers therefore play a very important role in the life of a diabetic patient. This is why there is a great need for healthcare providers to be sensitive, understanding and always willing to explain and teach people with diabetes how to manage it.

There is a great need for literature to be published on healthcare providers and their interactions with diabetic patients, because the relationship that they build with the patients will determine how effectively diabetic patients will follow instructions on how to best manage their diabetes, Nam *et al.* (2010: 4) add that a “better understanding of clinician factors is needed to improve diabetes self-management education and quality of diabetes care”.

Clinicians and doctors should understand that there are many different cultural backgrounds and different views and perspectives on how to best deal with diabetes and how to manage it. They must not criticize and must become more informed about the different people and different cultures. During a research projection one woman said that she is a Zulu woman and therefore needs to be treated by a Zulu traditional healer who will best understand her. “Black people should be healed using black healing methods”. Nam *et al.* (2010: 4) concur, adding that “patients and clinicians differ substantially in their perceptions, knowledge, and attitudes, which may lead to confusion and conflict, and in turn, to poor outcomes”.

Healthcare providers should make it their primary aim to educate patients about the importance of treatment compliance, as this will make all the patients aware of the importance of taking their treatment on time, every time, as compliance is one of the most important coping mechanisms needed to manage diabetes. “Physicians’ attitudes toward diabetes management may be more important than their actual knowledge of the disease; clinicians’ beliefs, attitudes, and knowledge influence patients’ adherence to the prescribed regimen. Many clinicians still consider type 2 diabetes to be a non-serious disease” Nam *et al.* (2011:4). Healthcare providers should also be able to make patients feel relaxed when talking to them, so that patients are not scared to ask questions when they find that they do not understand. They should not reprimand the patients,

because patients have very little knowledge about the disease. Health providers are the best source of knowledge on how to manage diabetes. If they scold the patients it becomes difficult for the patients to engage with them. Patients should not be afraid of healthcare providers. Healthcare providers should adopt a bio psychosocial approach to dealing with patients. This will allow patients to be included in the treatment of their disease. Patients will become more responsible when it comes to managing their diseases this will build a strong relationship between the healthcare provider and the patient. This means that the doctor has to hear the patient's perspective of the illness, understanding the whole person and not just the illness, and building a good relationship with patients by listening to them and explaining things that the patients do not understand.

Regardless of how well prepared or well educated on diabetes the healthcare providers are, if there is a language barrier then the information that they want to share with the patients will be useless. Shaw, Huebner, Armin, Orzech and Vivian (2008: 460) state that “cultural and language differences and socioeconomic status interact with, and contribute to, low health literacy, defined as the inability to understand or act on medical/therapeutic instructions”. One of the main problems that occur due to misunderstandings between the patient and healthcare provider is that the patients tend to do what they think they heard when being instructed on how to take their medication. “Healthcare professionals in primary care settings are often challenged by the cultural differences between themselves and their patients that may inhibit effective and satisfactory health care” Shaw *et al.* (2008: 461). Healthcare professionals are faced with the challenge of understanding and acknowledging that patients have their own views of the disease and causes and appropriate treatments that are believed to help in managing diseases and illness. “Cultural variation can be seen in beliefs about disease etiology, appropriate treatments, proper

self-care and preventive treatment, human physiology, and appropriate doctor and patient conduct” Shaw *et al.* (2008: 461). Good communication between patients and healthcare providers is very important for successful outcomes. How does this relate to diabetes?

Some patients do not see diabetes as a serious illness, to the extent that they do not feel the need to go to the clinic to get their own medication, but send family members to get it for them. During my fieldwork I interviewed a woman who told me that she is the bread-winner in the family and stays with her grandchildren. She told me that at times she forgets that she has not taken her medication because of the burden that she is carrying. Before she goes to work in the morning she has to make sure that she has prepared everything for the children so that they will not be late for school. She has to walk a very long distance to work every day. Because she is always in such a rush in the morning she sometimes leaves without eating and taking her medication. Sometimes her bosses at her workplace do not allow her to go to the clinic for her monthly check-up and to collect her medication. Ngamlana (2006; 78) asserts that “Treatment non-compliance is very dangerous and costly”. Access to information is another factor that contributes to some patients’ lack of management skills of diabetes. This can be due to the fact that other people are unable to access clinics or hospitals or because of financial constraints. Shaw *et al.* (2008: 462) warns that “too often, people with the greatest chronic disease burdens have limited access to health information and limited ability to process that information. Healthcare providers are often unable to recognize, however, when cultural differences between patient and provider contribute to misunderstandings around chronic disease management, health status, disease severity, and treatment regimens”.

To effectively manage diabetes one has to consider the economic conditions of the patient who is diagnosed with diabetes. Finances are very important as the person now has to change their lifestyle to accommodate their condition; they have to change the food that they eat to more healthy, expensive food and be able to afford specific prescribed medicines. They have to have travelling money to visit the clinic every month. Not having enough money may lead to many of problems for the patient such as not being able with comply with the diet given at the clinic. Diet change is one way in which diabetic people can manage and control their diabetes. “Poverty can affect the health of these people and this can unintentionally result in non-compliance, which can again aggravate the disease” Ngamlana (2006; 115).

#### **2.4 Coping mechanisms put in place to manage diabetes**

Like any other disease, DM requires the patient to maintain a good track record of taking their medication. Not taking medication as instructed may lead to health complications that at times may even become fatal. Patients need to change their lifestyles and conform to a healthier lifestyle. Hacıhasanoglu and Gozum (2010: 693) add that “Adherence is the level of conformity between the patient’s behavior and clinical recommendations, such as using the medications properly, following prescribed diet and incorporating relevant lifestyle behavior changes”. Interventions that are directed at diabetes patients on the necessity of complying with their medication can make an important difference in diabetes management. Good compliance is greatly influenced by the patient’s willingness to conform as well as the relationship between the patient and the doctor. A good patient and doctor relationship has a critical influence on the patient.

Traditional medicines are used among the sick and the healthy. (Ngamlana 2006; 85). Alternative medicine is a problem for healthcare providers in patients diagnosed with diabetes, as the alternative medicine tends to clash with the medication that the patients get at the clinic and hospital. Patients tend to neglect the medicine provided at the clinic for the medicine that they believe might help cure the diabetes. This usually complicates their condition as it becomes difficult to manage the diabetes. Hunt, Arar and Akana (2000) showed that ‘alternative medicine has increasingly become the subject of medical research, in part driven by a concern that such treatments, despite their apparent innocuousness, may harm patients by exposing them to unknown dangers or by drawing them away from medical treatments. As many as 1 in 3 people in the United States report using alternative treatments, most often for chronic illnesses such as diabetes. More than 400 herbal remedies for diabetes have been reported worldwide’.

After being diagnosed with diabetes, the diabetic individual now has to change his/her eating habits and adopt a new way of eating. “For persons diagnosed with type 2 diabetes complex negotiations of judgments of taste inscribed by the past, present, and future associations with food and eating: this is food as lived in their daily lives” (Ferzacca, 2004:44). The change in diet tends to be difficult as the individual has to now start eating foods that have a different taste and most of us like only the foods to which we are accustomed. Diet is an important factor in the diabetic’s life as it can help control glucose levels. Perceptions of food and cultural meanings attached to food are also concerns that should be addressed, especially for adult women with type 2 diabetes. Owens (2003; 154) stresses that “maintaining control of diabetes requires making healthy choices when preparing and consuming foods and carrying out other lifestyle changes. However, prescribing lifestyle change for patients with diabetes is challenging and complex because such change requires people to process the historical meaning of food in their culture

and its traditions across generations”. To properly manage diabetes, patients suffering from it have to eat healthy foods that will be low in starch, fats and sugars. Diabetic people have to eat large quantities of vegetables in order to keep their sugar blood levels under control.

Cockerham (2007; 155) observed that “living conditions qualify as a fundamental cause of health and disease through social mechanisms like the class position that impose health advantages or disadvantages on people”. For diabetic and poor people, management of the disease becomes a challenge, because the environment in which they live also has an effect on their health. Clarck (as cited in Mdolo, 2005; 44) states that poverty affects the health status of the population because it contributes to poor health. Poor people have to eat what is available to them, they do not have funds to buy what the doctors and nurses at the clinic prescribe. Adult onset diabetes can be managed by eating a healthy and balanced meal, but when all that is available to you is potatoes, cabbage and maize meal, which is just starch, it is difficult to follow the doctor’s prescription and adopt approved or appropriate dietary patterns in order to regain one’s health. In most cases, poor people eat large amounts of starchy porridge, potatoes or cabbage. Ngamlana (2006) states that “not only does poverty have an effect on the development and management of DM, but it is evident that DM also has serious economic consequences”, as people have to spend money on medication and healthy food, which is costly.

## **2.5 The importance of exercise**

Diabetics need to exercise to keep their glucose levels under control. They need to gain a better understanding of the importance and need for exercise, as this can help them lead a better healthier life. Keeping diabetes under control is of vital importance, as it prevents one from getting cardiovascular diseases as a result of poor diabetes management. Diabetics need to be

able to bring their weight down, as a big body also contributes to susceptibility to diabetes. Exercising can assist them in keeping their bodies in shape and this can help them to remain healthy. Thomas, Elliot and Naughton (2009:2) explain that “Exercise improves blood sugar control and this effect is evident even without weight loss. Furthermore, exercise decreases body fat content, thus the failure to lose weight with exercise programmes is probably explained by the conversion of fat to muscle. Exercise improved the body’s reaction to insulin and decreased blood lipids”. Exercise assists the body in better blood circulation. This is an important process for a diabetic person. “Diet and exercise changes are an effective way to improve the disease burden associated with both diabetes and hypertension” (Bacon, Sherwood, Hinderliter and Blumenthal, 2004; Brownell, 1998; Conlin, 1999; Miller *et al.*, 2002; Roberts & Barnard, 2005 cited in Orzech, Vivian, Torres, Armin and Shaw 2012:1).

## **2.6 Understanding diabetes and its complications**

It is important that a diabetic knows and understands what diabetes is and how to deal with it, treat it and manage it. Huang, Brown, Ewigman, Foley and Meltzer (2007:2478) warn that “diabetes significantly increases an individual’s risk of developing multiple microvascular and cardiovascular complications, and the risk of these complications can be significantly reduced with intensive and comprehensive diabetes care”. Proper understanding and management of diabetes can help diabetics to remain healthy. Understanding their illness encourages them to eat the right foods, use medication as instructed at the clinic by the nurses and the doctors, exercise and decrease the chance of their developing cardiovascular complications. All these mechanisms can assist and keep glucose at the recommended level. Pooley, Gerrard, Hollis, Morton and Astbury (2008:318) add that “because of the nature of the condition, considerable emphasis is placed on the ability of patients to manage their own condition. This requires effective

communication between health professionals and patients, and the creation of a setting in which patients feel empowered to manage the impact of diabetes on their lives”. The role of the diabetic educator is therefore very important, as it helps diabetics to change, understand and adapt to their new way of life. Anderson and Funnell (2008:110) elaborate: “Diabetes educators have interpersonal skills, personal values, and character traits that play an important role in their practice. They can feel and express compassion, empathy, and warmth. They can establish relationships with patients that are characterized by trust, respect, and acceptance. Such relationships create an environment of psychological safety and caring that nurtures patients”. Therefore having them as part of a diabetic’s life can be a life-changing experience for the diabetics.

People with diabetes need to be able to understand how the glucometer works. They need to understand how to read the glucose levels that appear after the test. As a diabetic having a glucometer can improve the manner in which the person takes care of themselves. Patients with glucometers have a better understanding of their glucose levels, as the glucometer is able to show them when their glucose levels have risen too high. They are able to act before they become hyperglycaemic.

## **2.7 Social networks within the community that assist black diabetic women manage their diabetes**

It is a common tendency for people across all cultures to find a way to manage, treat or cure whatever diseases they have, in a manner they best can. Family is the most important social network that a patient has. Family members are there as a social and personal support system for a person who has been diagnosed with a disease, especially a chronic one that will need a

management strategy. This is the case with a diabetic patient, as his or her condition can only be managed and not cured. Diabetic patients need family to help them manage their disease in many ways, the most important being medication compliance and change in lifestyle. “As a result of disease suffering, patients experience a restricted life (mainly due to deficiencies), some degree of social isolation and loss of independence, being forced to rely on others” (Florina and Babes-Bolyai 2011: 502). When patients are diagnosed for the first time with a chronic disease, some tend to be in denial and refuse to hear, accept and talk about the disease that they now have. Such diseases bring many disruptions into the life of the patient, who now has to give up their old life and adapt to a new life which at times forces many to give up their cultural practices and beliefs. In a study carried out by Florina and Babes-Bolyai in 2011, a patient diagnosed with cancer refused to be informed about her illness as she felt that knowing too much about it would make her situation even worse. “I do not want to know a lot about my illness, I just do not want to know. You know when you know too many things you put them together and they grow too much”. She insisted that her doctor tell her whether her procedure will go well or wrong. This is a trend that can be traced to diabetic patients too, as they are fearful when they are first diagnosed with diabetes, as this is a disease that comes with so many complications and forces one to change how they live and adapt to a new lifestyle causing many to abandon their cultures. This means that people have to change the food that they eat and comply with medication and exercise. The patient has to follow a lifestyle that is recommended to them by a clinician or a doctor if they want to properly manage their disease and live longer. “We can observe that during the healing process, doctors play the active while patients have a passive role” (Florina and Bolyai 2011: 509). Talcott Parsons, cited in Florina and Bolyai (2011: 509), talks about a functionalist model known as a “sick role”, which is a model that affirms that patients need to

give up their bodies and fully comply with medical examinations. Family is a very important part of a sick person's life. A study by Norwood in 2007 of a cancer patient who had been offered euthanasia as a solution to her problem because doctors were no longer able to help her, involved a whole process that required the family members to be with her and help her decide whether she was going to take this option. Norwood reached many conclusions, one of which affirms the statement, "for the dying patient, euthanasia talk can reaffirm his or her connection to self, family, and society" (Norwood 2007:165).

According to this model a patient is freed from his or her social obligations, for the moment that they are sick the duty of the patient is healing and following medical advice in order to achieve this goal. This is when the patient needs all the social networks that are available in their time of need; "the concept of the sick role becomes ineffective when it comes to relate to people suffering from chronic diseases. Failure of healing leads to an emphasis on how to manage symptoms and adapt to the new situation" Florina and Bolyai (2011: 509). The functionalist model theorized by Talcott Parsons highlights, also, that "when healing does not seem possible anymore, the doctor's role is practically annihilated, and control over the situation is taken over by the patient and often by his or her family". Social networks are an essential need during times of illness as they provide much-needed support for the patient. A person who is diagnosed with diabetes needs all the support that they can get from the family; they need to take medication, eat properly, and check their glucose levels and exercise. Many, if not all, of the management strategies for diabetes require the patient to change their whole lifestyle. Emotional support is needed at this particular point, because adjusting to this new life is not an easy thing.

Friends and family are the closest support system to the patient and have significant influence on the patient's life; they can force many of things onto the patient. Family members might not necessarily agree with the type of management style the doctor has recommended for the patient. They can suggest other types of management strategies that they believe will work much better. This can disrupt the patient's compliance to the medication which, in turn, may cause complications for the patient that can be fatal. A study that was carried out by Glick in New Guinea (1977: 69), cited in Pelto and Pelto (2008: 150), records that there is a strong link between health beliefs and social organization. "Gimi do not face illness alone or respond to illness as a phenomenon independent of the personal identity of the victim. An illness has meaning for a community, not just for an individual, and this is what is expressed each time a man or woman's kinsmen and friends gather to establish a diagnosis or to cooperate in a treatment procedure" (Pelto and Pelto 2008:150). Family structures are very important and play a very important role in the patient's life, as they are the immediate source of support and are more likely to have a lot of influence in the decision-making process of the patient of where and how to get treatment for the disease that they have. Dressler (2008: 462) cautions: "Cultural models of illness influence decisions about treatment, but those decisions are constrained by the availability of services, transportation, and wealth, all clearly structural factors".

Doctors and nurses form part of one of the most important network systems that patients have. It is through this network that patients get knowledge of how to better manage their illnesses. If there is a good doctor and patient relationship then the outcome will be good compliance with medication and other management strategies to keep the illness under control. Fugeli (2001), cited in Skerbekk, Middleton, Hjortdahl and Finest (2011: 1182) feel that "trust is an important quality of the doctor-patient relationship". For the relationship between doctors and patients to

be sustainable, doctors need not to look down on the beliefs of the patient. Nam *et al.* (2010: 4) adds that this above mentioned argument by adding that they concluded that “while clinician and educators would benefit from understanding individual perspectives about diabetes, understanding these perspectives within a larger socio-environmental context is also important because a statement regarding Hispanics’ cultural belief may not be applicable across all Hispanic subgroups”. Because of the different beliefs in causation and treatment, a woman at the support group felt that the nurses had lost their cultural values and beliefs because they would only put emphasis on Western medicine and none on traditional medicine or healers. To her it made no sense that a black person could think so highly of another race’s way of dealing with, managing and healing a disease when the black population also has had their own way. Levenstein and colleagues, cited in Saha, Beach and Cooper (2008: 1276), described the patient-centred clinical method as one in which the physician aims to gain an understanding of the patient as well as the disease, as opposed to an approach focusing strictly on the disease only.

People who sell medication such as boosters and other medicines that are supposed to help patients with all sorts of chronic diseases also form part of a network system for the patients. Medication brings hope to someone who is confronted by a disease. A person who is ill will take any advice given to them concerning a pill or medicine that has helped a person who was also ill at some point.

Thomas in 2008 proved that churches play a key role in influencing and understanding mortality and sexuality, factors that are clearly interrelated to perceptions of illness and death in the Caprivi region. “Strong religious beliefs endorse that illness is a self-inclined punishment for culturally unacceptable behavior, and HIV/AIDS is therefore interpreted within this framework

of understanding” Thomas (2008: 237). Patients with diabetes also have a way of fitting in religious beliefs to illnesses that they are faced with in their lives. The church serves as a place of hope for many people, who get support from church-members through prayer and explanation of the illness. People have different experiences with God. Some feel that illness is some sort of punishment from God, while others think it is just God’s plan and He will help them through their illness.

## **2.8 Conclusion**

Chapter Two was divided into six sub sections, each focusing on a particular objective that aims to show how each mechanism can be used by diabetic patients to manage their diabetes. Families and friends are an important feature in the life of a diabetic, as they serve as an immediate source of help for the patient. Healthcare providers are also very important in the life of a diabetic patient, as they empower patients with skills on how to best manage diabetes. Culture has significance on the beliefs, practices and choices that diabetic patients put in place to cope with and deal with their diabetes. Another emphasis of the chapter was on cultural meanings that are attached to diabetes and the choice in medication. In the following chapter a discussion of the findings and analysis will be provided.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

The present research was sought to reveal the types of coping mechanisms that black people have to manage their blood sugar levels properly. To answer this question, the researcher opted to use qualitative research, because they allow the researcher the opportunity to carry out the study in a natural setting. This will be the homes of the participants and the clinic. The researcher had the opportunity to observe and make sense of things that she could have not seen had another research method been used. Qualitative research also allows the participants the opportunity to provide data in their own words, giving the researcher the opportunity to observe the feelings, thoughts and attitudes of the participants. For this research to be a success, proper sampling had to be done and the sample had to be selected carefully in order to get reliable findings. Purposive sampling was used to select the participating women. A sample of 25 black females was used. Of the 25 women, 10 constituted the core group. The data collected during the research was later transcribed to make it easier to interpret. This chapter contains primary sources of data, as well as secondary sources. These are published articles and other relevant literature to support the interpretation of the data collected.

The chapter consists of six sections. The first describes the population of the study and how the sample was chosen; section two will describe the instruments that were used in the study for collecting the data; section three will deal with data analysis and how the data was handled and processed. Section four will discuss some of the ethical considerations that were put in place to protect the rights of the participants', section five will reveal the challenges that were faced during the research and chapter six will be the conclusion that will summarise the chapter.

Creswell (2003; 102) defines qualitative research as a way of exploring and understanding the meaning of individuals or groups ascribed to a social or human problem. Babbie, Mouton, Voster and Prozeskey (2006; 36) define qualitative research as that generic research approach used in social research, according to which research takes, as its departure point, the insider perspective on social action. Using qualitative research allowed me the opportunity to study the attitudes and behaviour of my participants. I also acquired a better understanding of the participants and how they live within their natural settings. Silverman (2011; 46) states that ‘the use of qualitative research has an added advantage for the researcher because the priority of the research is to use observation as their primary tool of research’. Qualitative methodology therefore gives priority to observations as its primary source. This is a good strategy for data collection as the researcher is able to see firsthand how the people he or she is researching live their lives; “the presence of the researchers in the field enables them to gain a better understanding of the conceptual meanings of their actions and behavior” (Silverman 2011: 46). This is an added benefit of using qualitative research, as the researcher has the opportunity to draw conclusions that he would have not been able to draw had another method been used. Qualitative researchers attempt always to study human action from the perspective of the social actors themselves, “also referred to by anthropologists as the emic perspective” (Babbie, Mouto, Voster and Prozeskey 2006). Qualitative research allows the subjects being studied to give much ‘richer’ answers to questions put to them by the researcher and enables research participants to provide valuable insights which might have been missed using any other method. Silverman (2011; 46) feels that a closer view of the routines and practices of the social actors facilitates the crafting of solutions to social problems. The qualitative research method was of great use, as many of observations were made.

Certain situations would have not been seen and interpreted had quantitative research methods been used.

Babbie *et al.* (2006; 16) explains that ‘the primary aim of qualitative research is in-depth (thick) descriptions and understanding of actions and events’. Babbie *et al.* (2006: 38) “Ethnography can be described as the data of cultural anthropology that is derived from the direct observation of behavior in a particular society” and “ethnography is the work of describing culture. The essential core of this activity aims to understand another way of life from the native point of view”. Ethnography is useful in the present study, in that it helped me understand the culture and way of life of the people that I was studying. This assisted me in understanding their behaviour and whether or not their cultural beliefs and way of living have an influence on their susceptibility to diabetes. Medical anthropology allowed me the opportunity to understand and respect people’s ways and beliefs when it came to managing their illness, because culture plays an important role in shaping people’s beliefs concerning illness and medication.

### **3.2 Population of the study and how the sample was chosen**

Sampling is a method that is used by researchers to select a certain section of a population, to attain information that is of interest to the researcher and will help to answer the objectives of the study. The section of the population that is chosen represents the whole population and that is why it is important that the researcher uses her own judgment selecting a specific sample. The sampling method is used by a researcher so that she can get a specific component to include in the research. Brink (2006, 124) defines sampling as a part of a fraction of a whole, or a subset of a larger set, selected by a researcher to participate in a research study. Sampling requires the researcher to select a specific group of the population at a very high degree of selectivity. Brink (2006) clarifies his definition by adding that a sample therefore consists of a selected group of

the elements or units of analysis from a defined population. For the intention of gaining rich findings the sample had to contain elements that the researcher felt would be able to meet the requirements for the research within the population. Purposive sampling was used in this study to ensure that a certain and specific component of the population was included in the sample and to make sure that the sample that was selected had all the requirements that were needed to answer the research question and produce valid results. “To get a good sample one has to ensure sample accuracy by making sure that every element in the population has an equal chance of being selected” (Bernard 2011; 111). The selection of the participants was strictly and entirely based on the judgment of the researcher; purposive sampling is flexible because it allows the researcher to choose participants that he or she feels will bring a large portion of significant information to the research. The requirements for the selection of participants entailed black diabetic women between the ages of forty and fifty. Tashakkori & Teddlie, 2003a, p. 713, cited in Teddlie and Yu (2007; 80), explain that purposive sampling techniques involve selecting certain units or cases, “based on a specific purpose rather than randomly”. With the help of Diabetes South Africa, the researcher was able to visit two clinics, which were in Umlazi N section and KwaDabeka clinic in Clermont. It was during the monthly visits that the researcher was able to observe people that were suitable to represent the rest of the population in the study. A selection procedure was carried out through thorough observation and selective judgement. Selective judgement of who to include in the study was done through a process of talking and listening to the women’s life stories and the different types of coping mechanisms that they use to manage their diabetes.

Purposive sampling is a type of non-probability sampling. It is this type of sampling that was used in the research to select the participating women. The research population for this study

consists of black diabetic women aged forty to fifty years. A sample of 25 black females was used these women were chosen because of their commitment to attendance for the Diabetes South Africa programme that runs in their clinic monthly. Of the 25 women, 10 will constitute the core group and they will also be the key informants, their selection was highly motivated by the fact that they did not have too many commitments during the week so the researcher could see them more often than the others. A study carried out by Baboolal in 2001 gives evidence that women are more susceptible to diabetes than man. Baboolal (2001) indicates that “research of Type II Diabetes mellitus indicates that women appear to be more susceptible to the disease”. She quotes Omar *et al.*, who carried out an epidemiological study in 1996 at a health care centre, where one thousand and ninety eight consecutive Indian Type II Diabetes mellitus patients were interviewed and women were found to be more susceptible.

The women that were selected in the present study are based in UMLazi N Section. They meet once a month, every month, at the clinic in UMLazi N section. Representatives from Diabetes South Africa attend monthly, to educate them on the best ways to manage the disease. The majority of these women come from poor families, where the only source of income for most is pension money, or earnings from informal jobs such as the selling of fruit in and around UMLazi. Going to UMLazi was compulsory for me because this is home to many of the participants. From the two clinics that I was introduced to by the Diabetes South Africa representatives I ended up choosing UMLazi N section over the KwaDabeka clinic because of the accessibility of the clinic and other factors such as transport and travelling distance.

There are a number of reasons why I chose UMLazi as my research site. I believed that this research area/site was suitable for my study because it had the suitable target group for my study.

Secondly, Umlazi is not far from where I stay; to get there I had to take two taxis, one from the university to town and one from town to Umlazi. The fact that Umlazi is not far from the University allowed me the advantage of spending more time with the participants. This was an added advantage, as there was no need to rush off because of travelling and safety considerations. Another advantage of the research site being in Umlazi was the fact that travelling was not going to be expensive as each trip cost 34 rands as compared to going to KwaDabeka.

### **3.3 Instruments used in the study**

Green and Thorogood (2004; 80) define interviews as ‘the most widely used method of producing data in qualitative research; it is directed, more or less, towards the researcher’s particular needs for data’. DeMarrais 2004, cited in Merriam 2009, define interviews as “a process in which a researcher and a participant engage in a conversation focused on questions related to a research study”. An interview guide was used as the main source of data collection throughout this research. Interviews are important in that they allow the researcher to ask certain questions that will allow the participants to give answers which provided relevant information and feedback to answer the research question. Merriam (2009, 89) states that “the main purpose of an interview is to obtain a special kind of information”. All of the research participants were asked the same questions. During the interview there was a need for two copies of the questions, one in Zulu and the other in English as most of the participants preferred using Zulu and not English. Using the interview guide assisted me, because it geared my research in one direction, I did not go off the topic and ask irrelevant questions. Even if the participant went off the topic the interview was used as a guide to bring the participant back to answering the questions that

pertained to the research. “Interviewing is important and necessary when we cannot observe behavior, feelings, or how people interpret the world around them, it is also necessary to interview when we are interested in past events that are impossible to replicate” (Merriam 2009, 88). Using interviews allowed me the opportunity to interact at a more personal level with the participants. It is through this process that a researcher can get a mass of relevant information that will produce rich findings for the research.

Semi-structured interviews were used to collect a large amount of information and to address the objectives of the study. Semi-structured interviews are flexible and allow for new questions to be brought up during the interview. They also allow a more focused, conversational, two-way communication that can be used to both receive and transmit information. “In a semi-structured interview the researcher sets the agenda in terms of the topics covered, but the interviewees responses determine the kinds of information produced about those topics and the relative importance of each of them” (Green and Thorogood 80). Semi-structured interviews provide one with the opportunity to learn and it allows the informants the freedom to express their views in their own terms. In this study, semi-structured interviews were used with the larger group of 25 women. Semi-structured interviews proved to generate the bulk of relevant information during the interviews. They gave the participants the opportunity to open up and tell me about their life stories and journey with diabetes. Babbie *et al.* (2006) states that in a “semi-structured interview the interviewer is prepared to be flexible in terms of the order in which the topics are considered, and, perhaps more significantly, to let the interviewee develop ideas and speak more widely on the issues raised by the researcher”. The emphasis of this type of interview is on the interviewee’s points of interest, where they get the opportunity to elaborate when they feel they have more to share. Interviews were scheduled for a time frame that was suitable for the

participants, as many of them had commitments that they needed to attend to; some of the participants had commitments such as work and family visits during the day, so another, alternative, time had to be taken, to respect the participants. As the researcher there was a great need to respect and understand the conditions and different situations of the participants. Interviews took place in the homes of the women or at the clinic, after the support group sessions. For ethical reasons interviews had to be held in a place where the participants would feel free and comfortable. This is why the homes of the women and the clinic were chosen. In the homes the interviews were held in the kitchen and would take roughly 50 to 60 minutes. Following the ethics and protocols of the research the researcher could not go to the workplace of the participants, as this would distract them or make them feel uncomfortable.

In-depth interviews were also used in this study; they are one of the most common qualitative methods of data collection, Boyce and Neale (2006; 3) state that “in-depth interviews involve conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea or situation”. This means that the researcher is able to interact at a personal level with the participants. This is an added advantage because the researcher will be able to talk directly with the participants and have the opportunity to probe and ask questions that otherwise he or she could not have done if another technique had been used. One reason for their popularity is that they are very effective in giving a human face to research problems. In addition, conducting and participating in interviews can be a rewarding experience for participants and interviewers alike. Such interviews are an effective qualitative method for getting people to talk about their personal feelings and opinions. In-depth interviews are conducted face-to-face and involve one interviewer and one participant. In the present study, in-

depth interviews were conducted with the 10 core informants. I chose to use in-depth interviews as well, so that I could have a more personal experience, with one individual at a time.

The two interviewing techniques allowed me as the researcher the opportunity to focus on the perspectives and experiences of the participants. These techniques gave the participants the opportunity to express themselves freely while sharing their feelings, thoughts and ideas. Each participant's permission to record the interviews and take pictures and videos was asked before the interviews took place. The digital information that was gathered in the interviews was saved on a flash disc. I also kept a diary of my own written notes. These records were kept where no one else besides me had access to. I would have preferred to use English as the medium of communication in the interviews and sessions, but some of the participants were happier and more comfortable with their home languages, namely Zulu and Xhosa, It was still possible for me to continue the discussions in one of those languages, as I am fluent in English, Xhosa and Zulu. It was thus not a problem to continue with the research in Zulu or Xhosa, as some of the participant were not fluent in English.

Choosing to use a tape recorder and diary for collecting data proved to be a great advantage, for because both these tools allowed me to obtain a mass of very important and valuable information. The tape recorder was helpful in that I was able to obtain and store reliable data without forgetting things or losing pieces of paper. Tape recording and not writing made things easier and more convenient for me, as I was able to communicate with participants without having to stop them while they were answering and ask them to repeat because I had forgotten what they had just said. This proved an advantage on my part because my participants' attention was not diverted to anything else besides what we were talking about.

### **3.4 Data analysis**

“Data analysis is the process of making sense out of data, making sense out of data involves consolidating, reducing, and interpreting what people have said and what the researcher has seen and read, it is the process of making meaning” Merriam (2009, 176). Data analysis is a very complicated process, which demands the researcher to go over his or her findings repetitively, to make meaning out of the data that has been collected. It is for this reason that Merriam (2009, 176) defines data analysis as the process used to answer your research question. The bulk of the information that was collected during this research was recorded on a tape recorder and some notes were taken for the comfort of those participants who did not want me to record the interviews. I made sure I transcribed each interview the day it was done, to avoid work piling up. All the interviews were transcribed, analysed and grouped according to the four stages of the grounded theory. The written notes were later typed, saved on a disc and kept in a safe place, so that no other person could have access to them. I had to make sure that I read through the findings time and time again, so that I could see if there were any similarities or differences in the experiences that the women had, and are having, with managing their diabetes. Grouping the findings into themes is an advantage when doing research in that the researcher gets the opportunity to see and take out information that is not relevant to his or research and can see all the similarities and differences that come out from the findings.

The data was analysed using the four stages of grounded theory, namely codes, concepts, categories and theory. Codes assisted me in identifying anchors that allowed for the key points of the data to be gathered. Concepts allowed me the opportunity to collect codes of similar content that allowed me to group the data. Categories gave me the opportunity to sort broad groups of

similar concepts that are used to generate a theory. Theories are a collection of explanations that explain the subject of the research. Using the four stages of the grounded theory helped me to analyse the data, because I was able to see the findings of the research from all perspectives. I was able to see all the similarities and differences of how the different women cope with managing their diabetes. Using the four stages of the grounded theory system allowed me the opportunity to see the least important information from the findings of the research. I was able to separate and organize the findings in a presentable manner.

### **3.5 Ethical considerations**

When one is conducting research one has to make sure that the interest of the participants are safe-guarded at all times because researchers go into their personal lives seeking information from them. Stake (2005, 459), cited in Merriam (2009, 231), cautions that “qualitative researchers are guests in the private spaces in the world. Their manners should be good and their code of ethics strict”. Therefore ethical measures were put in place for the purpose of this research and for protecting the participants. “All research is concerned with producing valid and reliable knowledge in an ethical manner” (Merriam 2009, 209). Patton 2002, 552 and Merriam 2009, 22 add that ‘To a large extent, the validity reliability of a study depends upon the ethics of the investigator’. The women’s participation in this research was voluntary and I requested that they give their informed consent to participate. All the participants signed a consent form which stated that their participation was voluntary and that they could withdraw at any point if they felt that they did not want to participate, for any reason. “Consent implies that the participant is capable of making a rational judgment about whether to participate, and that their agreement should be voluntary” (Green and Thorogood 2004; 58). When approaching the participants it was

clearly emphasised that they had a right, and that they consent, to participate in the study. The consent form clearly stated that the participants are free choose whether to participate in the study or not. Informed consent is the principle that individuals should not be coerced, or persuaded, or induced, into research against their free will, but that their participation should be based on voluntarism, and on a full understanding of the implications of participation (Green and Thorogood 2004, 57). Ethical measures were put in place for the purpose of the research and of protecting the participants. All the interviews were held in a private and confidential place and the participants were made aware of the fact that they were to be interviewed, before the interviews began.

Throughout my research I had to ensure that I respected and protected the participants' human rights, such as their right to privacy, anonymity and confidentiality. Brink (2006, 32) warns that "The researcher needs to secure the well-being of the subject, who has the right to protection from discomfort and harm, be it physical, emotional, spiritual, economical, social or legal". During the research there was a participant who was self-employed. She sold fruit and vegetables at the rank. She did not want me to come to her workplace, because it was uncomfortable for her. I had to respect her decision and only contact and talk to her when she was free and not working. Later she told me that the women that she works with are very meddlesome and she did not want them to know that she was diabetic or my reason for coming to see her. Researchers should make it their main priority to respect the privacy of the participant. If the participants share something with you and ask you not to share or publish it, than the researcher has the responsibility of making sure that the rights and wishes of the participants are respected. Brink (2006, 33) states that "The subject has the right to determine the extent to which, and the general circumstances under which, his/her private information will be shared with or withheld from others". Once data

collection was completed, securing the participants was the main concern. None of the participants' real names were used. All the recorded tapes were destroyed. No information was shared with anyone who was not closely related to the research. Everything that the participants asked not to be shared with other people was not written in the findings chapter.

For this research I made sure that all the women that participated in the research did so voluntarily. I explained to them from the very beginning where I was studying and what the research was about. I made sure that the participants understood what the research question was and what their role would be in the research, so that they would give consent while well aware of what they are getting themselves into. The subjects were aware that they had the right to participate and the right not to.

I had to go to great lengths to ensure that I protected my participants. To achieve this I had to make sure that all of the data I had collected was stored in a secure place, which only I could access. I did not, at any point, share any private information with other people who were not involved in the research without the knowledge of the participant also I had to make sure that I did not reveal the subjects' names. I had to follow proper channels in order to get interview sessions with my participants. I did not go to the homes of the participants without scheduling a meeting with them. I had to respect their privacy all the times. I reminded the participants who I was and what I was studying, to make the interview formal and to put them at ease. Before I started an interview I would make the participant aware that we were starting. I would ask for their permission and make them aware that I wanted to record the interview. I was always early for interviews with the participants because it would be wrong for me to keep them waiting when I was the one who needed their help. Brink (2006, 34) cautions that researchers should avoid

‘covert data collection’, which is the process of asking very personal questions that are difficult to answer and make participants uncomfortable. The researcher made sure that there was no physical or psychological harm done to the participants throughout the research.

### **3.6 Challenges faced during the research**

To help make this research a success I decided to approach medical practitioners in the Durban Central Business District. The first doctor that I approached refused point blank to help me with any information regarding his patients. He explained to me that as doctors they have to maintain a confidentiality policy. He referred me to another doctor in the same building, but explained to me that chances were I would get the same response from him. He was correct, as the second doctor also refused to assist me. I decided to go to King Edward Hospital, where I refused entrance by the security guard and nurses. The security guard told me that if I was not coming in for medically related issues I would have to have a letter from the university explaining the reasons for my visits. I was later able to talk to a nurse, who explained to me that I would need permission from the hospital’s Human Resources Manager. I was given a number for this manager and I called, but that attempt was also in vain, because I was unable to get hold of the manager over the phone.

After many failed attempts I used to Google to obtain Diabetes South Africa’s contact details and try find out where they were based in Durban, as they were my last resort. I was fortunate enough to get their number; I called them and was attended to by Jenny, who offered me her time and explained to me where they are based and where to get the information that I needed. She emailed me documents that she had on diabetes. I managed to obtain much of information on who to contact for my study. I volunteered to help them with their weekly clinic visits, which

turned out to be a blessing in disguise, because I got the opportunity of finding the sample that I needed and was able to select participants' and create rapport. At the clinic I assisted Jenny with translation when she was explaining important issues to the diabetic patients, when Nursing sister Gertie was not available to accompany Jenny on the clinic visits. In most cases, however Sister Gertie was always available to accompany Jenny to the clinic support groups. Sister Gertie and Jenny are both volunteers at Diabetes South Africa.

Diabetes South Africa visited clinics in Durban; they targeted mostly poor communities, where people cannot afford to get the best medical treatment. Diabetes South Africa donated and donates glucometers to people who attend their programme and support groups; during this time people also get the opportunity to ask questions to the Diabetes South Africa representative. The support groups involve discussion about diabetes. Jenny educates the ladies on the best ways they can follow to manage and maintain their sugar levels and how to stay healthy. Jenny showed the women different ways of exercising, without necessarily having to jog or do strenuous exercises that require a lot of energy and strength. She also took this time to show the women how to use the glucometers and when to use them. She explained to the women the types of foods that they should be eating, such as vegetables and fruit, how much they should be eating and how they should prepare what they eat. She also cautioned them on eating large quantities of foods such as bread, starch (be it pasta, rice or maize meal and potatoes), because they are dangerous for their condition. She also emphasized that these women should exercise. Most of the women who attend these monthly meetings were not fluent in English and I would be asked to translate from English to Zulu. If the women wanted to ask something they would ask me to translate their questions to English.

It was only after the meetings that I had the opportunity of talking to the women personally about issues related to my study. The women did not have a problem talking to me after the meetings, because I was someone that they had become used to. When I first attended these clinic visits I had to introduce myself and explain to them my reason for coming and what I wanted from them. They did not have a problem because I came with someone that they had known and trusted for a long time. I was able to attend two clinics while helping out Diabetes South Africa, which are the KwaDabeka clinic and the Umlazi clinic. I never had a problem of talking to the patients while visiting with the Diabetes South Africa representatives. After some time I had to go back on my own and encountered problems with the nurses in gaining permission to talk to the patients. I called sister Gertie to explain to her that I needed to go back to the clinic but I was being denied access. She gave me the number of the nurse who deals with chronic illnesses. I asked her what channels I had to follow to gain access to the clinic and she gave me the HR manager's number. I tried the number many times, but could not reach the HR manager on the phone. The nurses at the KwaDabeka clinic refused to grant me access until the HR manager gave me permission. I had to stick to the Umlazi clinic, but also had to wait until the Diabetes South Africa team went for their monthly support group meetings, to gain access. At other times interviews would take place at the homes of the women.

When I first started going to Umlazi N section, transport was not an issue, because I travelled with the representative from Diabetes South Africa. Jenny had her own transport and would pick me up and drop me off at the university when we were finished. There came a time when I had to go to Umlazi very often for my data collection and transport proved to be a problem in the afternoon. The afternoon is a busy time, as there are people coming back from town, school and work. There would always be a very long queue and the taxis took a long time to fetch people

and take them home because of the huge numbers. This was a problem for me because UMLazi is not a safe area, especially for someone who is not from there, because the locals can identify people that are not from the area. Not only was it dangerous to be in UMLazi late in the afternoon, I still had to catch another taxi from town to the university and walking alone in the dark is not very safe.

Not all of the participants were available when I wanted to talk to them. They agreed to be interviewed and gave up their commitments and time only when they had to go and get their treatment from the clinic, which is combined with the monthly support group visit by Diabetes South Africa. There were some participants that were not formally employed but were self employed. Some of the participants would cancel a scheduled meeting at the last minute. I would make appointments with others and go to UMLazi only to find that they were not at home they have gone to town or were visiting relatives. This was a great challenge for me and I could not find a way to remedy it, because these people were giving up their time to talk to me and if they felt that they did not want to have an interview session or had last-minute commitments I would have to understand, because they were volunteering. As a researcher I could not force people to participate in my study. I had to learn to be patient and wait for them. Majority of the participants were unavailable during the weekends, attending funerals, weddings, visiting their siblings or going to church functions. I initially thought that since some of them were busy during the week we could make time during the weekend. The women warned me that during the weekend I should not make a habit of going to UMLazi alone, because there were many people that wandered the streets drunk. These people were known to snatch bags and stab people for their cellphones, so that they could sell them and get money to buy drugs and alcohol.

I had to respect my participants' working hours, sometimes I had to wait until their duty was over or they had decided that it was time for them to go home, because a majority of them were self employed. Some of them sold fruit and vegetables in Umlazi. According to the ethics that this research is based on I agreed to only interview or talk to a participant when they were free and available to talk. Going to their workplace would be undermining confidentiality in case they did not want people to know that they were part of my study. I also feared that my presence would make them uncomfortable and they would not be able to attend to their customers because they were busy paying attention to me and my study.

After spending some time with the participants a relationship was created and the participant would divert from the questions that I was asking them and go on to talk about something else. This became time-consuming and I would return without much information. This was a challenge for me because of the limited of resources available to me, such as money and time. Some of the participants would tell me about problems that they were facing, especially money problems. This would be awkward for me because I would not know whether it was their way of borrowing money from me or just their way of making conversation with me.

All the information that was gathered throughout my visits was transcribed onto the computer. This proved to be a very long and arduous process for me. At each interview I had to explain to them that I was a post-graduate student at the University of KwaZulu-Natal, doing a study on the coping mechanisms of diabetic black women. This was to help them calm down, because these days it is not easy to trust a stranger and let them into your house. Interviews were conducted in the homes of these women; the kitchen was the most common sitting area for most of the homes that I visited.

### **3.7 Conclusion**

In this chapter a very detailed description was presented of qualitative research and how it allowed the researcher to effectively collect data. The chapter showed the different qualitative research tools were used to collect the bulk of information for the research. This chapter also highlights the purposive sampling procedure that was used to select a sample and the types of interviews that were used to collect data. In the following chapter a discussion of the research results and identified themes emerging from the data are presented.

## CHAPTER FOUR

### RESULTS

#### 4.1 Introduction

Chapter four begins by discussing some of the cultural meanings and beliefs that black women have concerning diabetes. The different coping mechanisms that black diabetic women use to control and manage their blood sugar levels will be examined. The chapter also deals with the role that networks play in assisting the participants of this study in coping with diabetes. The chapter will examine the relationship that black diabetic women have with their doctors and nurses and the relevance of information that these women get at the clinic on how to best manage diabetes. Pseudonyms will be used to protect the identity of the participants.

The sample for this study consisted of 25 black diabetic females, between the ages of 40 and 50 years. Of the 25 females, 10 constituted the core group. The 10 core participants were the key informants, they were chosen to be the key informants because they had less commitments during the week as compared to the rest of the participant. These women were chosen because of their commitment and attendance at the Diabetes South Africa support groups that are run at the clinic. In this study demographics showed that some of the participants were married, others were widowed, they all had dependents and all were not formally employed. Most were self-employed and others depend on pension money. Their minimum monthly income was between R500 and R1700.

#### 4.2 Cultural meanings and beliefs given to diabetes

There were two culture-bound illnesses that most frequently came up during the interviews that were believed by these women to be making them sick. These illnesses were *umeqo*, which takes place when a person walks over *muthi* (traditional medicine) that has deliberately been put there

by someone with the intention of making that person sick. The second culture-bound illness was *idliso*, which is when someone is poisoned by another person through the use of traditional *muthi*. *Idliso* can be done through sending bewitching creatures in someone's dream to feed that person *muthi* in the dream. It can also be done physically at gatherings, or even at home where the *muthi* will be poured onto the food of the person being targeted. Lupton (2012) states that the culture that an individual operates in influences the beliefs that that individual will hold and attach to illnesses that appear.

**Beatrice**, a 45-year-old African female, is a hard worker. She is poor, uneducated and unemployed and supports her family by selling fruit and vegetables. She is the mother of six children and depends on grant money allocated for her last-born child. She collects R280 for this child. She was diagnosed with diabetes in 1998. She was comfortable, kept appropriate body language and was well-spoken during the interviews.

When Beatrice's illness began she thought she had a culture-bound illness known to some black communities as *idliso* (poisoning). She had this belief because of the community, culture and beliefs that she was born into. The culture that one is born into has great influence on how an individual sees and perceives the world. It also affects the manner in which people distinguish, name and treat illnesses. Beatrice's belief about her illness was, in part, greatly shaped by her culture and how she has been taught, or has learned, to define and treat illnesses. When people have attached beliefs and cultural meaning to a disease they already know which type of treatment will be suitable for that particular disease and from where they can get help. Beatrice had diagnosed her condition and found that the illness that was troubling her was *idliso*; her urgent need for healing and belief directed her to a traditional healer within the community. The

traditional healer is appreciated more than doctors in some communities because healers are able to give perspective to patients seeking help and answers. The healer diagnoses the illness; identifies the person who has poisoned the affected person and gives the reason for the poisoning.

“Well... ummh... When my illnesses started I started losing a lot of weight, I was thirsty all the time and needed to urinate a lot. Regardless of the large quantities of water that I drank my mouth remained dry. One morning I woke up very angry because this problem would not go away, I visited Bab’ Nkosi, our local nyanga. The nyanga told me that the ancestors showed him a woman pouring something into a plate of food that was given to me at a family gathering. Idliso is what had been troubling me my child” (Beatrice).

**Angela**, is a 43-year-old, single, unemployed mother of five children who supports her family by selling ice lollies, sausages and by doing people’s washing. She said that she believed that at first she was suffering from something else, other than diabetes. Her early symptoms were weight loss and blurry vision. Her opening statement was that she knew she was sick and had to get help. Her eldest brother suggested that they see a traditional healer who would see what was going on with her and give her proper medication.

“When I first got sick my family consulted a traditional healer to come to the house and examine me because they suspected that *izinto zangamabomu* [meaning that they suspected that she was bewitched]. I also believed that I was bewitched, these things happen you know. People are never pleased when something good happens in your life she added, my oldest daughter is

getting married soon and that my child will make other people jealous because in this day and age only a select few children are blessed with marriage” (Angela)

Culture was deeply embedded in the belief systems of some of the participants; a visit to Beatrice’s home (as some of the interviews took place at her house) reinforced this. We used to sit in the kitchen. Everything was squashed together because the house was small and there were many of people that stayed in it. The house had a foul smell of paraffin. Just next to the chair that I was offered to sit in were two very old-looking paraffin flame stoves. On top of the one stove was an enamel cup which was clearly used to put out the stove. There were huge cow horns in the kitchen just above the cupboard; Beatrice explained that it is part of her culture to put horns or skin of a slaughtered animal as an offering to the ancestors. Just next to the horns was a cow’s ornament, which was also believed to be an offering to the ancestors. On top of the table was Beatrice’s medication, pills from the clinic and traditional medicine that was in a two litre container known “isipakupaku”. Beatrice explained that this traditional medicine is famous amongst diabetics in her community. It had a very bitter taste, from what she explained. The bitterness of the medicine supposedly shocks the sugar in the blood of a diabetic so that the sugar remains low and never rises. The diabetic person therefore never has to worry about her sugar levels rising. The belief was that if you used this medicine for a long time it may cure the diabetes. Beatrice has great confidence in this medicine and admitted that she will not stop using it because there is a possibility of it curing the diabetes.

Looking at this two litre container, shaking it and watching as it slowly formed a white foam, she says “Why should I stop using it if it may cure

this disease, the nurses have never said that their pills can cure my diabetes... but the nyanga assured me that if I carry on to use this muthi I will be cured from this horrible disease"... "Oh but it's very bitter" she added, as her facial expression also changed (Beatrice).

"It's not a lot you know, its half a cup twice a day. In the morning and in the afternoon" (Beatrice).

**Lindiwe** is a 48-year-old married, black, diabetic female with four children. She was diagnosed with diabetes in 2004 and freely volunteered to participate in the study. Lindiwe shared the same sentiments with Beatrice about traditional medicine.

"I heard about this medicine from a friend that I got to know through the clinic, she said it helps with the sugar, at the time I was having trouble controlling my sugar so I tried it"... "It is very bitter; I have to force myself to drink it every time. I have to eat something immediately after drinking it, just to take away the bitter taste... You see, my child, I am scared of bitter tastes, I only drink this medicine because it is helping me with my diabetes" (Lindiwe).

These women had a high degree of trust in this medicine; the belief that it may heal the diabetes is a major contributing factor to the continuation of its use. Beatrice did not mention Western medication very often; she only mentioned it when she was expressing her dissatisfaction in it because it is not able to heal diabetes, but only helps to manage the diabetes. Other participants such as Thandeka, had very different and opposing views and attitudes towards the choice and use of medication for a diabetic person.

**Thandeka**, a 47-year-old married, black, diabetic woman, has three children; she is self-employed and also gets grant money for her two young children. Thandeka does not believe in traditional medicines to cure her diabetes.

“I have never even tried it, others encourage us to use traditional medicine... they say it helps... besides not liking it I do not have the money to buy the *muthi* with”... “The medication that I have been getting from the clinic has been helping me a lot” (Thandeka).

Family members and friends had great influence on the decisions and choices that were taken by the participants. Older people in the families, such as grandmothers and mothers, had more influence than the other members. This could be because of the belief that older people have wisdom, have lived longer and therefore have more experience. What they say carries much meaning.

**Juliet** is a 45-year-old black, diabetic, female who has four children; she was diagnosed with diabetes just before she fell pregnant with her last-born child in 1995. A few weeks before she discovered she was pregnant she developed symptoms that she did not understand. She said that she felt tired all the time and could not understand why. She confided that she started developing skin problems and had blurry vision. When it was found out about the pregnancy her grandmother was sure that she was being bewitched by someone because of the pregnancy. The culprit had already been known to be a cousin who was unable to bear children. Gogo (grandmother) believed that it was *umeqo* and suggested that Juliet see a nyanga, who would give her *muthi* that will take the illness away and give her another medicine to protect both the baby and her.

“Before my older brother forced me to go to the clinic my grandmother had the belief that I was bewitched by my cousin, who was unable to bear children, she was jealous about the pregnancy... I believed it... why I was not getting sick all this time until the pregnancy” (Juliet).

“The nyanga gave me a small woollen rope that I had to wear on my waist; he said the woollen rope would protect us... I did not seem to get better and my brother took me to the clinic to be examined... he did not believe much in ukuthakatha (sorcery)”... “The nurses said I have the sugar disease, but why had it started just before my pregnancy”? (Juliet)

It was evident that Juliet had developed an attitude towards the cousin, who was believed to have been bewitching her. She believed strongly in sorcery; even after going to the clinic and finding out that she had diabetes her beliefs were still focused on the cousin who was jealous about the pregnancy. Gogo had significant influence on Juliet and her beliefs about her illness. For as much as Juliet had been using medicines given to her at the clinic, at times she confessed that she stopped taking the medicines from the clinic and used “imbiza”, which is a traditional concoction that is believed to keep the diabetes under shock because of the bitter taste.

“Muthi is never supposed to have a nice taste... the bitter it is the more it works in healing me”... “I use the medication from the clinic but not all the time, I focus on the imbiza because I feel a difference when I use it. Mhh mhh (clearing her throat)... I use the pills if I feel that the sugar in the blood is too high, I use them because using two medicines is better than using one” (Juliet).

**Brook**, a 50-year-old married, black, diabetic woman with three children and unemployed, was diagnosed with diabetes in 2010. She revealed that she was having problems managing her diabetes; she was obese and admitted to poor compliance to medication and a healthy lifestyle. Brook's experience had shifted her mind-set, from blaming people and creating her own causations about the disease, to focusing on learning how to properly manage her diabetes. Brook admitted that she used to use both traditional and Western medicines. She stopped using traditional medicines because they would increase her sugar levels.

“Ah, I have learned to stick to medicines given at the clinic by the nurses because when I combine medication given at the clinic with other medicines I find that my sugar levels go up... the nurses knew when I had used the another medicine”... (Brook).

#### **4.3 Diabetes coping mechanisms**

To properly manage diabetes one needs to have appropriate coping mechanisms. Like any other chronic disease, diabetes forces a change in lifestyle and the adoption of a healthier lifestyle. This change can create inner conflicts within the afflicted individual, as a healthier lifestyle may include abandonment of cultural practices and beliefs. Adapting to new a new way of life may be a serious adjustment that is difficult to get used to. Family members, friends, church members and community members form part of a network system that plays a very important role in controlling and managing diabetes. These networks give both emotional and physical support to afflicted individuals.

#### **4.3.1. Healthy eating behaviour**

An interview session that took place at Sarah's house revealed that the amount of starch consumption in her house was more than the recommended level. Her 13-year-old daughter had just come back from school; she put her bag down and asked Sarah what she was going to eat. Sarah had not cooked, so she answered "there is bread in the bread bin". Her daughter went to another room and came back with a handful of potatoes. She started peeling them, "I'm making fried chips, must I make enough for the two of you"? Hesitantly Sarah replied, "you know I cannot eat that, just give me a small portion". With a chuckle she said "I am not allowed to eat such foods you know, they are bad for the sugar and the body". When her daughter brought the food to us the bread was half soaked with oil from the chips, I observed how Sarah indulged; she did not mind the oil and she ate everything and asked for another slice of bread that she was going to use to clean up the left-over oil. Another one of her children came back from school and asked if anyone had eaten his food from yesterday's supper. "It's in the fridge" Sarah answered. The boy took the food out to warm it, a large enamel plate filled with a mountain of phuthu (coarse pap) and potato curry. These foods were both rich in starch and were being consumed in large portions.

**Sarah**, a 47-year-old, widowed, black, diabetic female mother of seven children, diagnosed with diabetes in 2007, was keen to participate in the study. She was obese and admitted to having problems complying with the new diet.

"I don't get used to the taste of food without cooking oil, I don't enjoy when I eat" (Sarah).

Sarah finds it difficult to comply with the new recommended diet. Her diet change entailed decreasing her starch portions and boiling food instead of frying. She has to avoid salty foods. She has to avoid take-away foods, as they are rich in fat, hidden sugars and salts.

“They said I must stop eating everything... everything that they said I must stop eating were foods that I liked... It’s hard to be me”... after some silence she continued to add “what must I eat”? (Sarah)

Sarah ran a little tuck-shop. She admitted eating some of the chips and vetkoeks while preparing them. She was sweaty and looked uncomfortable in the position that she was sitting in. She kept on fanning herself with a piece of paper that she took out of an old magazine that was on top of the table.

“I steal a lot, I cheat... I know I’m not supposed to eat these things but I can’t control myself, knowing that I cannot eat them attracts me more to them” (Sarah).

“I keep saying to myself I have to stop this, I have to stop it... in my mind I tell myself I will start tomorrow, everyday is always tomorrow... I know it’s killing me but I feel I don’t have control over it” (Sarah).

“The nurse says my body weight must not be this much, they say I have lose some of it” (Sarah)

**Pretty**, a 47-year-old diabetic, single mother of three, diagnosed with diabetes in 2008, gladly volunteered to participate in the study. Her opening statement was that she was finding it hard to cope with diabetes and the new diet change:

Ah, before I got this sickness my life was such a breeze. I did not have to worry about what I ate, when I ate it or how much I ate... Looking at her hands and playing with her ring she continues... Maybe, maybe that is what got me into this problem [referring to diabetes]. Everything has changed now. I feel like I am living another person's life... adapting to so many changes is really difficult you know, the nurses do not understand just how difficult it is. If they knew maybe they would not shout so much at times (Pretty).

Patients are given charts that show them the types of foods that they should eat and the portions that they should eat. They are also taught how they should prepare these foods. Giving patients charts and educating them is important, but will not help if the patients do not have the means of obtaining the diet recommended at the clinic.

**Angel**, a 49-year-old mother of three children, was diagnosed with diabetes in 2001. Angel was unemployed and depended on grant money allocated to her two young children; she had no other form of income. She collected R560 from the grant and had to support eight people with this money. Angel admitted that she would like to change her diet, but cannot because of financial constraints.

“I want to change what I eat but my money situation does not allow me to”

(Angel).

Angel lived with eight other people in a two-room house. This house consisted of a kitchen and bedroom; the house was crowded. Half the groceries were on top of a crammed table; on the table was a bucket of water and a dish used to wash the dishes. Underneath the table was a bag of

50kg maize meal and 10kg of rice. Next to that was a 10kg sack of potatoes. All these products had starches that were not recommended for Angel.

“I eat what is available so that I can swallow the pills from the clinic, I do not have money to buy separate groceries... the groceries sometimes do not last a whole month, when it is close to month end the only thing left is impuphu, we make pap and eat that with tea or coffee”... “I know it is not good for the sugar but what can I do”? (Angel)

**Amanda**, a 46-year-old diabetic, black women, mother of seven children, diagnosed with diabetes in 2010, was very keen in to take part in the study. She confessed that she feared dying and leaving her children behind. Amanda was unemployed; she sold sausages, fruit and vegetables. She said that she did not make enough money to support her whole family; sometimes she did not even have money to buy her stock and had to borrow the money from neighbours. Complying with a healthy eating plan was very difficult for Amanda; she did not have enough money to buy most of the food recommended at the clinic.

“I cannot afford the type of oil that they want us to eat, the brown foods are too expensive for me... if I buy these foods, how will I buy for the rest of the family”... “I want to control my sugar but am failing because I am poor” (Amanda).

“The nurse sometimes does not understand; sometimes she shout because the sugar in the blood is too much; she ask if I do everything that they teach me at the clinic” (Amanda).

“If I stop eating this bad food what will I eat? It is best I eat the bad food and swallow pills than to not eat and not swallow the pills” (Amanda).

Amanda was fortunate to receive a glucometer from Diabetes South Africa; unfortunately she does not use it all that often. When she runs out of needles it takes time for her to make enough money to buy more. She says that it depresses her to check her blood sugar levels because, since she is not following the correct diet, she feels that her sugar levels are always a little bit higher than they should be.

“The machine raises my stress; the sugar is always high when I check”  
(Amanda).

**Anita** shares these sentiments with Amanda. Anita is a 48-year-old married, diabetic, black female, is unemployed and has five children. Her sister had recently died and she had to take care of her sister’s four children as well. All these children, including hers, were in secondary and high school. Her husband was also not working, but got piece jobs now and again. She confided that she consumed a lot of the bad starch and was worried because she had been admitted to hospital once because her sugar levels had risen too high.

“That day I had had amasi (sour milk and phuthu) for supper, I started feeling sick after an hour or so after eating, my situation got worse and I was rushed to the hospital... the nurses at the hospital shouted and said my sugar is too high”... “They started asking what I had been eating, I told them I ate amasi, they said my sugar was 20 mmol/L” (Anita).

“They gave me 12 glasses of water to drink, after that the sugar had dropped to 12mmol/L” (Anita).

“Diet is very important for a diabetic it is the difference between life and death for some... not having the correct food scares me a lot because it means my sugar is not controlled properly, I can fall and die anytime” (Anita).

**Ntombi**, a 50-year-old diabetic, single mother of four, self-employed, was diagnosed with diabetes in 2006. Ntombi said that she did not have all the money in the world, but she did everything to try and balance her diet. Ntombi had a garden behind her house where she planted vegetables and fruit. She said she looked after her garden. When I went to her house for our interview session I found her working in the garden. She asked me to help her fetch water from a nearby tap, so that we could have time to talk while walking. Her garden looked beautiful. There was a lot of spinach and carrots and a huge pumpkin that she was thinking of cooking that night for supper.

“I boil all of the food that I eat; I eat a lot of vegetables... it took some time to get used to the new taste of boiled food but after some time of forcing myself I finally managed to do it” (Ntombi).

“I have cut down on the amount of bad starch and I noticed that I started losing some weight after changing diets... my family has also changed their eating habits to support me, we all eat, and we all eat boiled food now” (Ntombi).

Ntombi monitored her blood sugar by using a glucometer; the glucometer excited her and somehow added a fun part to her management of diabetes. She saw her glucometer as a gadget and does not mind explaining to people how it works and how she knows when her sugar levels are high and when they are normal.

“The sugar machine helps me a lot in knowing my sugar levels, it helps me balance the sugar in the blood, it lets me know when it is too high and I am able to act on it” (Ntombi).

Being selective of foods had become a culture to some of the participants; they had grown used to tastes that were once horrible and unusual. They realised that eating a healthy diet improved their management of the diabetes.

**Thembi**, a 4-year-old mother of two, admitted that she had become more selective of foods and noticed that her sugar levels were under control and she was feeling good.

“I have become more selective of foods that I eat, it really helps with controlling the illness. I have taught myself to enjoy eating healthy foods... it was not easy adjusting to a new taste though but for the sake of my family had to be done” (Thembi).

#### **4.3.2. Medication compliance**

Medication compliance is very important for a diabetic. Medication is an important coping mechanism as it vital in keeping glucose sugar levels under control. Participants thought that it was of vital importance for them to comply with medication usage. Some shared that they would put medication in a place that is close to them, where they can easily see it and remember to take

it. Others saved alarm reminders to remind them when it is time to take their medication. Participants had grown to understand that medication compliance is the most important means of managing diabetes. Some participants relied on both Western and traditional medicines. They believed that both worked and did not want to stop using either one. Participants said that nurses and the Diabetes South Africa team taught them the importance of medication compliance. All the participants knew and understood the importance of medication compliance, whether it was medicine from the clinic or from the healer. All the participants complied with either both or just one medicine.

**Zama**, a 49-year-old, widowed, diabetic female and mother of six, was diagnosed with diabetes in 1998. Her opening statement was that she knew the importance of taking her medication. She felt that medication was very important for a diabetic; she did everything in her power to keep adherence with her medication.

“It has become a tradition for me to drink my medication; my family reminds me when it is time to take medication”... “My children bring me the pills and water sometimes, immediately after meals” (Zama).

“I only use medications given to me by the nurses at the clinic; I have learned that to keep my diabetes under control I need to stick to medicines given to me at the clinic” (Zama).

**Diamond** shares these sentiments. Diamond, is a 44-year-old, married, diabetic women and mother of three. She believes that compliance with medication can save a person’s life. She believes that people should adhere to medicine, whether it was medicine from the nurses at the clinic or medicine from herbalists, or even traditional healers.

“medicines make a very big difference in my life, I make sure to drink the medicines as the nurses have told me to... my sugar has not given me problems I believe it is because I look after myself and use the medicines as prescribe” (Diamond).

**Ella** emphasised the importance of medication compliance. She stated that after taking medicines from the clinic her body started feeling much better, the tiredness went away and she felt fresh and rejuvenated.

“Ah, I have felt so much better, ever since I started taking the medicines from the clinic, my illness has never given me problem, I really want to thank the nurses at the clinic” (Ella).

Belief in the types of medicines used were greatly influenced by the belief and cultures that the participants were born into. Some of the participants refused to stop using traditional medicines, as they felt that these medicines played a very important role in managing diabetes. The nurses and representatives from Diabetes South Africa performed well in educating the participants on medicines and medication compliance, but they had no control over the choices that the patients made with regards to the types of medication that they would use.

Before the support groups started I would sit with the women and listen to their conversations. Some of the women had grown to understand that the types of medication that they use to manage their diabetes has a big of influence on the illness. The medicine will either help you or make you worse. With some it was still not important which type of medicine they used, just as long as they had medicine that they believed would help them. Some participants believed that using more than one type of medicine would be far more effective than using just the pills from

the clinic. Beatrice started recommending to the woman an imbiza that she was using for the diabetes. She told them how it had been working for her, that it made her forget that she had diabetes. The nyanga she got it from told her that if she uses it for a long period of time it could heal her diabetes. Beatrice's story elicited different emotions from the women. Some wanted to know more, so that they could purchase this imbiza, while others remained unmoved. Beatrice admitted that she used both traditional and Western medicines to manage her diabetes but did not want to admit it to the nurses, because she knows that they are not allowed to use alternative medicines.

“I use both traditional and clinic medicines. I don't know which one helps me the most between the two but I feel both are good for me” (Beatrice).

**Dorah**, a 46-year-old, married, diabetic black female and unemployed mother of three, diagnosed with diabetes in 2009, was more than keen to participate in the study. Dorah observed that she believed in compliance with medication to keep diabetes under control. Her husband believes that compliance is important and helped Dorah comply with her medication. She confided that her husband does not understand that they are not allowed to use alternative medicines for diabetes. She said that her husband had a tendency to buy medicines and herbs that are believed to help diabetics manage and even cure diabetes.

“I know he cares and is trying to help me get better, I have explained to him that we are not allowed to use such medicines, but he continues to buy them for me” (Dorah).

### **4.3.3 Exercise**

In black culture, exercise is not regarded as an important factor. Some black men find big, plump women attractive. Being big-bodied also carries a misconception of being healthy and happy.

Being fat or obese makes one more susceptible to diabetes type two. Diabetic women have been encouraged to exercise so that they can be healthier. Exercise is one of the coping mechanisms that the participants said they use as a management tool for diabetes. Participants said that the representatives from Diabetes South Africa taught them simple exercise routines that are not physically strenuous and are suitable for their age. Women stated that they also exercise to reduce body weight. This shows that sometimes health-seeking behaviour encourages people to go beyond their cultural norms and beliefs to find treatment or cures. Participants have said that exercise, combined with healthy and proper eating plans, help them with reduction of body weight.

Mbali, a 42-year-old, diabetic, black female, lived with her boyfriend and mothered four children. Mbali was keen to participate in the study; she was not very talkative but would try very hard to communicate during interviews. Mbali's boyfriend stressed her a lot and that worried her because stress is not good for her diabetes.

“I try to keep it out of my mind; the nurse says exercise can help decrease stress levels... Ah, I try to keep good exercise routines” (Mbali).

It seemed that a lot was bothering Mbali. Her quietness was not just because of the boyfriend that cheated a lot. She said that she was scared of dying and leaving her children. Maybe this added to the high stress level that she suffered from. In her opinion, exercise and proper medication compliance reduced blood glucose levels in a diabetic person.

“The nurses tell us to exercise a lot, this will help the body and the sugar in the blood” (Mbali).

The time spent with the women made it clear that some, such as Mbali, had grown used to and understood, the importance of exercise and knew what it meant for their diabetic condition. There were also people like Jessica, who did not care much about exercise.

**Jessica**, a 50-year-old, unemployed single mother of three, diagnosed with diabetes in 2007, was eager to participate in the study, was very talkative and laughed a lot. Jessica did not believe much in exercise. She felt that people would laugh at her and that she had never seen anyone in the family exercise before. Jessica shared that her mother was diabetic but she never saw her doing exercise. Jessica shared that her mother lived with diabetes for more than 15 years. Her mother's situation seemed to have encouraged Jessica not to exercise.

“I eat healthy and drink my pills, my sugar is always good when the nurse check, why should I exercise” (Jessica).

“What will people say when they see a grown women like me exercise, I don't want to be laughed at, even my own children will laugh at me” (Jessica).

All the participants had been educated on the importance of exercise for a diabetic person. Nurses and the representatives from Diabetes South Africa encouraged the participants to exercise. During one of the support group sessions, Sister Gertie asked the women to stand up. They all stood up and Sister Gertie taught them a new exercise routine which was accompanied by a song. All the women seemed to be happy and enjoying themselves, even Jessica, who was scared that people will laugh at her for exercising. After that session talking to Jessica was imperative, but she had not changed her mind at all about exercise.

“I don’t have a problem with exercise when it will be with the other women here at the clinic; at home I can’t do it alone” (Jessica).

“I will be fine without exercise; I will make sure that I eat vegetables and swallow my pills” (Jessica).

**Tracey**, a 43-year-old married, black diabetic woman and mother of five, diagnosed with diabetes after her last child’s birth in 2010, was keen on participating in the study. Her opening statement was she knew that she had to balance her life if she wanted to keep the diabetes under control. Tracey feared that if she did not keep her sugar levels under control she would get ill, die and leave her children. She was worried mostly about her last born, because he still needed her. Everything that she does to manage her diabetes is for her children, more than it is for her. Tracey seemed to be taking good care of herself; her children had come to understand that they needed to support her in managing her diabetes. An interview session that took place at Tracey’s house revealed a lot about her diabetes management, Tracey lived with her five children and husband, she was not formally employed and her husband received grant money. Tracey had a tuck-shop that sold vetkoek, sausages, fried chips and “junk foods” such as chips, sweets and biscuits. It was clear that the family cared deeply for her and her diabetic condition; her children assisted her with the house chores and made sure that she had taken her medication. This could be because that Tracey’s mother, who had lived with them, died from diabetes complications. When Tracey’s oldest son came back from school he asked if Tracey had eaten and taken her medication. Tracey’s children helped her with exercise routines. Tracey added that they helped her with her routines in the afternoon; they would move the table in the kitchen to allow her more space to exercise.

“Exercise with proper eating is good for the sugar levels, exercise is also very good, that is why I exercise... it helps a lot with the sugar” (Tracey).

#### **4.4 Networks**

Diabetic people need strong support from family and friends so that they can cope with, and properly manage, the diabetes. Networks are a very important part of a diabetic patient’s life. Networks form part of a large support system for patients living with diabetes; there were a number of networks that were available in the lives and communities of the participants. There were immediate networks such as family and friends and those that come to the rescue of the patient with emotional and spiritual support such as churches and community support groups.

**Carly**, a 47-year-old married, black, diabetic female and mother of five children, was diagnosed with diabetes in 2007. It was a shock for her to discover that she was diabetic, as she had had the misconception that one becomes diabetic through over indulgence in sweet foods. Carly had a very strong network system that helped her manage her diabetes. Her initial statement was that the people around her helped her manage her diabetes and made life much easier for her to bear. Carly’s network system consisted of her husband, her children, her neighbour church friends and the priest. Her family, especially her husband, helped her with medication compliance and healthy eating. Her husband would cook for her and take the food to her.

“I was not getting used to the new diet, I would cry all the time when it was time for me to eat because my tongue was just not getting used to this new horrible taste” (Carly).

“My husband encouraged me not to stop, he would boil vegetables for me every night and make sure that I eat them, “it’s for your own good” he would say” (Carly).

Her children also helped her a lot with medication compliance. They would remind her about her medication. If she was working outside they would take her medication to her. They made sure that she took her medication as recommended by the clinic. Her oldest child was very knowledgeable about her mother’s medication, because she went with her to the clinic whenever she was free to do so. At times if her mother was unable to go fetch her medication her daughter would go for her. Carly and her husband were not employed and depended on grant money allocated to her three children. She collected R840 altogether per month. She had a large family and sometimes this money was not enough to sustain the family for a whole month. At these times she would need to go to the clinic, but not have the money to go; her neighbour would assist by lending her money to go to the clinic.

“A good relationship with the neighbours is needed; my neighbour helps me so much. When I don’t have money to go to the clinic she borrows me the money and I pay it back when I can”. (Carly)

Her neighbour also helped by buying her vegetables if they were on sale. The neighbour was a nurse who worked in one of the clinics around Umlazi, and she would bring Carly medication and pamphlets from the clinic.

“She works at a different clinic to the one I attend, she brings me new things whenever they get them, sometimes she also brings me needles and

strips for my glucometer because I do not always have money to buy more... I know God put her here to help me with this illness” (Carly).

Carly also had church friends that helped her with emotional support. Carly believed fervently in God and the power of prayer. In her house there were crosses and pictures of Jesus. The Holy Bible remained on top of the table with a pen and old-looking highlighter. She believed that God had a plan for everything and that the diabetes that was troubling her was part of God’s plan.

“With God’s plan and guidance I will get through this” (Carly).

“The church people give me hope. Walking with them and God makes my life much easier to bear” (Carly).

**Clair** is a 46-year-old, single, diabetic female and mother of four. Diagnosed with diabetes in 2008, she lives with her mother, four children, her sister and her sister’s three children. Her network system consisted of her family and it is her mother and children that help her the most to manage her diabetes. She also has church networks.

Both Clair and her mother were diabetic. They helped each other by reminding each other of the different types of coping strategies that they were taught at the clinic. Clair’s children helped them by cooking and cleaning the house and encouraged them to eat healthy foods and exercise. Clair’s oldest child had a part-time job. She would buy them some of the recommended food that they were told to eat. This helped them to change bad foods for food that were healthier. Other family members that were not diabetic ate their own food. The interviews that took place at Clair’s house showed the type of life that they lead. Some of the groceries were separated, Clair and her mother had their own Flora margarine, while the other people ate Rondo margarine.

They ate brown sugar, while the rest of the family ate white, no-name brand sugar. They had their own Flora cooking oil, while the rest of the family had a huge, five litre container filled with no-name cooking oil.

“We try to cook how the nurses say, the foods are expensive but we put money together and buy them” (Clair).

Church members were also helpful with regards to emotional support. They helped with encouragement and prayers in times of need. Clair was a prayerful person; they would always be playing gospel music when I went to her for our interview session.

“I think it is better for one to have religious connections, a spiritual support, especially when he or she is troubled by illness. No matter what the problems are guided by God I can find the answers and the inner peace that I so long for” (Clair).

**Sophie**, a 48-year-old diabetic black female, was a widowed who had three children. Her children do not stay with her due to family conflicts. Sophie lives in a two room house with her grandchildren; she did not have any friends or close family members. She had to manage her diabetes alone, which sometimes proved to be difficult. It was a challenge for her to cope, because she had no one that helped her and she had no one to talk to.

Sophie told me about her life: She stays with her grandchild because all her children have died. She looks after herself because her grandchild is never at home. She had her foot amputated six months ago because she had a diabetic foot and it would not heal. She basically runs the household herself

because there is no one to look after her or cook and clean the house. If it happens that she gets hypoglycaemic, which she explained to be a state where the body is running on very low glucose, this affects the brain, resulting in impairment of function. She further explained that she has to deal with it herself. She explained that her biggest fear is that one day she will be found dead because the attacks do not warn when they are about to start. I found that this participant was well-informed about her condition, as she was able to explain to me a lot about diabetes and how to manage it (Sophie).

“The sugar is a very serious illness; it needs to be controlled properly. When you have no one it becomes harder to handle it” (Sophie).

“I have no one to turn to; even when I feel sick there is no one to help me I am just alone” (Sophie).

#### **4.5 Doctor/nurse patient relationship**

The doctor and patient relationship is very important in the lives of diabetic people, who need to be well-informed on ways that can help them to best manage and keep their glucose at a recommended level. This relationship is of the utmost importance, as it can create a conducive environment for proper diabetes management if a proper relationship is founded between patients and healthcare providers. As much as healthcare providers are important in the life of a diabetic, the diabetic becomes the doctor at home. It is up to the patient to follow all that she has been taught at the clinic or to ignore it. Good doctor and patient relationships encourage patients to look after themselves, because they do not want to disappoint the doctor. If patients are well

educated on how to manage diabetes it becomes easier for them to look after themselves. Some of the participants seemed scared of the nurses; the generalisation that nurses are rude was embedded deep within the psyche of some of the participants. Some participants had a bad attitude towards the nurses.

**Gloria**, a 45-year-old, married, diabetic woman was diagnosed with diabetes in 2009. Her first statement was that she feared nurses and did not like the way that they shouted at people. She felt continued to add that the nurses did not have any respect for the patients.

“I find it difficult to talk to the nurses sometimes because some of them do not have a respectful approach to us patients. I am old, my child, I have children that are as old as these nurses and my children respect me not only as a mother but also as an adult. Therefore I find it rather difficult to be shouted at by a child who is the same age as my child. In our African culture as you know [looking at me straight in the eye] we are taught that we need to respect our elders. These nurses lose their sense of respect for elders just because they are educated. How do I them confide in a nurse who shouts at me or treats me like a nobody? How am I supposed to ask questions about things that I am not clear on when it comes to managing this disease that I have” (Gloria).

Clair confirmed this situation when she added her own experience with healthcare providers at the clinic.

“When I first started going to the clinic I found that I had a problem in communicating with the nurses, they would always shout and make me feel

like a small child being shouted at for doing something so very wrong and more than anything being shouted at would make me feel very stupid. The treatment I got from the nurses was very different to the one that I got from the traditional healer. The traditional healer treated me like a normal human being and respected me; I found it to be very easy to talk to the healer as compared to the nurses” (Clair).

It is not all nurses or doctors that have attitude problems towards patients and not all the patients felt this way. A visit to the clinic for the diabetes support group proved that some of the nurses do actually care and love their jobs; nurses were socialising with the diabetic patients, talking about their diabetes, finding out how the patients were managing the diabetes at home and how the family members were assisting them in coping with diabetes. The participants seemed to be comfortable and replied to the nurses, sharing their experiences and how they were dealing with certain problems. It was clear that a relationship had been created between the participants and the nurses.

**Rose**, a 43-year-old, single, black diabetic female and mother of seven children, was diagnosed with diabetes in 2011.

“We have to understand that they are people, they will have good and bad days. We never acknowledge when they treat us well” (Rose).

“The education that we get at the clinic is very important because we use it to manage and keep our diabetes under control; there are a lot of things that I have learned from the nurse’s clinic that I did not know about diabetes. I

learned that drinking water is a very important thing for a diabetic... my child I have learned so much from the nurses here at this clinic” (Rose).

**Clerissa**, is a 47-year-old, single diabetic, with three children. She was diagnosed with diabetes in 2009 and shared the same sentiments as Rose. She observed that she had learned a lot from the clinic on how to best manage her diabetes; she noted that the nurses do not shout if you listen to them and follow proper management strategies for your diabetes.

“At the clinic I learned that I have to cut down on eating too much starch. I have to have a lot of vegetables and eat lots of water. I learned that eating too much starch is not good because it has a potential of increasing my weight. The nurses tell us that we have to make sure that our medication is stored in a safe place and that when I am visiting friends or family I have to pack my pills in separate containers because it is not advisable to put them in one container it makes them less effective” (Clerissa).

“I have learned that taking medication is very important but it becomes ineffective if the patient does not change their entire lifestyle. I need to stop eating too much starch and add a lot of fruits and vegetables in my food” (Clerissa).

Talking to the doctors and the nurses proved to be difficult due to their busy schedules. Fortunately I was able to talk to some of the nurses, but the conversations were not long. The clinic was always filled with patients and the nurses were always up and down attending to the patients.

**Nurse A** said that being a nurse is not an easy job, but because she loves it it seems easy to her. Dealing with people can be a challenge because people have different attitudes; some are nice and some are rude. Nurses already have a label of rudeness so some of the patients approach them with that in their minds.

“Working with the diabetic women has its ups and downs; we have our good days with them and the bad, we try our level best to educate patients on how to manage diabetes” (Nurse A).

“I have never had a bad experience with any of the patients... some of them listen and some do not, it is our duty as the nurses to continue trying to get through the patients” (Nurse A).

Alternative medicines are always an issue, which always creates a problem between nurses and the patients. When talking about this, the nurse’s facial expression changed. She paused for a minute...

“Alternative medicines give us a problem as nurses because patients neglect medicines that they are given by us for them, some of these medicines are not good, they raise the glucose levels” (Nurse A).

“Patients always hide it from us, but when a good relationship has been created some patients do admit to using them” (Nurse A).

**Nurse B** was very vibrant and out-spoken. Her relationship with some of the patients was very good and she shared jokes with the patients. She really seemed to have a calling for nursing.

“It is very rare that I shout at the patients; if I do it is always for a good reason. I shout because I care... Some of the patients do not listen, you tell them this month to follow the guidelines on how to manage their diabetes so that they will be able to control their sugar levels, they will come back the following month with a glucose level of > 10mmol/L which is an indication that they do not follow the guidelines that we give them” (Nurse B).

#### **4.6 Conclusion**

Diabetes is a serious chronic illness that needs proper management strategies. Networks play a very important role in the lives of diabetic black women patients. Networks are a source of support, both physically and emotionally. This chapter has shown the different types of coping mechanisms that are used by black diabetic women. Although culture may define us when it comes to issues of health and illness, people tend to go beyond cultural boundaries to be healed. In the following chapter the findings will be discussed.

## CHAPTER FIVE

### DISCUSSION OF FINDINGS

#### 5.1 Introduction

This chapter will summarise the results of the study and discuss the findings from the data that was collected through the use of semi-structured interviews and in-depth interviews, when interviewing black diabetic woman in Umlazi N section. The goal of this study is to find and explore the different coping mechanisms that diabetic women have in place to manage their diabetes. The data collected will be used to develop literature that can assist both healthcare workers and diabetic patients.

#### 5.2 Cultural meanings given to diabetes

Participants had opposing cultural beliefs that they had attached to diabetes. Participants who had been with the N clinic for a long period of time had come to understand that diabetes is a disease that is present in every culture and race. They had also grown to understand that the symptoms are the same in all race groups, regardless of the different beliefs and culture systems. Participants did not have this understanding of diabetes before they were educated at the clinic; also it was not all the participants that had traditional attachments to diabetes as others felt that religion had a great part in their illness. A study carried out by Hatcher and Whittemore (2007) found that “Mexican Americans believe that diabetes is caused by *susto* meaning “fright or surprise”, and occurs during a startling event”. In their culture the belief of the causation of diabetes is not embedded in the lifestyle that they lead. Some of the participants believed that it was God who had placed them in the situation that they were in and it was Him who would see them through it. Similarly, Hatcher and Whittemore (2007) found that Hispanic diabetic patients believed that “the reason they had diabetes was that it was God’s will or punishment”.

Family members and friends are the closest networks to people that are confronted with diseases and they therefore have a high degree of influence on the type of medication and healing process that a patient who is in their care should follow. There are many different beliefs with regards to illness. Even though there are Western definitions of illnesses and diseases, people from different cultures have their own ways and means of defining illnesses, diseases and means of healing. Family members and friends of diabetics play a vital role in making sure that the diabetic patient takes their medication when they are supposed to. They are the backbone of the patient as they are the ones that encourage the patient to follow proper compliance to manage and maintain his or her sugar levels. Cockerham (2010: 35) adds that “the reactions of others, particularly the family and people emotionally close to the sympathetic person, play an important role in determining how the affected person reacts, that is how he or she defines and handles symptoms”. Similarly, in the present study, patients admitted that their family members had a strong influence on the beliefs and meanings that they gave to diabetes.

Participants who had cultural attachments to diabetes thought they were bewitched by people who were jealous of them, for reasons such as progression in life, part time jobs, buying new furniture, family feuds and church positions. Lupton (2012: 40) states that “Medical anthropologists have recognized that the culture within which a patient is operating influences the illness experience”. Some participants believed in sorcery. If something bad had happened to them they blame it on sorcery. Some of the participants attached dreams that they had to sorcery. If they dreamt of themselves eating then they would automatically link that dream to sorcery and call the act of eating the food in the dream *idlliso*. The belief behind *idlliso* is that if you ate the food in the dream you have to wake up first thing in the morning and vomit, so that the muthi can come out through vomiting. Some of the participants believed that the diabetes that they

have in their bodies was put into their bodies through the process of *idliso*. Dahlberg & Trygger (2009: 84) found that patients that were suffering from TB attended the clinic, but after seeing that medicines take a long time to make them feel better they turned to traditional healers. “A woman described how people sought help at the clinic for chest complaints and were told that they had TB. If the treatment did not help they would turn to a *nyanga*, when it might be discovered that the patient really had *idliso* an *isifo*, caused by witchcraft, against which Western medicines are ineffective. Several healers said that there are two kinds of TB and that they could cure the one caused by *idliso*” (Dahlberg & Trygger 2009: 84).

During the interviews two culture-bound illnesses that featured the most, that were believed by these women to be making them sick. These culture bound illnesses were *umeqo* and *idliso*. Lupton (2012) explains that the culture that an individual operates in influences the beliefs that that individual will hold and will attach to illnesses that occur. A pattern that arose was that someone is always the cause of illness; it was never a matter of the individual’s reckless lifestyle, or just nature. It seemed that these two culture-bound illnesses shared very similar symptoms to diabetes, from the perspective of the participants. They believed that when one has either of these culture-bound illnesses they lose weight, they have a dry mouth and are always thirsty due to the poison; they always feel tired, even when they had not done any strenuous physical work and sometimes caught got skin infections. All the symptoms that they had known to be symptoms of these two culture-bound diseases also presented as diabetes symptoms. The belief that the participants were bewitched and the fact that diabetes to them at that particular point was an unexplained disease triggered them to seek explanations for the causes of the illness. Cockerham (2010: 35) adds: “what people do when they begin to feel unwell, the manner in

which they react to symptoms, have been found to vary across cultures”. Participants consulted traditional healers as they felt that they would get a suitable diagnosis for their illness. Awah, Unwin and Phillimore (2009: 6) elucidate: “episodes of unexplained, untreated illness may prompt a person to seek explanations from a traditional healer. When that occurs the traditional healer will diagnose the patient to seek to determine the illness, but will color it with divination. His divination may diagnose a living agency, witchcraft, or a supernatural one, ancestor as those responsible for its occurrence”. A study based on HIV was carried out by Thomas in 2008 in a Caprivi community. After examining HIV and the different belief systems that people attached to HIV, Thomas found that “a wide variety of misfortunes can be explained by witchcraft, including failure to marry, poor school grades, or bad harvest, and illness and death. Illness caused by witchcraft may manifest itself in a variety of forms and, as with Kahomo symptoms, are often similar to those associated with HIV/AIDS”.

In the present study, participants admitted to traditional medicine usage. Although it was not brought up in the early stages of the interview sessions, participants admitted to the fact that they kept it from the nurses because the nurses shouted at them. A study carried out by Kolling, Winkley and von Deden (2010) noted that patients use medicines that they feel will help them the most. Kolling, Winkley and von Deden (2010:35): found that “From the interviews with the healthcare professionals at the clinic researchers were told that most or many of their patients had tried, or took some sort of traditional therapy”. The study found that several patients that participated in the study confirmed that they had interrupted their biomedical treatment in order to follow an ethno-medical treatment. Using medicines that would help manage diabetes did not sit well with some of the participants, as they felt that medicine should cure and not help to manage the illness. Some of the participants used plural means of medication as they felt that

between the two medicines one was not as effective. Groth *et al.* (2011) found that participants wanted medicines that cure, not to manage diseases, “I’ll take medicines today, tomorrow, and the day after, and if I’m not cured, I have to abandon that medicine to find another one that will work” (Groth *et al.*, 2011: 4).

Kolling, Winkley and von Deden (2010: 6) point out that healers offer cures, something that biomedicine cannot. The fact that traditional healers assert that they heal attracts more people to them, because people want illnesses to go away, not to be managed. Groth *et al.* study (2011) also found that ‘patients do not go to hospitals because they will not be cured, but will only be given information cards on how to manage the disease’. Participants deal with, and attend to, illness the best way they knew how, which was influenced by their culture and the manner in which they were groomed to believe in health, illness, healing and cure. Findings in the present study showed that, although the diabetic women were taking oral Western medicines some were combining it with traditional medicines. Germond and Cochrane (2010: 308) add that “pluralistic health-seeking strategies are most frequently found in multi-cultural environments, but more homogenous settings of health and illness, and health seeking behaviors, can also vary considerably according to class, gender and stage”. If the families and diabetic patients themselves choose to use management strategies that are not suitable for the disease, such as treatment and types of networks to support the patients, then the results can be fatal. Weller, Bear, Garcia, Rocha (2012) warn that “if families of diabetic patients misunderstand the symptoms and management of diabetes, including dietary and exercise needs, the resulting lack of support may result in poorer adherence to treatment recommendations”. Kolling, Winkley and von Deden (2010: 5) affirm that “Researchers attribute complications and high mortality to poor medical management and harmful self-care practices, including use of ethno medicine”. Families

of participants that had opted for alternative treatment, rather than going to the clinic, found that participants did not get better at all and some even had very high glucose levels that indicated poor management on the part of the support structure of the patient and the patient. A participant who had neglected medication from the clinic and continued with alternative medicines became very ill.

Berenson (2011: 14) states that “Knowing about the patient’s culture and individual’s beliefs is as important as knowing about their physical problems, functional limitations, and response to illness to provide safe, competent and comprehensive nursing”. Participants felt that the nurses had a way of knowing if they had used traditional medicines and would shout at them for using the traditional medicine. Participants reported that nurses said that the traditional medicines make their sugar levels high. Networks have had some sort of influence and persuasion in the usage of traditional medicines. An understanding of the patient, their culture and background, by the nurses, is important to avoid situations where patients feel that they are not treated in a respectful manner by the nurse. An example of this would be when nurses shout at patients for using traditional medicines. Conflicts between nurses and patients can create situations of medication non-compliance. The relationship that is created between a nurse and a patient has an important influence on patient compliance. Participants also used boosters sold to them by entrepreneurs; these boosters are believed to help with diabetes and many of other chronic diseases. Participants who have consulted traditional healers said that they felt much more comfortable communicating with the traditional healer than they did with the nurses; they confided that at times nurses can be very rude and unapproachable, compared to traditional healers.

Some participants used an imbiza for their diabetes. This well known amongst some diabetics. It has a very bitter taste and the belief was that it shocked the diabetes to remain dormant in the blood, meaning that the glucose sugar levels would never go up if this imbiza was used. It was supposedly believed by the participants to cure the diabetes if used for a long time and effectively. Some participants wanted this imbiza because of these beliefs but could not afford to buy it. Some participants admitted to using both traditional and Western medicines to manage their diabetes. They were not sure which one was working better, but they were satisfied with using both. Participants said that after consistent visits to the clinic and proper diabetes education they stopped using traditional medicines and concentrated on medicines that they were getting from the clinic. Other participants felt that traditional medicines worked better than the pills that they got from the clinic. One participant was saved from having her foot amputated by traditional medicine that she got from a traditional healer.

### **5.3 Coping mechanisms that women adopt for dealing with diabetes**

Networks proved to be very important in the lives of the participants in this study, as they not only gave emotional support but also encouraged participants not to give up, as adapting to a new lifestyle was very difficult for some patients. Networks helped patients through the transition, by helping them with medication compliance, exercise and healthy eating. Family members would cook for the diabetic patient, encouraging them to get used to the new way of preparing food and the new taste.

Networks were a very important coping mechanism for the participants; networks gave emotional and physical assistance to the participants. Anthropologists have said that “kinship system is characterized by social dependency and mutual obligations between kin and has a high degree of self reliance in coping with disease and illness, as patterns of family treatment are

deeply embedded within the kinship system” (Kolling, Winkley and von Deden 2012: 7). Diabetes is a very demanding disease; participants were required to be able to comply with proper management mechanisms in order to keep their blood glucose levels under control. “Care giving is primarily a matter for families, close friends, and the afflicted individuals themselves”. (Kleinman 2010: 96). The life of a diabetic is not easy. Patients had to make sure that they looked after themselves, to avoid cardiovascular diseases that may come as a result of poor diabetes management. Patients had to learn to put their own lives first. Adapting to the new way of life was difficult, but had to be adjusted to, if patients wanted to live longer and healthier. Participants within the study found it difficult in the beginning to adapt to the new life changes, but were able to do it with the help of the networks that they had assisting them.

Diabetes requires the affected person to change their entire lifestyle, making life difficult and sometimes miserable, as they need to conform to a new way of life that may even include abandoning their culture and beliefs. This new life meant changes in diet, which posed as a challenge for some, as they needed to give up foods that they had been eating for very long periods of time. This new change required very strong supportive networks that were going to help them with the new change. Berkman and Syme, 1979; Mendes de Leon *et al.*, 1996; Veenstra, 2001, cited in Ferlander 2007: 122 add that “It has been suggested that strong bonding social networks may affect health through psychological mechanisms. These networks tend to provide emotional support, affecting individual health through mechanisms such as promotion of self-efficiency (a sense of personal control) and reduction of stress”. Exercise routines were an addition to the participants’ new way of life. This proved to be another hurdle for the participants because in certain cultures exercise is not considered as important. Florina (2011: 502) explains that “All types of diseases affect the individuals’ daily lives, but chronic or severe diseases

determine with predilection a major intrusion into one's personal history. Disease, particularly chronic disease, is a major experience that more or less undermines the structures of everyday life, our knowledge about the world, or values that guide our existence". Diabetic patients need to learn to look after themselves, whether they have strong support systems or not, because the diabetes is affecting them severely. "According to Mol 2008 cited in Guell 2012:518, care is increasingly framed as a consumer choice, where patients are expected to assume an "empowered" role, rather than accepting paternalistic care decisions. Chronic illness care requires the patients to become their own caregivers who must manage their own illness and integrate this "care" into their everyday lives. They must become "expert patients", whose health knowledge and practice can at least help to prevent the development of any of the comorbidities that come with chronic illness (Wilson 2001, cited in Guell 2012:518).

Networks helped participants by reminding them about their medication, preparing healthy food, helping with exercises and emotional support. Family networks gave them hope and strength to carry on. Religious networks gave faith, inner healing and comfort to some of the participants. Participants had formed a network of their own at the clinic; they exchanged numbers and telephoned each other when they were confused about something or discovered new medicines and other coping strategies that they felt other diabetic patients should know about.

Diabetes is a silent killer that strikes when one is least expecting it. Participants feared that they had very little time left with their families; they were scared because if they died they would not be there to see their children grow up; and there were things that they still wanted to do for their children and other family members that they could not do if they died. Having strong family support made them feel that they had proper management mechanisms that would help them live

longer. Zhou (2010: 321) confirms that when people have proper support structures available to them they tend to deal with, and manage, their illnesses with confidence; “those who had received more support from their families, social networks, health institutions, had less concerns about the flow of linear time” Zhou (2010: 321).

Ngamlana (2006: 58) elaborates that: “Diabetes is more than just an inconvenience, the condition impacts strongly upon all aspects of a person’s life. The way an individual has experienced life prior to being diagnosed with diabetes changes and the individual tries to conform to new rules, which may seem confusing to her and those that are close to her”. Networks have an immense influence on a patient’s views, beliefs and attitudes related to issues of health, illness and options of healing and medication, as they are the immediate help for patients, regardless of the disease that the patient is faced with. Thomas (2008: 249) adds “discussions regarding the care and treatment of a person afflicted by illness are rarely the responsibility of one person alone; instead a number of people within and beyond the household may influence care and treatment seeking responses and may differ in their beliefs and understandings of the cause and remedies of the illness”. Networks play a major role in choosing the available treatment options that are available, Cockerham (2010: 208) states that “the options available to people seeking health care vary greatly across countries and cultures, even in modern, developed country like the United States, people may not look at modern medicine as the only or right option”. Participants in the present revealed that treatment and management options were decided by the family and not the individual on their own. Other family members prevent patients to go to the clinic, but wanted them to use a dual medication system.

Kalyango, Owino and Nambuya, 2008, cited in Adegbola 2009: 6, emphasise that “Diabetes is considered to be one of the most psychologically and behaviorally demanding of the chronic

diseases”. People with diabetes need all the assistance that they can get from the networks that they have close to them. Networks are a vital source of survival when one is confronted with illness. Friends and family form part of a patient’s coping mechanism. They are the ones who look after and care for the patient, they give comfort and support throughout the period of illness, more so when it is a chronic illness. For Sarah, networks have proved to be one of her most important coping mechanisms. They give more than just emotional support.

Findings from the present research showed that family members had an important role that to play in the lives of the diabetic women who participated in this study. All the participants had family members and friends that supported them during their journey with diabetes. Only one woman in the sample had no one to rely on. She lived on her own and did not have any friends either. Families were very hands on in assisting their family members manage diabetes. Participants reported that their family members would remind them when it was time to take medication; they would help them with their exercise routines and encourage them to eat healthily. Cockerham (2010: 36) confirms that “Group closeness and exclusivity increases the likelihood of a person responding to a health problem in a way that is consistent with his sub-cultural background”. Family members had grown to know more about diabetes and its management. Cohen, Sharma, Acquaviva, Peterson and Patel (2007: 337) affirm that “Increased social support has the potential to positively affect outcomes through a number of mechanisms, including decreased levels of depressive affect, increased patient perception of quality of life, increased access to health care, increased patient compliance with prescribed therapies, and direct physiologic effects on the immune systems”.

Exercise was another means of coping and managing diabetes. Nursing Sisters and Diabetes South Africa emphasised an exercise routine. Participants found exercise helped them as a coping mechanism, because it would make them feel fresh and active. Sigal, Kenny, Wasserman, Castaneda-Sceppa and White (2006:1433) state that “For decades, exercise has been considered a cornerstone of diabetes management, along with diet and medication”. Exercise is important for the body even if one is not diabetic, one of the participants added. Participants had learned, and come to understand, that exercise was important to keep the body healthy and to manage the glucose levels in the blood of a diabetic person’s life. Water played an important role in the lives of the participants. Some however, would eat all of the foods that they were not allowed to eat and drink lots of water because they believed that water substitutes all the bad, unwanted substances present in the food that would make the sick.

Eating healthily was considered to be very important by the participants. Participants were taught by nurses and the Diabetes South Africa team the dangers of eating unhealthy foods. Healthy food choices could mean the difference between life and death. Large portions of starch, fried foods and sugary foods were forbidden to participants if they wanted to keep their blood sugar at the recommended level. Participants were guided by food charts that they were given at the clinic. These showed the correct amount portions they were supposed to eat. Patients had become more selective of foods that they ate. Food was a sensitive issue to some, as they wanted to follow the guidelines that they were given at the clinic on how a diabetic person should eat, but could not, due to financial problems. Kamat (2008: 108) stated that “in dealing with and managing diabetes one has to be stable economically. Diabetes includes a lot of facets that need for a person to money”. He adds that “some researchers have argued that the introduction of user fees at public health facilities is persuading poor people to consult healers because they offer alternatives to

cash payments such as compensation in kind or in work”. All the participants complained that the virgin oil that they were recommended to buy was very expensive and they could not afford it. Participants were worried about their starch intake because the whole wheat that they were recommended to buy was comparatively more expensive. Vegetables did not prove to be a problem, because many of the participants had started their own gardens. Financial difficulties proved to contribute to non-compliance in the management of diabetes. Participants observed that nurses and the Diabetes South Africa team had taught them about the glucometer, which most participants referred to as ‘the machine’. Diabetes South Africa was giving out glucometers for free at one point, but because their sponsor withdrew support they were no longer able to supply free glucometers. Participants who were not attending the diabetes support groups while glucometers were provided free were very unfortunate, because they could not afford to buy them on their own, due to the high price. Glucometers were a very important tool, as they allowed the participants to act promptly if they saw that their glucose levels were high.

#### **5.4 Family and community support system for diabetic women**

Participants’ networks consisted of family members, friends, churches and community support. For many diabetic women in the study, family members were the closest support system; they were their immediate source of help. Kolling, Winkley and von Deden (2010: 6) affirm that “the family members in the household, particularly the nuclear family, provide care, and treatment to the person afflicted by diabetes in terms of acquiring medicine, accompanying them to the health care services, knowledge sharing and upholding a healthy diet”. Family members helped participants with decision making about the management options available to them. Zhang, Norris, Gregg and Beckles (2007:274) speculate that “Social support may help persons achieve appropriate preventive health care services, overcome some of the costs associated with diabetes

management, enhance the ability to maintain positive health behaviors, and perhaps mitigate the physiological effects of stress”. However, the participants felt that their family members did not know much about diabetes and its proper management. Participants felt that the information that their families knew was what they had been told by the participants. Participants were worried that family members would not know what to do if the patient’s sugar levels were too high (hyperglycaemia). Participants worried that sometimes their sugar levels would go up too high and they might die because their family members would not know what to do. Friends also have a role to play; they are part of an important support system. Their role is as important as that of the family. They have a strong of influence on the decisions that the participants made. Some of the participants believed that God had brought diabetes into their lives for a reason and He would lead their way through their journey with diabetes. Hatcher and Whittemore (2007: 539) found that participants placed faith in religious beliefs. Patients that participated in Hatcher and Whittemore’s study were quoted as expressing their belief and faith in God: “I think what helps me is my belief and faith in God”; “May God give us a cure”. Participants in their study noted that church networks had the ability to make them feel at peace and in synchronisation with their lives and their situation. Community members formed part of the support group, in that they would share information. If, for example, they heard about something new that could help diabetics with their management of the disease, they would lend money to participants to go to the clinic or to buy needles and strips for their glucometers.

### **5.5 The clinic as a source of information on how to manage diabetes**

Doctors and nurses played a very important role in the lives of the participants. Healthcare providers provided the participants with all the necessary and relevant information needed by participants to manage and keep their blood glucose levels at the recommended level. Therefore

it is of great importance that a good relationship is created between the patient and the healthcare provider. This relationship has great influence on the patient's compliance with medication. Patients also find it easier to talk to and confide in doctors when a good relationship has been established. Mykhalovskiy (2008: 147) warn that "social distance between medical doctors and patients is a source of trouble in the clinical encounter".

Diabetes is a disease that needs proper management and one must understand what sufferers need to do in order to properly manage their diabetes. The doctor and patient relationship is of great importance, as it will influence the patient's attitude towards the doctor and the patient's compliance with medication and other management mechanisms. Kleinman 1988:129; see also Marsella and White 1982:82, cited in Borovoy and Hine 2008:19, explain that 'when medical anthropologists began to theorize the culturally particular nature of the illness experience, Arthur Kleinman compellingly called on physicians to reimagine illness and its meanings in the context of the patient's daily life and, thus, to make "healing" a process of forging symbolic connections between personal experience and authorized cultural meanings such as biomedical classifications'. There needs to be a relationship of engagement and trust between the doctor and the patient, as this will create a good relationship rapport the doctor and the patient. Anderson & Dederick, Hall 2006; Hall, Dugan, Zheng & Mishra 2001; Safran et al. 1998; Thom *et al.*, cited in Skerkebekk, Middelthon, Hjorydah, Finest 2011: 1182, state that "Patient trust has an impact on patient satisfaction, adherence, and continued enrollment".

It was evident from our talks that participants received sufficient information from the clinic on how to best manage diabetes. They were taught which foods they should to eat and which foods they could not eat. They were given charts demonstrating portions of food intake and how the

foods should be prepared. All the participants were aware that they are not allowed to eat large portions of starch, sweet foods, foods with hidden sugars, fats, salts and fried foods. Patients complained that it was a long procedure getting used to and adapting to new foods but they were trying. Tippens, Oberg and Bradley (2012: 138) feel that “as individuals become empowered, they begin to change the way they think about their place in the world and in society, the way they think about the way they consume foods and products, and how they balance activities in their lives”. Participants revealed that they ate mainly boiled foods, with lots of vegetables and very little starch. Drinking water before meals and after meals was mentioned by many of the participants to be important as it prevents one from eating too much. Participants also shared that water was very important if their sugar levels had gone up; it helped to bring the sugar levels down.

Participants acknowledged that they were very well educated on medication compliance; they understood that they had to follow strict medication compliance rules if they did not want to have complications. Ito (2008: 349) states that “clinic and administrative staff noted that, for compliance, it was important to find the decision-maker in the family, who might not necessarily be the client and to work with that individual so the client would agree to the treatment”. For better adherence, nurses opted in including authoritative members of the family to convince the patients to comply with medication given at the clinic. Participants shared that they were taught not to put their medication in a container with other different medications, because this tempered with the effectiveness of the medication. At the clinic, participants were also taught how to use glucometers, so that they could monitor and keep their glucose levels at the recommended level. Participants were really excited about the glucometers. Participants knew simple exercises that

did not require them to do over-exert. Each exercise routine had a song, which they sang while exercising. This made the exercise fun for the participants.

### **5.6 Diabetes South Africa**

Diabetes South Africa played a very important role, reinforcing what the participants had already been taught at the clinic by the nurses. Diabetes South Africa representative went beyond Western means of treatment and beliefs. Nursing Sister Gertie educated them about cultural meanings that are attached to diabetes and how to think beyond those meanings. Participants said that it was much easier to have sister Gertie explain things to them, because she was a black women who understood and respected their culture and their way of thought. Glucometers were distributed by the Diabetes South Africa team to the participants for free and women shared that they were taught by Diabetes South Africa team how to use them. Participants said that glucometers made it easier for them to know when their glucose levels were too high.

It is evident that black diabetic females between the ages of 40-50 that participated in the study had been influenced in one way or another by their culture and beliefs to choose a medication and healing method that they believed would help them the most. Coping mechanisms that had been put in place for managing diabetes were all effective, although some were hindered by financial constraints.

There were cultural meanings that were attached to diabetes. Umeqo and idliso were the two culture-bound illnesses that were thought to be making people ill, whereas it was diabetes. Participants believed that these two culture-bound illnesses presented symptoms similar to diabetes. Patients revealed differences in the types of medications that they used for diabetes; some used Western medicines provided at the clinic and others used both Western and traditional

medicines. After thorough and extensive education on diabetes management from the clinic and Diabetes South Africa, some participants used medications given at the clinic only, while others refused to stop using traditional medicines (imbiza) together with the Western medicines that they received from the clinic. Patients were not honest with the nurses when asked whether they used traditional medicines or not. This could be because they were scared of the nurses, as they hold a superior position to patients. Patients were scared of being shouted at and being judged, since there is a belief that traditional medicines are backward, or that the patients do not want to be told that they should stop using traditional medicines.

Participants found it hard to create a relationship with the nurses, because some had the attitude and belief that nurses are rude. Some of the participants found the generalisation to be true as nurses would shout at them when they suffered hyperglycaemic episodes. Symptoms would be aggravated by shouting whilst patients were trying to get better from the attack; it would add to the stress that they already had from being sick. After a few visits to the clinic, participants felt that their relationship with the nurses started to improve. This could be because participants were attended to by the same nurses every time they visited the clinic. Participants found it much easier to communicate with nurses after a relationship had been formed.

Women received enough information on how to manage their diabetes from the nurses at the clinic and the Diabetes South Africa group. Participants had become aware of foods that they could eat, the importance of drinking water, the importance of exercise and of medication compliance. Participants were aware of all the effects of not complying with proper diabetes management strategies given at the clinic and by Diabetes South Africa, such as rise in glucose levels, damage to the eyes, kidneys, nerves, skin and the weakening of the body's immune

system, the body's ability to fight infections. Participants were very selective about the foods that they ate after education on diabetes and diet. Participants were well educated on medication and medication compliance; they even knew that the name of the pills they were taking was "Metformin".

When sugar levels were too high, participants knew that they had to drink a lot of water to stabilise the amount of glucose in their blood. However, participants relied too much on the use of drinking water. They would eat foods that they are not allowed to eat and substitute them with volumes of water. Whenever they went to gatherings such as parties, funerals and weddings they would eat foods that they are not allowed to eat, such as starches, fatty foods, sweet foods and fried foods. Even though the patients understood the importance of a proper diet in managing diabetes, they were still not disciplined enough to shun foods that they were not supposed to eat. All the participants admitted to doing this and drinking at least eight or more glasses of water afterwards.

Diabetes South Africa played a very important role in the lives of the participants in this study. They educated the participants on the different ways available to them on how to best manage diabetes; they were also able to get through to some of the participants on cultural beliefs that were attached to diabetes and persuade participants to use medication that was suitable for their condition. Diabetes South Africa also sponsored participants with Accu-chek glucometers, so that they would be able to check and know their glucose levels. Diabetes South Africa is a non-profit organization that relies on donations. Representatives also taught participants different exercise routines that were simple to do and did not require great of physical strength.

Participants depended on themselves more than they depended on networks to manage diabetes. However, family members and friends also play an important role also. They had a great influence on the decisions that participants took about the different management strategies that were available. Family members were the immediate source of help for the participants, they helped with medication compliance, even if it was both traditional and Western medicines. They encouraged participants to fetch medication at the clinic and at times would even go with the participants. Yates-Doerr (2012: 142) found that healthcare practitioners encouraged patients to come with family members: “bring people with you to the clinic; you will need someone to help remember all of this, to help you cook in this new way, to encourage these changes”. The present study proved the importance of having someone accompanying the patient to the clinic. Family members and friends encouraged participants to eat healthy foods that were recommended at the clinic. Some families went as far as changing the diet for the entire family. Families and friends encouraged participants to exercise regularly, as they had come to understand that exercise helps the body respond better to insulin and can reduce blood glucose. Therefore family members played a very important role in the management of diabetes for the participants.

Financial constraints prevented many from managing diabetes to their best level and in the way that they were taught at the clinic. Financial constraints prevented participants from eating foods that were recommended at the clinic, because they were too expensive for the participants’ budgets, as they do not have formal, well-paying jobs. Whole-wheat products proved to be too expensive for the participants, compared to normal starch. Another challenge that the participants faced was that, since they are the bread-winners, they have to buy groceries for the entire family and separate foods for themselves. Many of the participants had large families that they were supporting. Glucometers are very expensive, because there were participants who were not at the

clinic the day free glucometers were handed out. Buying two sets of groceries is impossible for some of the participants as their financial situations do not allow this. Participants who came from long distances had to borrow money from neighbours to attend the clinic.

Cultural meanings that were attached to diabetes by the participants were discredited through proper and extensive education on diabetes; participants grew to understand that diabetes is a disease that affects all the different race groups and that in the different race and culture group's diabetes symptoms are the same. Participants learnt that having a big body is not at all a good thing, as it attracts all types of diseases, mostly chronic. There is a belief among some black men that big bodied women attractive and are healthier. Participants have disregarded their and added exercise as part of their daily lives; black people do not consider exercise as an important aspect in their lives.

### **5.7 Limitations of the study**

- Not being granted permission by other clinics to talk and interview patients from these clinics.
- Generalisations could have been made because a sample from one clinic and one area only was used; other people could have had different ways of managing and controlling their diabetes and could not contribute because they were not part of the sample.
- The study only involved the experiences of black diabetic women in Umlazi N section. This can cause the generalisation that all black diabetic women share the same experiences as the women from Umlazi N section.

- Lack of similar South African studies on this topic made it difficult to compare the findings with studies that have recently been done. More studies on such issues should be done in South Africa.

## **5.8 Conclusion**

Chapter Five has concentrated on discussing the results of this dissertation. Findings show that some participants had cultural beliefs that they had attached to diabetes. After thorough education on diabetes these cultural attachments were abandoned and participants focused on methods taught by the nurses and the Diabetes South Africa team at the clinic on managing their diabetes. Participants were well educated and received much information from the nurses at the clinic on how to cope with, and manage, diabetes. Networks proved to be a very important feature in the lives of the participants, as they played a great part in assisting the participants to deal with their diabetes. Participants changed their lifestyles by changing their eating habits and adopting a healthier lifestyle, including exercise and proper medication compliance. The discussion of the findings indicate that, with proper education, diabetes can be managed if nurses become more culture sensitive, respect patients and include patients in decisions made their about own health.

## CHAPTER SIX

### CONCLUSION AND RECOMMENDATIONS

#### 6.1 Introduction

This chapter is a summary of the findings. It draws conclusions and recommendations that are based on the analysis of the results of the study, looking at the coping mechanisms of black, diabetic women between the ages of 40 and 50. A sample of 25 black females was used. Of the 25, 10 constituted the core group. The study was conducted in Durban Umlazi location, in N section. Umlazi is home to the women who constituted the core group. Qualitative research methods were used to generate a plethora of data. Semi-structured and in-depth interviews were conducted to increase the knowledge of the researcher about the study. To analyze the data that was collected the researcher used the four stages of the grounded theory, namely codes, concepts, categories and theory.

The study sought to find the types of coping mechanisms that black diabetic females have in place to manage their diabetes.

This study attempted to answer the following:

- What are some of the cultural meanings that are attached to diabetes?
- What coping mechanisms do these women have in place for dealing with diabetes and managing it?
- Do the family members and community form part of a support system for the women?
- Do these women get sufficient information at the clinic on how to manage diabetes?

## **6.2 Summary of findings**

South Africa has experienced a high increase in the occurrence of diabetes, more especially amongst the black population and in the rural areas; diabetes was never a common problem in South Africa's past, compared to how it is now. This can be attributed to culture change and urbanization, changes in diet and lifestyle. The food that is consumed nowadays encourages many chronic illnesses. These are foods that are high in fats, carbohydrates, hidden sugars and salts and are deep fried. These new foods are a danger to the body, in that they can lead to excessive weight gain and obesity, which, in turn, leads to health complications such as increased susceptibility to diabetes, cancer and heart disease. Another contributing factor to this situation is the fact that life has become more fast-paced. People no longer walk or exercise; everything has been made easy and has encouraged laziness. Poverty makes it more difficult to handle and manage diabetes; poverty stricken individuals living with diabetes are not able to afford some of the items and foods that they are encouraged to buy. Poverty has impacted negatively on the diet of these people because they end up eating food that is available and not the type of food that is required of them. Diet has a lot of influence on the sugar levels of a diabetic person; too much starch is bad as it increases the glucose levels. Some of the participants wanted to stop eating starch but could not because it was the only food that they could afford. Poverty forced some participants to seek other types of medications rather than the medication given at the clinic.

The data that was collected in this research was divided into themes to be analysed and interpreted; this process had led to the conclusion stage. The present research revealed that diabetic women had some cultural beliefs that they had attached and given to the diabetes disease. This belief encouraged them to name and identify symptoms using their cultural belief

systems. Management strategies were greatly influenced by cultural beliefs and the definition of their symptoms. This was a descriptive study that focused on the coping mechanisms of black diabetic women between the ages of 40 and 50 years, themes that emerged were cultural and spiritual beliefs given to diabetes, coping mechanisms, the importance of networks and the doctor patient relationship.

### **6.2.1 Cultural and religious beliefs given to diabetes**

Patients that participated in this study had different views of the causation of their illness. Some believed that they were bewitched by people who were jealous of their achievements, while others believed that the illness was sent by God for a reason that only He knew and that God would see them through their journey with diabetes. From the interviews two culture-bound illnesses came up the most; participants initially thought they were suffering from *umeqo* and *idliso*. This belief stems from the culture that these women were raised in. Risor (2009:507) states: "Illness explanations of how an individual perceives his/her disorder, his/her personal understandings and interpretations of the causes, thoughts about treatment and the future development of the illness and his/her attempts to find a reason for the suffering". Participants believed that these two culture-bound illnesses presented symptoms that were very similar to diabetes symptoms: these were symptoms such as weight loss, dry mouth, fatigue and blurry vision. The belief that participants were bewitched influenced their health-seeking options. Participants attended traditional healers, who not only were able to diagnose them but also told them the causation of their illness and identified the person who had made them sick. This type of diagnosis drew more clients, because the participants received information that they would not have received had they gone to a clinic. Traditional healers were a better option to some of the participants, for the simple reason that they looked at the afflicted person holistically and did not

just focus on the disease alone. Chelsa, Skaff, Bartz, Mullen and Fisher 2000: Jezewski & Poss 2002 cited in Santos, Hurtado and Sneed 2009:397 explain that “culture provides a framework from which illness is interpreted, as well as how symptoms can be experienced and the type of help-seeking behaviours that are sought from folk or biomedical practitioners”.

Some participants believed that the causation of their illness resided in a higher being; they believed that it was God who had brought the diabetes into their lives, for a reason. They believed that He was going to see them through their journey with diabetes. Similarly, a study carried out by Maman, Cathcart, Burkhardt and Frieda (2009:967), on the role of religion in HIV-positive women’s disclosure experiences and coping strategies found that religion formed part of a coping strategy for some people. A participant in their study was quoted as saying: “I asked God to give me inner peace because I totally missed peace”.

A study of Mexican American diabetes patients found that “traditional medicines and beliefs were not especially important to the patients and presented no barriers to medical care. Indeed patients utilized different health beliefs simultaneously in their search for optimal treatment” (Castaneda 2010:15). Similarly, participants in the present study used different belief systems simultaneously to find the treatment that they believed was best for managing, or even curing, their diabetes. The use of both traditional and Western medicines seemed a tendency in some of the participants. They used a traditional medicine called *imbiza* that had a very bitter taste. It was believed that this bitter taste shocked the glucose levels in the body and made them remain dormant. The use of this *imbiza* was encouraged by the fact that the *nyanga* who sold it promised the buyers that if they used it over a long period of time they would be cured. The fact that the illness would be cured, and not merely managed, attracted more people to buy and use *imbiza*.

Connor 2004, cited in Baer 2011:419 showed that “subjects indicated that another household member had engaged in a pattern of mixed therapy regimes. A scenario in which people maybe using multiple types of therapists and therapies simultaneously, or practitioner to practitioner, in seeking to resolve their health problems”. The *imbiza* was used simultaneously with medicines given at the clinic by the nurses.

### **6.2.2 Coping mechanisms**

Participants had become more selective of foods that they consumed. This was not an easy process, as they had to give up foods that they had been consuming for a long a period. Some participants were not able to comply with the new diet, as they could not afford to buy some of the new things that they had to eat. Family members helped some of the participants adapt to the new eating style by cooking for them and encouraging them to eat, regardless of the horrible, unfamiliar tastes. Other families went as far as eating food that was boiled, in support of the family member. Guell (2012:525) found that “Any dietary changes involved the family, and while some changed the whole family’s diet, others prepared separate dishes for themselves and the rest of the family”. Participants had understood the importance of exercise for diabetic family members and encouraged and helped participants to exercise. Participants adhered to proper medication compliance; they had come to understand that medicines helped them in keeping their blood sugar at the recommended level. They kept compliance whether it was traditional or Western medicines, as they were in a quest to manage and keep their diabetes under control.

### **6.2.3 Networks**

Networks played a major role in the lives of the participants; they encouraged and supported new lifestyles. Networks had a strong influence on the beliefs, meanings and healing options that were available to the participants. Those with strong support networks seemed to be managing

and dealing well with diabetes coping mechanisms, compared to participants who had weak network systems.

#### **6.2.4 Doctor/nurse patient relationship**

Patients were scared of the nurses because of the generalisation that nurses are rude and that they shout at patients. After continuous clinic visits participants and nurses created a bond that negated the generalisation that nurses are rude. However, some participants still had the mindset that nurses are rude, due to the experience and service that they got from attending the clinic. They did not open up to the nurses and no bond was created. Some participants experienced being shouted at by the nurses and became even more scared of them. The relationship that the nurses and participants had created exercised a lot of influence on the medication compliance of the participants. Participants who had a good relationship with the nurses tried by all means to comply with their diabetes management strategies, as they did not want to disappoint the nurses that educated them on how to handle diabetes and manage diabetes. Participants who were using alternatives medicines were hiding it from the nurses, because they did not want to be shouted at by the nurses and doctors. Bodone in (2008:203) found that “most patients he had encountered in Brittany who adopted pluralistic health seeking strategies attempt to conceal their involvement with alternative therapies from their biomedical physicians”.

The present study has enabled the researcher to draw the conclusion that culture played a very important role in the lives of the participants. It influenced many of decisions that they made with regards to their health-seeking behaviour while others were influenced more by their religious beliefs. After proper and thorough education on diabetes that participants received at the clinic by the nurses, more especially Diabetes South Africa staff, they were able to manage their diabetes and understood that diabetes is not *umeqo* or *idliso*. Participants had formed their

own network system with each other from the support group meetings that they attended at the clinic; they shared much information, even in their homes. If there was something that one was not sure about they telephoned each other to find out. Participants were aware of the bitter muti; some used it as they believed that the bitterness shocks the diabetes in the body. Some continued to use it as they were told that prolonged use would cure the diabetes. Participants had differing views on their relationships with the nurses; some were pleased with the treatment and education that they had been receiving from the nurses while others were unhappy. Those that were unhappy complained that the nurses were rude and unapproachable. Throughout the research it was evident that the participants had grown to understand how to best manage and cope with diabetes. The Diabetes South Africa team, along with the nurses, did their best to empower this group of diabetics. Participants had learned the importance of proper management of diabetes and the implications of non-compliance. Participants were afraid of some of the effects that diabetes had on the body. They all feared that at some point their feet or legs will be amputated. Looking after themselves and complying with proper medication had become an important thing to them. Dual usage of medicines continued with some participants, as they felt that if they used two different types of medicines then their diabetes would be kept well under control. Others continued because of their culture and beliefs; they believed that they needed to use traditional medicines as the people who sold them tell diabetics that their medicines will cure diabetes. Financial constraints made it very difficult for some of the participants to be able to properly manage diabetes. Much lot of what was required for the participants to do, to manage their diabetes, required that they also have money. This affected many of their diets. Participants had to lead a healthier lifestyle, change their diet and reduce their starch intake. Many could barely afford groceries for the family, let alone two sets of groceries, this really affected the

participant's management of their diabetes, as sometimes they would eat foods that they are not allowed to eat and their glucose levels would rise.

### **6.3 Recommendations**

The following recommendations are based on findings from the research that took place in Umlazi N section clinic, based on the coping mechanisms of diabetic black women.

- Diabetes should be given as much attention as HIV. Diabetes is a very serious chronic illness that is killing many people in South Africa; there should be as much awareness of diabetes as there is of HIV.
- Traditional healers should be incorporated into the public health system for the safety of the patients. Healers should be empowered and be able to treat patients using medicines suitable for that particular condition of the afflicted individual, knowing the correct physical symptoms.
- Doctors and nurses should adopt a more culture-sensitive approach. They also need to develop a more approachable attitude towards patients. Nurses should find a more receptive and sympathetic manner of communication with the patients, so that patients do not feel like they are being shouted at or are being disrespected.
- Medical anthropologists should be incorporated into the health system in South Africa to work alongside nurses and doctors, because South Africa is a very diverse country, with many different cultures and belief systems.
- More studies should be conducted that concentrate intensively on the different types of medicines that are being used by diabetic patients.

- More studies should be conducted to reveal proper and-up-to date information on diabetes and the different coping mechanisms among different race groups, so that more literature can be built up to help struggling diabetics to find coping mechanisms that are helping other diabetics.
- The government should sponsor Diabetes South Africa; it helps communities enormously and could do a lot more if it had money allocated to it by the government.
- The government should allocate money to buy glucometers for those who are unable to afford them, because they are a very important tool for diabetics. They allow diabetics to keep track of the glucose levels in their blood.

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## APPENDICES

### APPENDIX A

#### Interview schedule

1. Are you getting any help from your family members to manage your diabetes, if yes how do they help you?
2. Do you feel that your family members understand diabetes and the causes?
3. Does the family know which type of diabetes you have; if yes are they aware of how to assist you if you happen to get ill/complications?
4. Do your friends assist you in anyway?
5. How knowledgeable are you with diabetes; do you read on diabetes, is there any other way of gaining knowledge and how is that assisting you in managing your diabetes
6. How knowledgeable are in on how to manage diabetes
7. What coping strategies do you have I place to manage diabetes
8. Do you work; if yes does your employer know about your diabetic condition and how do they help?
9. How long have you been associated with this diabetic clinic that you are currently using?
10. How much assistance are you getting from the clinic?
11. Are you now selective of the foods that you eat?

12. Are you using any traditional herbs or medicine; do you see a difference in using them if you do?
13. Do you use both traditional and western medicine?
14. Where do you get your traditional medicine/ how did you come to know about your supplier?
15. Have you been given new instructions on a new diet; are there any changes that you are facing with the new diet?
16. How much do you do you earn; how big is your family; how big is the size of your household; are you the bread winner?
17. Why are you not using a bangle that indicates that you are diabetic?
18. How do you manage church fasting since you are diabetic?

## **APPENDIX B**

### **Informed Consent Form**

My name is Yonela Scina and I am currently enrolled in a Masters degree in Anthropology at the University of KwaZulu-Natal My Student registration number is: 207514930

I am conducting a study of the coping mechanisms that are used by black diabetic women. This study intends to find out strategies that are in place for black diabetic women in managing their disease, the relevant networks that they have within their families and communities on the management of diabetes looking also at the cultural meanings and attachments that have been given to diabetes.

You have been chosen as a possible participant in the study. Participation in this study is voluntary, you may, at any stage, withdraw from this interview or choose not to answer any of the questions that you may not be comfortable with. For the purpose of this research study, your comments will be anonymous unless you request that your personal information be revealed and used. I will make all possible efforts to preserve confidentiality including using pseudonyms and arranging a secure place for data storage. Information gathered through this study may be published in academic journals and presented orally. But here too your confidentiality will be maintained.

Please note that there will be no form of compensation.

Should you agree to take part in this study you will be required to take part in an in-depth interview which will allow you to express your feelings regarding the topic at hand. Interviews will be between 30 and 45 minutes. Should there be a need for another schedule your permission will be requested. With your permission all interviews will be tape recorded and transcribed.

Would you like to continue with the interview? YES \_\_\_\_\_ NO \_\_\_\_\_

If you have answered 'YES' above please fill in the agreement and consent section below which we will both sign and keep a copy of.

My Name/Signature: Yonela Scina \_\_\_\_\_

Participant Name/Signature: \_\_\_\_\_

Date \_\_\_\_\_