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LIVED EXPERIENCES OF PEOPLE LIVING WITH HIV AND HYPERTENSION WITH REGARD TO DISEASE MANAGEMENT IN THE EASTERN CAPE

BY

LWANDILE TOKWE

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NAME: Lwandile Tokwe

STUDENT NUMBER: 213313774

QUALIFICATION: Master of Nursing (Research)

TITLE OF PROJECT: Lived experiences of people living with HIV and hypertension with regard to disease management In the Eastern Cape

DECLARATION:

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SIGNATURE: L. Tokwe

DATE: 1/11/2019

DEDICATION

This study is dedicated to all my clients at Primary Health Care clinics who are living with the co-morbidity of HIV and Hypertension.

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ABSTRACT

Globally, approximately 36.9 million people in 2017 were reported to be living with the human immunodeficiency virus (HIV) across the world. In South Africa, 7.52 million people in 2018 were reported to be living with HIV. In light of the increased life expectancy among people living with HIV (PLWH), which is attributed by availability and enrolment to Highly Active Antiretroviral Therapy (HAART), chronic non-communicable diseases (NCDs) compound the management of HIV in PLWH. South Africa is encountering a burden of communicable diseases and NCDs, in particular, the co-morbidity of HIV and hypertension (HTN).

The aim of the study was to explore and describe the lived experiences of people living with HIV and HTN with regard to disease management in the Eastern Cape. Qualitative research design was used and amongst its methods, Husserl's descriptive phenomenological method was utilized to explore the lived experiences of the participants.

The Health Belief model was the theoretical framework that underpinned the study. The study was conducted at Sakhisizwe sub-district located in the Eastern Cape Province, South Africa. The target population were adults living with HIV and HTN who were accessing care from Primary Health Care (PHC) clinics and who met the researcher's inclusion criteria. A purposive sampling method was used and nine participants were interviewed using semi-structured interviews. The data was analysed using Giorgi's (1985) phenomenological method of data analysis which facilitated the emergence of the themes from the data. Four themes and 14 sub-themes emerged. The participants reported that they experienced illness-related stigma, support of different influential people, self-love in the form of taking ownership of the diseases, experience of creating self-care practices and transforming lifestyle modification behaviours. Recommendations for clinical practice were made to support the professional nurses in the management of the HIV and HTN in the PHC setting. The study findings reflected the lived experiences of the patients of the selected setting and was conducted only in one province rather than in the entire South Africa.

KEY WORDS: HIV, HYPERTENSION, LIVED EXPERIENCES, PHC

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ABBREVIATIONS

AIDS	–	Acquired Immunodeficiency Syndrome
ART	–	Anti-retroviral Therapy
BP	–	Blood pressure
CCMDD	-	Centralized Chronic Medicines Dispensing and Distribution
DM	–	Diabetes Mellitus
FCD	–	Fixed Combination Dose
GBD	–	Global Burden of Disease
HAART	–	Highly Active Antiretroviral Therapy
HBM	–	Health Belief Model
HIV	–	Human Immunodeficiency Virus
HSFSA	–	Heart and Stroke Foundation South Africa
HSRC	–	Human Sciences Research Council
HST	-	Health System Trust
HTN	–	Hypertension
ICRM	–	Ideal Clinic Realization and Maintenance
NCDs	–	Non-Communicable Diseases
NDOH	–	National Department of Health
NIDS	–	National Indicator Data Set
PC	–	Primary Care
PHC	–	Primary Health Care
PLWH	–	People Living with HIV
PMTCT	–	Prevention of Mother to Child Transmission
RDP	–	Reconstructive Development Programme
RNA	–	Ribonucleic Acid
STI	–	Sexually Transmitted Infections

TB – Tuberculosis

TROA – Total Remaining on ART

UNAIDS – The Joint United Nations Programme in HIV/AIDS

WBOT – Ward based Outreach Teams

WHO – World Health Organization

CHAPTER ONE

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Globally, the health care system is burdened with the rise in communicable diseases which are compounded by the co-morbidity of non-communicable diseases (NCDs). Such burdens are placing a strain on the health care system (Nguyen, Peer, Mills & Kengne, 2015:4; Maseko & Masuku, 2018:2; Rodriguez-Fernandez *et al.,* 2016:6). In South Africa, it is reported that a quadruple burden of diseases such as communicable diseases (HIV and Tuberculosis), maternal and child mortality, NCDs such as hypertension (HTN), Diabetes mellitus (DM) and injury-related mortality is experienced (World Health Organization, 2018a:1; Pillay, van-Wyk, Msemburi, & Laubscher, 2016:642; Groenewald, Bradshaw, Day & Laubscher, 2015:218; Basu, 2018:48). Amongst the quadruple burden of diseases experienced, there is an increase in the co-morbidity of HIV and HTN in South Africa and this trend is evidenced by the rise in the number of people living with co-morbidities of both communicable and NCDs in Africa (Lalkhen & Mash, 2015:134). HIV is reported to be responsible for infecting 76.1 million people since it was identified as a health burden globally (The Joint United Nations Programme in HIV/AIDS, 2017). In addition to HIV, Abegaz *et al.* (2017:1) state that globally HTN is the leading heart disease across the world, and due to the rate at which it occurs, is projected to rise by a rate of 30% by 2025. In 2016, it was reported that 19.4 million people were living with HIV in Eastern and Southern Africa (UNAIDS, 2017). A study by van Zoest, van den Born and Reiss (2017:513), found that HTN trends in people living with HIV (PLWH) are more highly increased than in people not infected with HIV and the predisposing factors leading to this burden include lifestyle factors, genetics, use of Highly Active Antiretroviral Therapy (HAART) and environmental factors. Supporting this, Medina-Torne, Ganesan, Barahonna and Crum-Cianflone (2012:23) discussed that there was an increased prevalence of HTN of 31% among PLWH in both male and female participants with median age of 41 years.

According to Statistics South Africa (2018:7), the number of PLWH in South Africa has increased from 4.25 million in 2002 to 7.52 million in 2018, with 13.1 % of the general population living with HIV. Moreover, it is noted that the success of HAART has resulted in a decrease of HIV related deaths from 37.29 in 2002 to 22.06 in 2018 (StatsSA, 2018:7). Similarly, Molapo and Massyn reported that approximately 7.9 million people in South Africa are living with HIV (2018:191). While this echoes positive public health advances with regard to HIV interventions, the resultant effect of an ageing population of PLWH also presents unique health care challenges, in particular the management of HIV and the rise of commonly occurring non-communicable diseases, in particular HTN (Balt, 2013:127). Supporting this, is the recent empirical evidence which highlights the dual burden of HIV and HTN currently experienced in South Africa (Ameh *et al.,* 2017:473; Boccara *et al.,* 2013:511). Similarly, Juma *et al.* (2019:7) argue that Sub-Saharan Africa is burdened with a rise of NCDs in PLWH.

The Eastern Cape (EC) is the second largest province in South Africa and is predominately rural, still reports a significant prevalence of HIV and NCDs (Human Sciences Research Council (HSRC), 2018:3; Monakali *et al.,* 2018:3; Morris-Paxton, Rheeder, Ewing & Woods, 2018:4). The recent national reports from the Health Systems Trust (HST) highlight that 57.6% of the total remaining on Antiretroviral care (TROA) in the Eastern Cape (HST, 2018:202). Similarly, to that of HIV, HTN prevalence in the Eastern Cape was reported to be 21.9% in 2016/2017 (Kengne & Sayed, 2017:186). This supports the results of a study conducted in the Buffalo City Metropolitan of the Eastern Cape; which demonstrated that almost 49% of the participants had a diagnosis of HTN (Owolabi, Ter Goon, Adeniyi & Seekoe, 2017:3). Moreover, the prevalence of HTN in 2016 was reported to be 53.7% in the Eastern Cape (StatsSA, 2016:7).

1.2 BACKGROUND OF THE STUDY

Globally, approximately 36.9 million in 2017 were known to be diagnosed with HIV across the world and 21.7 million PLWH enrolled in HAART care and of that, 35.1 million are adults (UNAIDS, 2018:1). The recent empirical evidence highlights an increase in PLWH from the year 2016 to 2017 from 36.7 million people that were reported. Further to this, the number of PLWH enrolled to HAART also increased from 18.2 million to in 2016 to 21.7 million in 2017 (World Health Organization, 2017:30, UNAIDS: 2017:1). In addition, the number of AIDS-related deaths has decreased from 2016 to 2017 due to the access of PLWH to HAART from 1.1 million AIDS-related deaths in 2016 to 940 000; therefore, this clearly indicates that HIV is becoming a chronic manageable illness with more people living longer (UNAIDS, 2018:5; UNAIDS, 2016:3). While HIV continues to rise in the world, another health burden, which is the NCDs, has been reported to increase in the world. NCDs are reported to be the leading cause of death in the world and are the main challenge in the low and middle income countries (WHO, 2018b:7). Further to this, in 2016 NCDs were responsible for approximately 71% of the 57 million world deaths (WHO, 2018d:11).

In South Africa, NCDs such as HTN have been reported to account for 51 % of the country's deaths. In a sub-Saharan study done in 2018 in exploring regional and sex differences in the prevalence of HTN and assessing the awareness of HTN among adults in the Eastern, Western and Southern Africa, looking at both genders, it was reported that the prevalence of HTN in South Africa in the selected sites was above 40% as compared to parts of the African region such as Kenya and Ghana (Gomez-Olive *et al.,* 2018:3). The prevalence of NCDs in South Africa has been associated with the predisposing factors such as obesity, excessive alcohol consumption, high salt intake in the diet and sedentary lifestyle (WHO, 2018:8). Based on these reports, South Africa has a burden of disease.

Furthermore, studies have demonstrated that there is an established link of HTN being especially prevalent among PLWH due to several risk factors such as age, being overweight and other HAART medication (Antonello *et al.,* 2015:403; Medina-Thorne *et al.,* 2012:20; Lloyd-Sherlock, Ebrahim & Grosskurth, 2014:8). The established link and rise of HTN among PLWH on chronic medication predisposes to poor medication compliance. According to the South African National Department of Health (NDOH, 2016a:7), compliance to chronic medication, in particular NCDs, TB and HIV, is a problem that is continuing to expand. This is demonstrated by a study conducted by Addo, Sencherey and Babayara (2018:4) which reported that 61.7% of PLWH and 53.3% of people with HTN were non-adherent to their chronic medication, hence responsible for an overall percentage of 55.5% of non-adherence. Further to this, the co-morbidities of chronic conditions such as HIV and HTN in people on chronic care result in poor adherence to medication due to factors associated with time schedules of taking medication and the quantity of the medication (Monroe, Rowe, Moore & Chander, 2013:4).

1.2.1 The change in the health profile

Recent research demonstrates a global trend of changes in the health profile of many countries; this is particularly noted in the rise of NCDs in many developed and developing countries, such that by 2035, PLWH are estimated to be living with a co-morbidity of NCDs with a rate of 15.2% (Smit *et al*., 2018:1).

Globally, in the past 30 years, HIV has been a health concern which poses a threat to the number of years people are living due to its mortality and morbidity rate in developing countries such as Zimbabwe, Swaziland, Botswana and South Africa (Maseko & Masuku, 2017:1). In addition, 6.7 million people are reported to be living with HIV, which is accountable for 1 million deaths from AIDS-related illnesses (UNAIDS, 2017:12). The initiation and access to HAART to PLWH has decreased the mortality rate from 1.5 million deaths in 2000 to 940 000 deaths in 2018, making HIV to be a long-term illness and thus increasing the life expectancy of PLWH (Medina-Thorne *et al.,* 2012:20; van der Valk & Reiss, 2017:1481; UNAIDS, 2018). Consequently, PLWH are encountering a prevalence of age-related non-communicable diseases, in particular HTN (Geuye *et al*., 2017:728; Losina *et al.,* 2017:1266). In addition, South Africa has the highest number of PLWH ever since the access to HAART with an estimated number of 7.9 million reported to be living with HIV and 115 167 deaths in 2018 (Levitt, Steyn, Dave & Bradshaw, 2011:1690; UNAIDS, 2018:40; StatsSA, 2018:7). Recent reports by the WHO (2018:26); and the National Institute for Communicable Diseases (NICD) (2018:11) indicate that South Africa in 2016 was accountable for a rate of 5.58% of HIV new infections and 199 700 people newly infected with HIV aged 15 to 49 years in 2017. In addition to HIV, 6.2 million people are living with HTN and of these 3.2 million have blood pressure >160/90 mmHg which is above normal range, and approximately 53 men and 78 women die daily from the effects of HTN (Rayner, 2013:3). Furthermore, a research study by Ntuli *et al.* (2015:3), which explored the prevalence of HTN in rural South Africa, reported that HTN was prevalent by 41.4% and predisposing factors included advances in age.

The incidence of HTN in South Africa is increasing and while this increase is observed, similar trends at a provincial level are taking place. People aged 40 years and older are being diagnosed with HTN especially at this age range and this causes a change in the health profile. This is supported by the South African Health Systems Trust, that found the incidence of HTN in South Africa was 19 per 1000 population in adults aged 40 years and older which is an increase from 2015/2016 incidence rate (Kengne & Sayed, 2017:186). Furthermore, the incidence of HTN diagnosis in 2016/2017 in the Eastern Cape Province was 22 per 1000 population aged 40 years and older while in the Chris Hani district of the Eastern Cape, the HTN incidence was 27.2% in 2016/2017 indicating a rise of 10 per 1000 population aged 40 and above from 2014/2015 report.

HAART in South Africa was introduced to the public health setting in 2004 (UNAIDS, 2014; Nattras, 2007:131). Ever since the access to HAART, it was noted that the lifespan in PLWH increased thus the frequency in PLWH on treatment also rose. This is evidenced by increased access to HAART of clients of 50 years and older with a rate of 42.7% and a rise in the access to HAART in PLWH aged 15 to 49 years with the rate of 28.9% in 2012. Among the 6 422 177 PLWH reported in 2012, 2 002 350 of these were on HAART, and the percentage of females (34.7%) was high as compared with males with 25.7% (Shisana *et al.*, 2014: 56). In further explaining the increased life expectancy, 4.2 million PLWH aged 50 and above were reported (UNAIDS, 2014:3).

1.2.2 Non-communicable diseases

PLWH are at an increased risk of developing NCDs which decrease life expectancy. NCDs are reported to be responsible for mortality of clients both in the universe as well as at a country level and they were accountable for 43.3% deaths in 2012 (Pillay-van Wyk*, et al*., 2016:646). NCDs, including heart diseases, high blood pressure; diabetes and HIV, are collectively the dominant causes of the overall burden of disease (Global Burden of Disease (GBD) 2013 Mortality and Causes of Death Collaborators, 2014:117; WH0, 2013:9). Globally, non-communicable diseases contribute towards 63% of the 57 million deaths annually (Pfaff, Scott, Hoffman & Mwagomba, 2017:1). In addition, recent studies reveal that the deaths caused by NCDs take place in low and middle-income nations (Price *et al.,* 2018:208; WHO, 2014:10; van Heerden *et al.,* 2017:1). According to Pillay-van Wyk, Dorrington and Bradshaw (2017:1), cardiovascular disease such as HTN were reported to be the leading NCDs responsible for increase in mortality rate in South Africa. Recently, 26.2% of mortality rates have been reported to be due to NCDs in South Africa (WH0, 2018c:31).

In South Africa, it is reported that in 2016, 46% of women and 44% of men were living with high blood pressure from the age of 15 years and above (South Africa Demographic and Health Survey, 2016:18).

1.2.3 Effects of HIV on hypertension

The burden of living with a co-morbidity of HIV and HTN is noted to be contributing to the negative health outcomes. Chhoun *et al.* (2017:12) argue that NCDs such as high blood pressure and others like heart diseases and DM, have direct and indirect interaction with HIV infection and HAART. The interaction and the relationship between these illnesses appears to be true, based on the evidence that predisposing factors such as the diet eaten and the way of life of the clients linked to NCDs are noticeable, as noted in their cross-sectional study which explored the prevalence of Diabetes Mellitus, HTN and hyperlipidaemia, as well as risk factors in men and women living with HIV in Combodia (Chhoun *et al.*, 2017:12). In this study, the prevalence of hyperlipidaemia, DM and HTN ranged from 9.4, 15.1 and 33.7% and the mean systolic blood and diastolic blood pressure was high in males as compared to females (Chhoun *et al.*, 2017:12). In addition, predisposing factors such as high smoking behaviour and alcohol usage, eating less fruit and vegetables and a sedentary lifestyle were noticed in PLWH in this study (Chhoun *et al.*, 2017:12). Therefore, the predisposing factors mentioned above increase the risk of NCDs in PLWH.

However, Medina-Torne *et al.,* (2012:23) argue that HAART is not connected with HTN but rather the duration of the treatment that has an effect on the vascular changes on clients living with HIV that are caused by the virus, thus increasing blood pressure. Supporting this, there are several studies that highlight age as a modifying determinant of HTN among people living with HIV, especially people over the age of 40 years (Temu *et al.,* 2016:3; Antonello *et al.,* 2015:406). In further explaining the interplay in HIV and HTN, Maseko and Masuku (2017:2); Cheppchirchir *et al.* (2017:5) and Bloomfield *et al.* (2015:1) argue that as the age of PLWH on treatment increases, the risk of developing NCDs like HTN also increases.

1.2.4 Co-morbidity between communicable and NCDs

The prevalence in the co-morbidity of HIV, TB, DM, HTN and mental illnesses in the world and national is increasing. In South Africa, the spontaneous co-occurrence between communicable diseases such as HIV, TB and NCDs like HTN is reported to be increasing, hence causing an enormous strain in the health care system in the country (NDOH, 2016a:3). In addition, a cross-sectional study done by Oni *et al.* (2015:4), which described the epidemiology of multiple morbidities in Khayelitsha primary health clinic, revealed that out of all the diagnoses in the setting, HIV, HTN, TB and DM were responsible for most of clients coming to clinic for medication follow up of these illnesses and were reported to be accountable for 45% of the medications issued in the clinic. Furthermore, 95% of the participants had the co-morbidity of HIV and DM and it was frequently observed, 5% had the co-morbidity of HPT, DM and HIV. DM clients were reported to have 97% co-occurrence with HTN; 81.1% of TB clients had a co-morbid illness of HIV. The study in the management of co-morbidities suggested that more needs to be done on the models of integration of care to ensure optimal integration of these illnesses in the clinical settings. Similarly, Masuku and Maseko (2016:1) argue that HTN and DM are responsible for the incidence of diseases in PLWH and deaths as well. Furthermore, the co-morbidity of DM and HTN is contributing to the incidence of illnesses in developing countries that are adding to HIV which is an epidemic alone.

While South Africa is faced with the increased number of PLWH, an additional growing incidence of cardiovascular diseases is reported to increase as well (NDOH, 2016a:3; Levit, Steyn & Bradshaw, 2011:1690). In addition, recent literature demonstrates that South Africa has the largest number of HIV incidence reported to be responsible for 19% of the world's PLWH, including a rate of new infections reported to be 15% and mortality of 10% (UNAIDS, 2016). NCDs are also increasing and are predisposed by the way clients live and were reported to be accountable for 30% of the mortality rates in 2012 (Levitt *et al*., 2011:1690). HTN is reported to be accountable for most deaths in South Africa (Siko & van Deventer, 2017:72).

1.2.5 Gaps in the management of HIV and HTN

South Africa has a substantial number of PLWH being treated for HIV, TB and NCDs that are increasing (NDOH, 2016:13). While there is this increase, lack of integration in the management of chronic illness, in particular HIV and HTN, has been noted. This suggests a gap in how the professional nurses in the PHC context are managing PLWH and other co-morbidities, one being HTN. This gap is demonstrated by a study by Mutemwa *et al.* (2016:282) which highlights that PLWH aged 40 years and above in the clinics are still being missed from being screened for HTN, thus the increased prevalence of HTN in PLWH. Furthermore, another South African study by Knight, Schatz, Ferdinand and Mukumbang (2016:4), which explored the barriers of older PLWH and an NCD as co-morbid illness, were being treated for the two illnesses in different clinics. The study results showed that many older PLWH were being treated for HIV in one clinic and NCD in another clinic, suggesting that patients had to go and be treated at different clinics for HIV and HTN. This demonstrates lack of integration of HIV care and other chronic NCDs due to lack of support to the PHC Nurses to manage people living with co-morbid illnesses of HIV and NCDs.

1.2.6 Roles of PHC Nurses in the management of HIV and HTN

The PHC nurses have been managing the PLWH and HTN using different guidelines provided by the NDOH. The role of PHC nurses regarding the management of HIV and HTN is changing. Previously the NDOH (NDOH, 2014:4:16) introduced the essential guidelines to manage the illness by PHC nurses which had a stepwise approach that the PHC nurse had to follow to ensure that the HTN is managed properly, which had five steps. Once the client’s blood pressure becomes greater than 140/90 mm Hg on separate occasions in the clinic, the client is started on high blood pressure care (NDOH, 2017:73) as stipulated in the Primary Care (PC) 101 guidelines by NDOH (2014:74) if the BP is controlled on treatment, the PHC nurse should continue with the medication that is used, then check the client in six months. Currently there are new Adult Primary Care (APC) guidelines (2017:81) which require the PHC nurse to follow in the management of HTN of a patient as stipulated. In addition to HTN, the NDOH introduced the national consolidated guidelines for prevention of mother to child transmission (PMTCT) and management of HIV in children, adolescents and adults in 2015. The NDOH (2015:72) states that for PLWH to be initiated on HAART treatment, the following criterion must be met, that is: The CD4 count should be less than 500 cells/ul regardless of the WHO clinical stage. In 2016 an integrated adherence guideline for HIV, TB and NCDs was introduced with the aim of increasing life expectancy to 70 years and reduce the incidence and uncontrollable effects of NCDs in clients with co-morbidities (NDOH, 2016:3) However, contrary to the 2015 National consolidated guidelines, in 2016 the NDOH issued a circular to all relevant health practitioners in following the fast-tracking implementation of the 90-90-90 strategy for HIV, through implementation of a universal test and treat policy and same day initiation to HAART of PLWH. In the current Universal test and treat protocol, all PLWH are initiated on HAART regardless of the CD4 count (NDOH, 2016:1). With these changes in the management of HIV and HTN, there are lack of recommendations to support the PHC nurses in the management of people living with HIV and HTN. The guidelines only focus on TB and HIV and TB co-infection and the PHC nurses are not supported in how to manage the HIV and HTN co-morbidity.

1.3 PROBLEM STATEMENT

Presently, South Africa is challenged with an increase of people living with HIV and HTN. This is demonstrated by various studies which report on the dual burden of care currently experienced in South Africa of HIV and HTN (Mutemwa *et al.,* 2016:282; Sehole & Van Der Heever, 2016:95; van Heerden *et al.,* 2017:3). Further to this, it is also demonstrated that the co-morbidity of HIV and HTN is especially prevalent among adults over the age of 40; this is evidenced by studies conducted in South Africa by Manne-Goehler *et al*. (2017:7) and Clark *et al*. (2015:7). Moreover, it is reported that people living with a co-morbid illness of HIV and HTN often experience a challenge of treatment compliance burden and this leads to poor retention to treatment (Abara *et al.,* 2016:2677; NDOH, 2016:7). Furthermore, studies conducted demonstrate that people living with the two co-morbid illnesses tend to struggle to balance the treatment management which results in them putting more attention to one illness, hence, resulting in poor adherence to medication (Monroe *et al.*, 2018:205; Temu *et al.,* 2016:4).

The researcher who is currently working in a PHC clinic in Sakhisizwe sub-district observed similar trends as evidenced in the literature that there is a greater burden of disease management among PLWH and a co-morbid illness of HTN, who are older than 40 years. The researcher observed that PLWH and HTN struggle to accept the diagnosis of the two illnesses which tend to affect their adherence to the medication. The researcher observed that a problem to accept the diagnosis and non-adherence to medication is also associated with the different time frames of taking the medication and this often leads to one condition being given more attention than the other. In addition, the researcher also observed that PLWH and HTN often have their viral loads unsuppressed and the BP remaining above 140/90 mmHg. Therefore, this leads to poor retention and health outcome to chronic care. Furthermore, there is limited research on the experiences of people living with HIV and HTN in the rural areas of South Africa. There is also a paucity of evidence on the recommendations to support PLWH and HTN especially within the PHC setting. With this gap noted, the researcher became motivated to explore these lived experiences.

1.4 RESEARCH QUESTION

The central research question guiding this study was "*What are the lived experiences of people living with HIV and HTN with regard to disease management?"*

1.5 AIM OF THE STUDY

The aim of the study was to explore and describe the lived experiences of people living with HIV and HTN with regard to disease management. Further to this, the study aimed at making recommendations on the management of HIV and HTN by professional nurses working in a PHC setting.

1.6 RESEARCH OBJECTIVES

The research objectives which underpinned the central research question were to:

- 1.6.1. Explore and describe the lived experiences of people living with HIV and HTN in the Sakhisizwe Sub-district, Eastern Cape;
- 1.6.2. Explore and describe the facilitating conditions and inhibitory conditions experienced by people living with HIV and HTN with regard to disease management in the Sakhisizwe Sub-district, Eastern Cape;
- 1.6.3. To make recommendations on the management of HIV and HTN by professional nurses working in a PHC setting.

1.7 SIGNIFICANCE OF THE STUDY

This study had a potential of contributing to generation of knowledge in the following areas: Nursing practice, education and research.

1.7.1 Nursing practice

The findings of the study will be used according to the understanding of the lived experiences of PLWH and HTN. Secondly, it is anticipated that the findings of this phenomenological study can used to make recommendations that can be used to support professional nurses working in the PHC context with regard to disease management of PLWH and HTN.

1.7.2 Nursing education

It is hoped that the study findings will make recommendations to Nursing Colleges and Universities in educating the community health students and PHC students regarding the management of PLWH and HTN in the PHC context as part of the exit outcomes in an undergraduate and post graduate level.

1.7.3 Nursing research

The study findings will provide recommendations for further research regarding the management of HTN and HIV by professional nurses in the rural PHC context.

1.8 CONCEPT CLARIFICATION

In this section, the key concepts, together with how they will be used in the study, will be discussed.

1.8.1 Facilitative condition

According to Kiem and Dahlsten (2008:603), a facilitative condition refers to a condition that intensifies a curative relation to produce desirable result. In this study, the facilitative condition referred to conditions that were experienced by the participants that enhanced effective management of their co-morbid illnesses.

1.8.2 Hypertension (HTN)

Hypertension refers to a systolic blood pressure of ≥ 140 mmHg and diastolic blood pressure ≤ 90 mmHg which is measured on two different occasions in a health setting in a period of two weeks (Divala *et al*., 2016:2). In this study, hypertension will refer to a diagnosis of a blood pressure above 140/90 mmHg receiving anti-hypertensive medication.

1.8.3 Human Immunodeficiency Virus (HIV)

HIV is defined as a single stranded Ribonucleic Acid (RNA) which is capable of destroying the bodily system cells, particularly the CD4 cells that protect the body against foreign substances. When the HIV attacks the body cells in its developed stage, it causes a failure in the immune system to combat any virus so that during such stage the CD4 cells decrease (NDOH, 2014:11.16). In this study, HIV refers to a positive diagnosis of HIV.

1.8.4 Inhibitory condition

According to Thurston and Cassaday (2015:69), inhibitory conditions come into existence when the stimulus prohibits an action that commonly happens or is encountered in a specified state. In this study, an inhibitory condition refers to conditions experienced by participants that prevented or hindered the management of the co-morbid illnesses.

1.8.5 Lived experience

Boylorn (2012:2) defines lived experience as the first-hand accounts and impressions described by people undergoing a specific phenomenon or event, which is usually investigated through qualitative research methods. In this study, lived experiences refer to the accounts and personal descriptions of the participants with regard to living with HIV and HTN, in particular their experience of managing with both diseases.

1.9 THEORETICAL MODEL

It is important to emphasize that there are debates regarding the use of a theoretical model in phenomenology. This is demonstrated by some scholars in a qualitative inquiry that have argued against the use of a theory in phenomenology (McLoed (2001:34; Creswell, 2007:94). However, Tavallaei and Abu Talib (2010:575) argue that in Husserlian phenomenology, a theoretical model is discreetly connected with methodology. Similarly, Creswell (1994:94) argues that in a qualitative inquiry, a theory may be unfolded later in the data gathering process and analysis of the research process and be utilised. Furthermore, another argument by a phenomenological scholar, Gorgie (1985), as cited in Tavallaei and Abu Talib (2010:575), suggests that a theoretical approach is crucial for sciences that are based on a branch of knowledge.

The theoretical framework that underpinned the study was the Health Belief Model (HBM). According to Rosenstock (1974:3), the HBM was originally formulated to explain (preventive) health behaviour. This health behaviour is defined by Kasl and Cobb (1966:246) as any activity undertaken by a person with an intention of promoting health and preventing diseases. According to Rosenstock (1974), the HBM is made up of the following constructs, namely:

1. The perceived susceptibility which refers to an individual's belief of the likelihood of having a disease or an illness;
2. Perceived severity which refers to a person's outlook or perspective on the seriousness of the disease or illness;
3. Perceived benefit which refers to an individual's belief on the benefit of pursuit that will prevent or minimize a condition from occurring;
4. Perceived barriers which refer to a person's belief about prohibitory factors to a health pursuit which can include funds, inconvenience, or characteristics of the treatment - one being side effects;
5. Cues to action refer to a person's preparedness to engage in an activity to minimize the illness, and self-efficacy is the person's assurance in engaging in the pursuit. The person may engage in the activity or action if he is of the view that the cue has a possibility of preventing or minimizing the illness (internal cue) or using a prescribed advice (external cue).

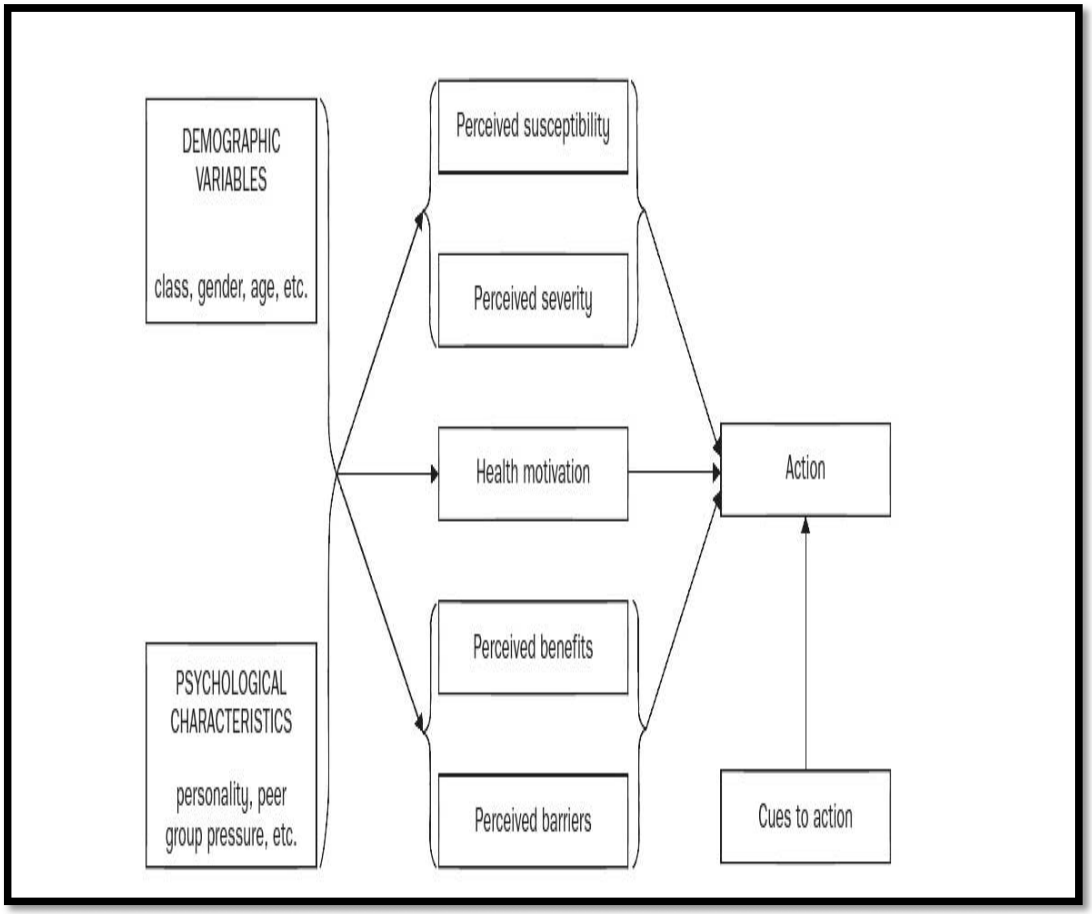


Figure 1.1: The Health Belief Model (Abraham & Sheeran, 2005:32).

The HBM has been used in several studies in the PHC context in guiding qualitative research in the PHC and for exploring health beliefs of patients. In a study conducted by Al Subhi, Kendall, Al-Shafae and Al-Adawi (2016:2), HBM guided the study in exploring the health beliefs of people with DM type 2 in PHC. Similarly, the HBM has been used also by Aldohaian, Alshammari and Arafah (2019:4) to assess the beliefs and behaviours regarding cervical cancer screening among Saudi women in the PHC. Moreover, in a study conducted by Martinez *et al.* (2016:3), which explored the effect of changes in health beliefs among African-American and rural white church congregants enrolled in an obesity intervention, a qualitative evaluation, HBM, was used in women in living with a co-morbidity of HTN and DM. Therefore, based on the similarities in terms of the context and the type of participants, as well as the HBM used, it was deemed appropriate to allow the study to be underpinned by it in exploring the lived experiences of PLWH and HTN in the PHC context.

1.9.1 Application of the Health Belief Model to the study

The researcher used the HBM in describing the lived experiences of people living with HIV and HTN and the model assisted the researcher in probing the lived experiences in PLWH and HTN. The researcher applied four constructs of the HBM, namely the perceived severity, perceived benefit, perceived barriers and the cues for action in this study. In perceived severity, the researcher sought to explore and describe the lived experiences of PLWH and HTN to get the meaning that is perceived by PLWH and HTN about the seriousness of living with two life-threatening chronic illnesses. This construct assisted the researcher in establishing which illness between the two the participants perceived to be severe, as compared to the other. With perceived benefit, the researcher used the HBM to explore the facilitating conditions that are experienced by PLWH and HTN that promote health behaviour of compliance to the medication. This construct assisted the researcher in probing and identifying the facilitating conditions experienced by PLWH and HTN with regard to the management of the two illnesses. With perceived barriers, the researcher used the HBM to explore the inhibitory conditions experienced by PLWH and HTN that hinder the management of the two chronic illnesses. The construct assisted the researcher in exploring the factors that hinder the management of the two co-morbid illnesses. The remaining two constructs, namely cues of actions and self-efficacy, assisted the researcher in establishing ways and actions which enabled and assisted PLWH and HTN in the management of the two chronic illnesses. The researcher applied the HBM constructs in describing the exhaustive description of the lived experience of PLWH and HTN.

1.10 LAYOUT OF THE STUDY

Chapter One: Overview of the study
Chapter Two: Literature control
Chapter Three: Research methodology
Chapter Four: Presentation of findings
Chapter Five: Discussions of the findings and conclusions
Chapter Six: Summary, conclusions, recommendations, limitations

1.11 SUMMARY OF THE CHAPTER

This chapter provided an overview of the study by outlining a brief introduction to the problem under study, the background of the study, problem statement, research question, study aim, research objectives and significance of the study. Further to this, the concept clarification that will be used throughout the study was briefly discussed. The following chapter will focus on the technical literature review that was conducted regarding the phenomenon under study.

CHAPTER TWO

LITERATURE CONTROL

2.1 INTRODUCTION

The aim of the study was to explore the lived experiences of PLWH and HTN with regard to disease management in the Eastern Cape and to make recommendations on the management of HIV and HTN by professional nurses in the PHC context. This chapter presents a brief overview of literature on the burden of HIV and HTN globally, nationally and provincially. Literature review refers to all written sources that are relevant to the phenomena under study (Brink, van de Valt & van Rensburg, 2012:71). In addition, the literature sources were used for the following purposes:

- To determine studies that have been conducted on the problem under study to establish what has been already researched in the topics of interest
- To collate the research findings with research studies that have been conducted on the phenomenon under study.

Conducting literature review in phenomenology has been surrounded by debates which include when it should be done and how wide a researcher should search. Fry, Scammell and Barker (2017:50) argue that in phenomenology, literature review forms an essential part in presenting the information that is known about the topic investigated. Supporting this, Streubert and Carpenter (2011:92) argue that a superficial literature review may be conducted to make certain of the importance of conducting a study, as well as the suitability of method selection.

2.1.1 Search strategy

The researcher employed the following online databases in acquiring relevant articles from different journals. Conceptual evidence was obtained from peer reviewed databases, namely: Google scholar, Pubmed central, SAe Publications, Science Direct, Taylor and Francis online and SpringerLink. The key words that were used are “living with HIV AND hypertension” and “co-morbidity of HIV AND hypertension”. Statistics for HIV and HTN were obtained from Google search engine which provided primary evidence with regard to the statistics, and search words were “HIV statistics in South Africa”, “Hypertension statistics in South Africa” and “HIV global statistics”. The researcher selected the search from recent articles since 2015. This provided the researcher with up to date articles that have been conducted on HIV and HTN and which are not older than 10 years.

2.1.2 Scope of the literature review

The first segment of the literature review was superficial for the purpose of orientating the researcher to HIV and HTN that are under study. It is important to note that given the study is phenomenology, the researcher searched for literature on both HIV and HTN so as to provide an overview of the topic under study which assisted in the significance of conducting the study and identification of gaps. Supporting this, Streubert and Carpenter (2011:92) argue that a superficial literature review may be conducted to make certain of the importance of conducting a study, as well as the suitability of method selection. It is important to emphasize that a full literature review on the disease management of HIV and HTN was conducted after data collection and analysis so as to achieve the methodological stance of bracketing. This is because in phenomenology, literature review is conducted after the researcher has conducted data collection and analysis to prevent the researcher’s openness to meanings of the lived experiences of PLWH and HTN from being clouded or affected (Brink *et al.,* 2013:72). Further to this, Streubert and Carpenter (2011:92) and Hamill and Sinclair (2010:20), as cited in Chan, Fung and Chein (2013:2), argue that delaying literature review helps the researcher to obtain refined descriptions of the participant’s lived experiences and it also prevents researchers from asking questions and analysing information for themes that are in the literature. Therefore, the literature search was done in a manner that excluded articles with experiences of people living with HIV and HTN, thus allowing the researcher to focus on the lived experiences of living with HIV and HTN as described by the participants. The second portion of the literature review was conducted after data collection and analysis to collate the findings of this study and the findings of other relevant studies that have been conducted, hence achieving literature control (Streubert & Carpenter, 2011:93; Brink *et al.,* 2012: 72). Furthermore, much of the second portion of literature review forms chapter five discussion of literature with research findings

2.2 HYPERTENSION AND HIV/AIDS

Hypertension refers to a systolic blood pressure of ≥ 140 mmHg and diastolic blood pressure ≤ 90 mmHg which is measured on two separate occasions in a health setting in a period of two weeks. Hypertension is further classified according to stages (I, II and III) and level of severity (mild, moderate and severe). For stage I, the level is mild where the systolic pressure ranges from 140-159 mmHg and the diastolic pressure ranges from 90-99; for stage II, the level is moderate with systolic blood pressure ranging from 160-179 and the diastolic pressure ranging from 100-109, and finally for stage III, the level is severe with the systolic blood pressure ranging from ≥ 180 mmHg and the diastolic blood pressure ranging from ≥110 mmHg (Divala *et al.* (2016:2).

The human immunodeficiency virus (HIV) contaminates the cells in the immune system, thus demolishing their capacity to function. Contamination with the virus results in the immune system being deteriorated. Hence, the immune system is considered incomplete when it can no longer serve its purpose of protecting against infectious diseases and illnesses. Furthermore, Acquired Immunodeficiency Syndrome refers to the progressive stages of the HIV virus (WHO, 2017:1). Similarly, van Dyk (2013:115) defines Acquired Immunodeficiency Syndrome as a number of symptoms of opportunistic diseases and cancers taking place in a body of a client whose immune system is already made deficient by HIV virus.

The access to HAART by PLWH has resulted in prolonged life expectancy across the world and the Sub-Saharan African region is amid the parts of the world that have achieved desired outcomes in the HAART programme (Manne-Goehler *et al.,* 2017:1). This is demonstrated by the empirical evidence in the parts of the region, namely Eastern and Southern Africa, that have increased in access to HAART care from 24% in the year 2010 to 54% in 2015 with above 10 million PLWH enrolled in HAART care (UNAIDS, 2016:3). While the HIV has moved from being a deadly disease to a chronic manageable illness amongst PLWH, Fiegl *et al.* (2016:5) argue that as the number of years increase in PLWH, there is also an increase in NCDs amongst them, such as HTN and DM, thus making PLWH to live with an NCD as a co-morbid illness.

2.3 THE BURDEN OF HIV AND HTN

The burden of HIV and HTN in adults is growing and the statistics have revealed that the trend occurs across the world, regionally and nationally. The statistics below will show the trends of both HIV and HTN.

2.3.1 Global trends

Globally, approximately 36.9 million in 2017 were known to be diagnosed with HIV across the world with 21.7 million PLWH being enrolled in HAART care, and of that, 35.1 million are adults (UNAIDS, 2018:1). While HIV continues to rise globally, there is also an increase in the number of people living with HTN. According to Lim *et al.* (2012:11) and WHO (2019) HTN is a cardiovascular disease that is increasing globally from 600 million to approximately 1 billion people living with HTN in 2008. Moreover, HTN is responsible for 9.4 million annual deaths on the globe. Mills *et al*. (2016:442) argue that in 2010 1.39 billion people were living with HTN, making up 31.1% of the world population. According to the Heart and Stroke Foundation South Africa (HSFSA) (2016:1) and WHO (2014:14), cardiovascular diseases are responsible for over 17.3 people annually worldwide, thus being responsible for 31% of the world's deaths. In addition to this, HTN is reported to be accountable for 13% of the world's deaths (HSFSA, 2016:3).

2.3.2 Regional trends

Sub-Saharan Africa is amid the regions in the world that has been able to attain an achievement in the HAART programme for PLWH (Manne-Goehler *et al*., 2017:1). In 2017 it was reported that in Eastern and Southern Africa, 19.6 million across this region were living with HIV and 12.9 million people were enrolled in HAART, a number which is high across all regions across the globe (UNAIDS, 2018:5). Further to this, the region had 380 AIDS-related deaths in 2017 and it is reported that approximately 66% of the PLWH in this region have had access to HAART. Moreover, this region has had an increase in the number of PLWH in contrast to the 2016 statistics of 19.0 million. However, in between 2016 and 2017, the number of AIDS related deaths decreased from 470 000 AIDS affiliated deaths to 380 000 PLWH (UNAIDS, 2018:6; UNAIDS 2016:4). This evidence therefore highlights that while the people living with

HIV increase in this region, the deaths are becoming low as HIV now is becoming a chronic illness and more people are enrolled in HAART.

2.3.3 South African Trends

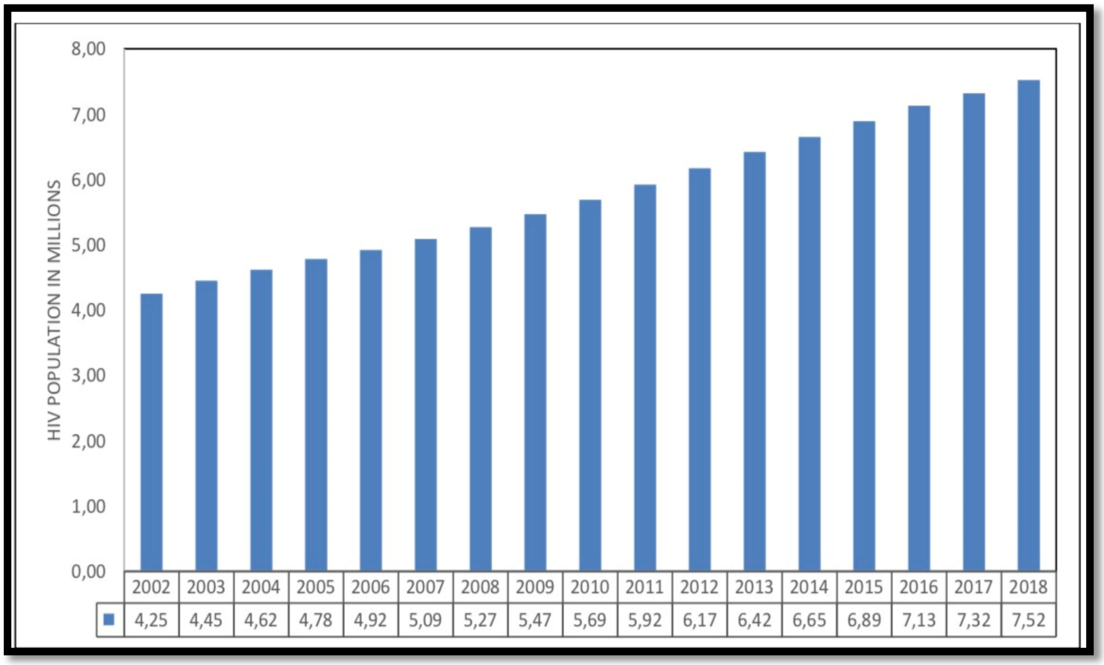
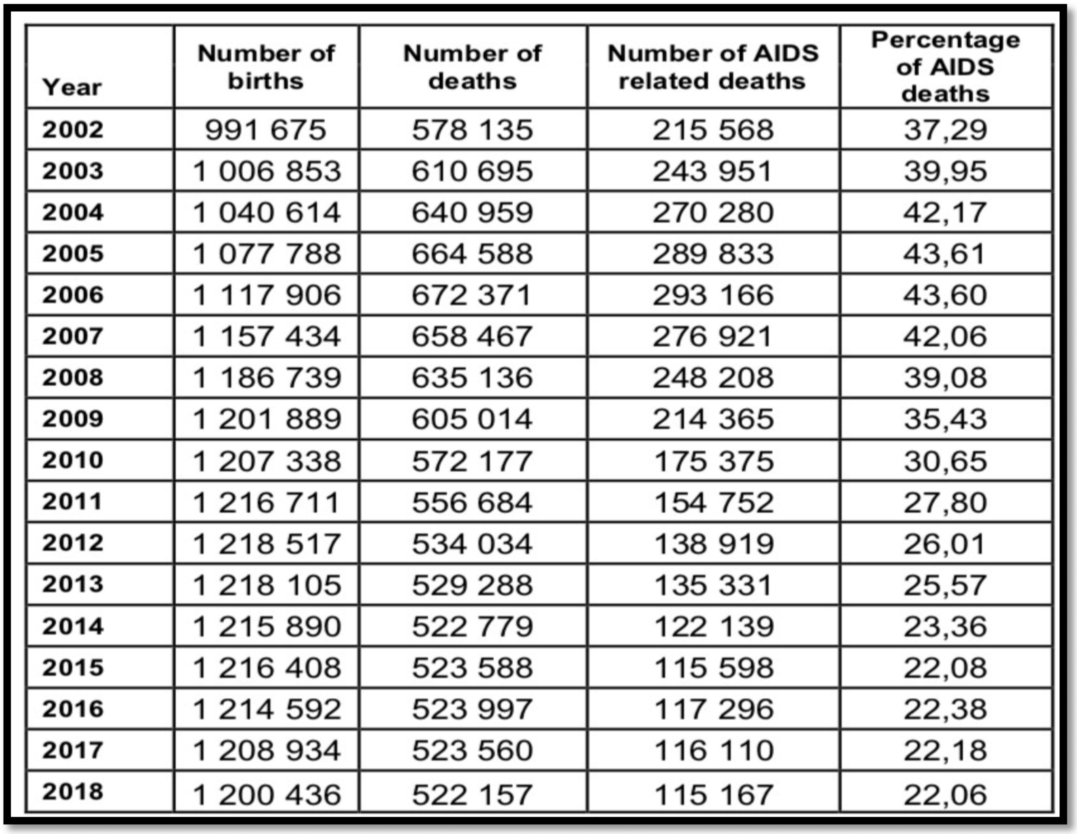


Figure 2.1: HIV population from 2002-2018 (Statistics South Africa, 2018:8).

In South Africa the incidence of HIV has increased in comparison with the 2017 statistics which have been reported. According to Statistics South Africa (2017:7), the number of PLWH increased from 4.94 million in 2002 to 7.06 million in 2017 with 12.9% of the general population living with HIV. However, the recent statistics indicate that in 2018, 7.52 million people in South Africa were living with HIV making approximately 13.1 % of the general population to be living with this chronic illness as indicated in Figure 2.1 (StatsSA, 2018:7). Moreover, the percentage of AIDS-related deaths has decreased as compared to those in 2002 which were 37.29% and in 2017 and 2018 the percentages were 22.18 and 22.06 as indicated in Table 2.1. This implies that due to the access to HAART by PLWH, the number of AIDS-related deaths in South Africa has become lower also and HIV is becoming a chronic manageable illness.

Table 2.1: Births and deaths from 2002-2018 (Statistics South Africa, 2018:7).



Year	Number of births	Number of deaths	Number of AIDS related deaths	Percentage of AIDS deaths
2002	991 675	578 135	215 568	37,29
2003	1 006 853	610 695	243 951	39,95
2004	1 040 614	640 959	270 280	42,17
2005	1 077 788	664 588	289 833	43,61
2006	1 117 906	672 371	293 166	43,60
2007	1 157 434	658 467	276 921	42,06
2008	1 186 739	635 136	248 208	39,08
2009	1 201 889	605 014	214 365	35,43
2010	1 207 338	572 177	175 375	30,65
2011	1 216 711	556 684	154 752	27,80
2012	1 218 517	534 034	138 919	26,01
2013	1 218 105	529 288	135 331	25,57
2014	1 215 890	522 779	122 139	23,36
2015	1 216 408	523 588	115 598	22,08
2016	1 214 592	523 997	117 296	22,38
2017	1 208 934	523 560	116 110	22,18
2018	1 200 436	522 157	115 167	22,06

In addition to the prevalence of HIV in South Africa, Cardiovascular diseases are the second most causes of increased number of deaths in South Africa (HSFSA, 2016:1; Msemburi *et al.,* 2014). Further to this, Norman *et al.* (2007) as cited in HSFSA (2016:3), argue that HTN is a predisposing factor to Cerebrovascular accident such that it accounts for 50% of CVA and 42% of myocardial infarction. Moreover, Lloyd-Sherlock *et al.* (2014:8) argue that HTN is announced to be increased in South Africa from age 50 years and above as compared to other countries in the globe to a point where more people from age 50 years and above are found to be hypertensive in South Africa. In an African study conducted in 2018 which explored regional and sex differences in the prevalence of HTN and assessing the awareness of HTN among adults, HTN prevalence in South Africa in the selected sites was above 40 % as compared to parts of the African region such as Kenya and Ghana (Gomez-Olive *et al.,* 2018:3).

2.4 RISK INFLUENCES OF NCDS TO PLWH

Non-communicable diseases have several risk determinants which predispose PLWH to NCDs such as HTN, namely age-related determinants, lifestyle (obesity, alcohol and smoking, diet), pharmacological, educational, and hereditary elements (Maimela *et al*., 2016:4).

2.4.1 Age

Age as a determining factor among PLWH has been linked to the development of HTN such that several studies are in agreement that indeed as PLWH age, the risk of NCDs increases. A Kenyan study by Cheppchirchir, Jaoko and Nyagol (2017:5), which explored the risk indicators and effects of HTN on disease progression of HIV/AIDS, demonstrated that the frequency of HTN in HIV clients is related to known predisposing factors such as ageing. In the 297 participants, HTN diagnosis risk in PLWH was viewed according to age, such that clients with age 30-39 were nine; 40-49 years were 40 and 50 years and above were 20. This study revealed that as PLWH get older that is, above 40 years, the risk of HTN increases. Similarly, literature studies are in agreement that clients who are 40 years and above living with HIV were reported to be in a risk of developing HTN (Antonello *et al.*, 2015:406; WHO, 2012:1; Bloomfield *et al.,* 2015:1; Xu, Chen & Wang, 2017:536; Alikor, Emem-Chioma & Odia 2005:18; Njelekela *et al.,* 2016:1). Therefore, ageing is a predisposing influence to HTN in PLWH.

2.4.2 Lifestyle influences

The lifestyle that PLWH adopt influences the development of HTN and due to that several studies done have demonstrated that amongst other risk factors, stress, obesity, alcohol consumption, smoking, diet and sedentary lifestyle are predisposing to NCDs (Njelekela *et al*., 2016:4; Antonello *et al*., 2015:406; Chhoun *et al.*, 2017:6; Temu *et al*., 2016:3).

2.4.2.1 Stress

Stress has been identified to be a predisposing influence to NCDs and studies done have shown clearly on how stress contributes. In a study conducted by Temu *et al*.

(2016:3) it is stated that stress can predispose HIV clients to HTN. Additionally, Ofili, Ncama and Sartorius (2015:6) are in agreement with stress as a predisposing factor to NCDs. In their study, which assessed the prevalence of HTN and associated risk factors amongst adults of three villages in Nigeria, it was revealed that most participants were married, with a percentage of 75.4%, and due to that, it was reported that HTN prevalence was at an increased rate in those clients married. The increase in HTN was closely linked to the stress encountered by married clients due to house accountability. Furthermore, studies by Erhun, Olaiwola, Agbani and Omotoso (2005:117) and Alikor *et al.* (2013:22) also report that stress is a risk factor for HTN due to loss of significant others in both males and females.

2.4.2.2 Obesity

In a study conducted by Kotsis *et al.* (2010:386) and Malaza *et al*. (2012:5), it was discussed that being overweight predisposes one to HTN both in adults and children. Similarly, a Tanzanian study by Njelekela *et al*. (2016:4), which investigated the prevalence of HTN and its risk factors among HAART naïve clients in Tanzania, revealed that obesity and being overweight observed increased the risk of development of HTN as compared to clients with normal weight. Obesity and overweight in the study were classified according to a body mass index (BMI) of 25-29.9kg/m² and > 30kg/m². The risk for HTN was related to 54% and 94% in obese and overweight clients, according to the researchers. Furthermore, an elevated BMI and waist circumference were also identified to be risk factors for hypertension by several researchers (Chhoun *et al*., 2017:9; Lloyd-Sherlock *et al*., 2014:8). Moreover, it has been suggested that obesity is associated with increased blood pressure Krishnan *et al*. (2015:7.) Therefore, increased body weight predisposes clients to HTN.

2.4.2.3 Lack of exercise

An adopted lifestyle which lacks physical activity predisposes clients to NCDs. In a cross-sectional study on the social epidemiology of HTN in Buffalo City Metropolitan Municipality by Owalobi, Ter Gro, Adeniyi and Seekoe (2017:3), sedentary lifestyle, which is a lifestyle that lacks physical activity, was reported to be a risk factor which is related to the development of HTN with the rate of 51.5%. In addition, Kavishe *et al.* (2015:11) argue that socio-demographic and behavioral factors such as residing in a city and office work increase the risk of one or more communicable diseases due to the relaxed environment which does not stimulate clients to engage in moderate exercises.

2.4.2.4 Smoking tobacco and alcohol consumption

A lifestyle that lacks modification such as smoking cigarettes and drinking alcohol increases the risk of NCDs. Literature from studies conducted suggests that the use of alcohol and smoking by PLWH are risk factors to HTN (de Simone *et al.,* 2006:166). Furthermore, a study by Lloyd-Sherlock *et al.* (2014:9) suggests that alcohol consumption and smoking in PLWH is thought to be responsible for development of HTN. Similarly, de Gaetano, Cauda and Lacoviello (2010:5), are in agreement that smoking is a predisposing factor to HTN. Therefore, the lifestyle choices such as smoking and alcohol have been identified to increase the risk NCD such as HTN.

2.4.2.5 Dietary influences

The kind of a diet that clients consume influences the development of NCDs. According to Kavishe *et al.* (2015:11) and Lloyd-Sherlock *et al.* (2014:8), consuming fewer vegetables and fruit in a diet and food with inadequate nutritional value contributes to the risk of developing NCDs. In addition to the mentioned dietary influences, a Nigerian study which assessed the prevalence of HTN in rural communities and associated risk factors amongst adult clients by Ofili *et al.* (2015:6) demonstrated that increased salt intake in food preparation is a risk factor contributing to HTN. Similarly, Ha (2014:8) argues that dietary salt intake is indeed the predisposing factor to HTN due to its negative effect on the cardiovascular system. Therefore, high salt intake has an effect of increasing blood pressure, hence making clients prone to cardiovascular diseases.

2.4.3 Pharmacological influences

The medication taken by PLWH, despite their ability to reduce the viral load, can predispose clients to NCDs**.** According to Shaffer *et al.* (2014:6), Nevirapine, containing antiretroviral (ART) drugs, is responsible for the rise in cholesterol and triglycerides, which are also predisposing factors to cardiovascular diseases. In addition to effects of Nevirapine containing antiretroviral drugs, Lopinavir/Ritonavir was discovered to cause an increase in diastolic blood pressure. Furthermore, in a cross-sectional study conducted by Divala *et al.* (2016:6), which explored the burden of HTN and DM treatment at the urban and rural HIV clinics of Malawi; it was revealed that Zidovudine, Lamivudine and Nevirapine medication was linked with HTN in PLWH. Therefore, literature suggests that although HAART prolongs the life expectancy in PLWH, it also predisposes the clients to HTN.

2.4.4 Educational influences

The level of education that clients have is crucial in order to maintain their lifestyle. Ofili *et al.* (2015:6) argue that lack of education regarding diet in the community of Delta State, where the study was conducted, had an effect on the dietary intake of the clients in the study that was conducted. Similarly, in a study done by Temu *et al*. (2016:40) which explored the lay beliefs about HTN among PLWH in Kenya, it demonstrated that only a small number of respondents regarded high fat diet, raw salt intake and sedentary lifestyle as predisposing factors to HTN. Therefore, lack of education to clients regarding lifestyle modification plays a crucial role in the development of NCDs.

2.4.5 Genetic or hereditary influences

Heredity has been linked to the development of NCDs, particularly HTN and DM; literature demonstrates that a family history of HTN is a predisposing factor. This is evidenced by a study done by Alikor *et al.* (2013:22) which explored prevalence, and risk factors of HTN in a rural community in Rivers State, Niger, and the Delta Region. During interviews, it was discovered that clients had an idea that a family history predisposes them to HTN. Similarly, in a recent Kenyan study by Temu *et al.* (2016:4), clients who were interviewed stated that HTN was hereditary, such that if there is a family history of HTN in a family then it is passed from one generation to another. Therefore, heredity is associated with HTN based on the evidence provided by two studies.

2.5 LANDSCAPE OF PHC IN SOUTH AFRICA

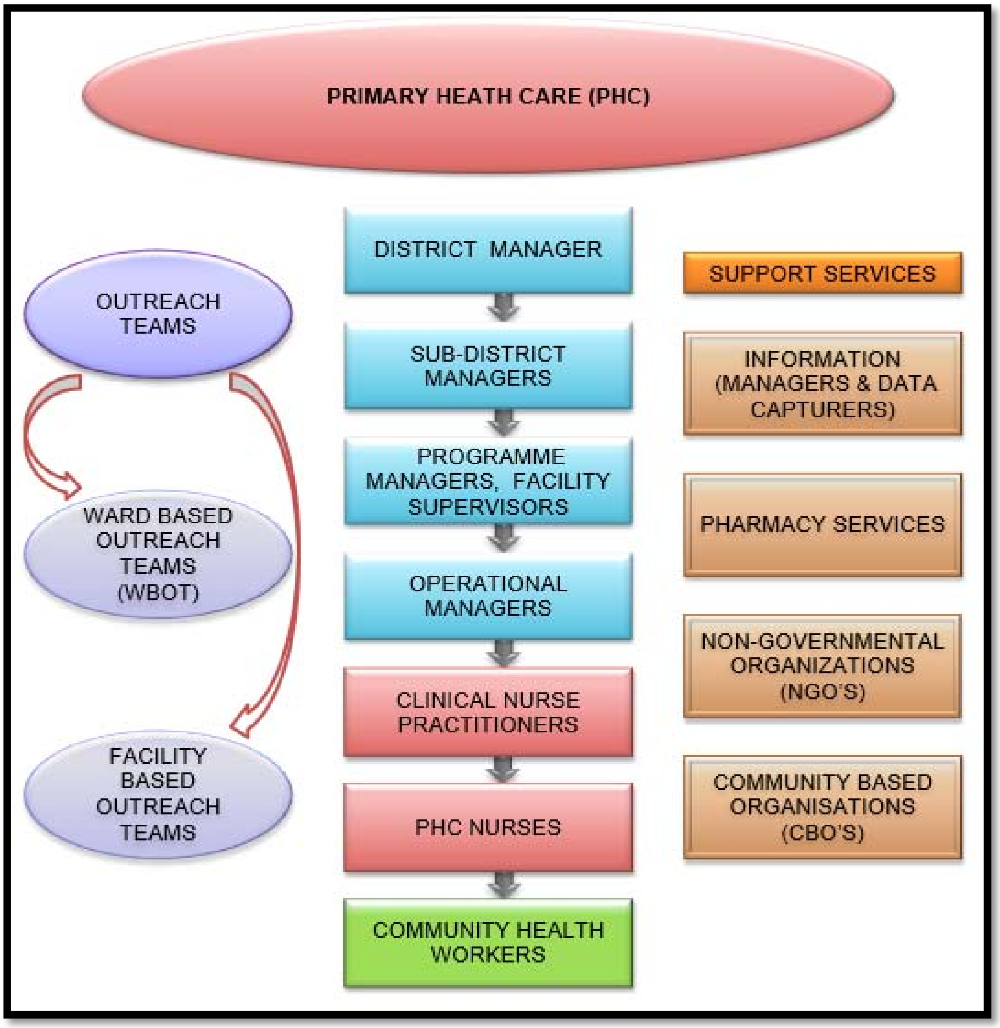


Figure 2.3: Thematic representation of the Landscape of PHC in SA

The thematic representation (Figure 2.3) depicts the landscape of PHC and referral pathways within the current Department of Health structure in South Africa. The PHC clinics are overseen by the district manager and the sub-district managers of the district report to the district manager. In the local service areas, this is where the sub-district managers are placed in PHC along with the programme managers, information managers, clinic supervisors. The blue colour represents the management in the PHC team starting from the district managers to the operational managers. The operational managers are placed in the PHC facilities where they are the immediate supervisors to the clinical nurse practitioners, who have a speciality in PHC (red) and PHC nurses who have been trained in community health nursing also represented by red. The community health workers are the mediators between the community and the PHC facilities and they form part of the structure of the PHC. On the left-hand side are outreach teams in the PHC that are divided into ward and facility-based outreach teams. The curved arrows represent the types of outreach teams that exist in PHC. The ward-based outreach teams (WBOT) work together with sub-district and PHC facilities to reach those areas away from the facilities. The WBOT teams are made up of professional nurses and enrolled nurses. The facility-based outreach teams are made up of a professional nurse and community health workers within the facilities. On the right hand side are the support services which include the data management of the facilities, Non-Governmental Organizations (NGOs) and Community Based Organizations (CBOs). These organisations assist the sub-district and the PHC facilities in terms of compliance with standards of practice as stipulated by NDOH and the programmes that are provided at PHC such as HIV, TB and mother and child services.

PHC is defined by the WHO as the necessary health care that is built on scientifically sound and socially acceptable methods, which are accessible to everyone who requires health care in the community (WHO, 1978:1). The PHC clinics provide a service that is led by professional nurses and are imperative to provide an integrated PHC health care services utilizing a one-stop approach for eight hours a day, five days a week. The PHC services that are offered range from the mother and child services, which include integrated management of childhood illnesses (IMCI), reproductive health and immunization of children as per the expanded programme on immunization, management of acute illnesses such as acute diarrhoea, Sexually Transmitted Infections (STI), adolescent and youth services, and dominated by TB, injuries, HIV and mental health (NDOH, 2001:19; Mash *et al.,* 2012:1). PHC facilities have fixed clinics and also utilize mobile clinics with the assistance of the WBOT teams to reach rural areas that are out of reach (Mash *et al.,* 2012:2).

In addition, Mash *et al.* (2012:1) argue that the post-apartheid South African government formulated a district health system that is based on the implementation and utilisation of PHC principles at the PHC facilities. This was accomplished by the integration of the fractions of health departments and the provision of free access to the PHC services where PHC nurses are in the front line. The nurses were then supported by PHC doctors to intervene in cases that are above their scope of care.

In South Africa, the public and the private sector function at a parallel level. While that is the case, the public sector serves the majority of the South African population both in rural and urban areas (WHO, 2016:3). It has been reported that the PHC is dominated by NCDs such as HTN, DM, HIV and TB (Mash *et al*., 2012:11). In addition, about 16.2 %, which is about 8.2 million people in South Africa, are covered under medical schemes, thus using private services, and 84 %, which is about 42 million of the population, is utilizing public services (NDOH, 2011:9). It was reported in 2013 that the vacancy rates were appraised at 56% for medical doctors and 46 % for professional nurses. In addition, it was reported that only about three per cent of the medical doctors are allocated in the rural areas where half of the South African population resides and approximately 70% are employed by the private sector. This causes most of the patients in the rural areas to be seen by PHC nurses in the clinics (Britnell, 2015:75).

The public health care sector in South Africa is based on PHC principles, with PHC clinics offering first-level care which includes chronic services such as HIV, HTN, TB and acute illnesses, as well as mother and child health services (Ruud, Srinivas & Toverud, 2009:29). In 2016, it was reported that in South Africa there are about 3 863 public clinics and 610 private clinics that are run by PHC trained nurses. In addition, the Eastern Cape Province has the largest number of PHC clinics of 731 in South Africa (Makhombo, 2016:1). Reports provided by the NDOH highlight that the number of people utilizing PHC clinics is rising. In the years 2015 and 2016, an estimated 127 million consultations were made by professional nurses working at PHCs and about 160 000 deliveries were conducted and about 3.4 million people on HAART were provided care at the clinics and Community Health Centres (CHC) (Gray & Vawda, 2017:112). In addition to the Anti-retroviral Therapy (ART) programme, the mother and child services also excelled with 90% immunization coverage achieved at PHCs and ante-natal care before 20 weeks at 61.2% (NDOH, 2016:30).

In addition, due of the large number of PLWH in SA that is increasing annually, in November 2003 the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa was approved, which was later accompanied by a National Strategic Plan for 2007–2011 (Ruud *et al.,* 2009:29). When South Africa was free from apartheid, a new health care policy emphasised public health care, which is established and provided in the PHC setting. The National Strategic Plan provided and promoted the distribution of ART through the public sector, and more specifically at PHC level (Ruud *et al.,* 2009:29).

2.6 MANAGEMENT OF HIV AND HTN AT PHC FACILITIES IN SOUTH AFRICA

According to the NDOH (2015:1), the national consolidated guidelines for prevention of mother to child transmission (PMTCT) and management of HIV in children, adolescents and adults are designed to be utilized in all settings of health care such as clinics, community health centers and hospitals. This implies that HAART can be accessed to all levels of health care.

2.6.1 HIV management

The NDOH introduced the national consolidated guidelines for prevention of mother to child transmission (PMTCT) and management of HIV in children, adolescents and adults in 2015. According to the NDOH (2015:19), the guidelines encouraged the provision of care to clients to move in a systematic manner from HIV testing and counselling to connecting to the management and treatment and lastly to keep them in HIV care to ensure that care provided in PLWH continues.

2.6.1.1 Eligibility for HAART in late adolescents above 15 and adults living with HIV

The NDOH (2015:72) states that for one to be initiated to treatment, the following criterion must be met, that is;

- The CD4 count should be less than 500 cells/ul regardless of the WHO clinical stage or in their Progressive HIV Disease stage, or one must be living with Tuberculosis, pregnant HIV positive women or breastfeeding and urgency should be given if the CD4 count is less or equal to 350 cell/ul irrespective of the WHO clinical stage.

2.6.1.2 Timing of HAART

- HAART should be initiated to PLWH as soon as they are ready within a minimum of two weeks after a CD4 blood count was taken.
- If the client is found to be co-infected with Tuberculosis (TB) and HIV then TB treatment should be initiated first, then start HAART within a period of two months.

However, in 2017 the NDOH (2017:1) issued a circular to all relevant health practitioners in following the fast-tracking implementation of the 90-90-90 strategy for HIV, through implementation of a universal test and treat policy and same day initiation to HAART of PLWH. This is currently what has been added in the HIV management protocol. According to the NDOH, new HAART clinical guidelines for management of HIV in adults, pregnancy, adolescents, children, infants and neonates (2019:3), the principle for management of HIV is the same, that being that all PLWH should be initiated on HAART regardless of HIV and where PHC patients have no contra-indications on HAART, they should be started on HAART within a week and immediately on the same day if possible. On the same day of initiation strategy following confirming that the client is HIV positive through testing, the client should be counselled prior to HAART initiation in order to determine the preparedness to start HAART immediately. Then, if following that, the patient should be thoroughly examined by the PHC nurse for WHO clinical staging as stipulated by guidelines (NDOH, 2015:74; NDOH, 2019:3). If the PHC patient does not have any evidence of opportunistic illnesses then the client should be initiated on the same day as per guidelines but must come in a week for blood interpretation, that is looking at the blood results that were taken (NDOH, 2017:3).

2.6.1.3 Baseline bloods and routine laboratory assessment in PLWH

The baseline blood taken following the HIV diagnosis is the CD4 count to assess if the PLWH are qualified for HAART, that is whether the CD4 count falls within the criterion of being less than 500 Cells/ul, to check for cryptococcal infection which occurs when the CD4 count is less than 100 and warrants treatment with anti-fungal fluconazole, and lastly if clients qualify for cotrimoxazole as a prophylaxis to skin infections if the CD4 count is less than 200 (NDOH: 2015:74, 98). However, with the same day initiation that has been implemented, all PLWH are initiated to treatment irrespective of their level of CD4 count to attain viral load suppression (NDOH, 2017:2). The second blood is the creatinine if the client requires the first line drugs contained in the fixed combination dose (FDC) to check for renal adequacy. The creatinine normal level is when the clearance is 50ml/ min and creatinine should be <100 umol/L (NDOH, 2015:70). Creatinine comes together with the weight and height which determines which medication to use.

2.6.1.4 Pharmacological treatment for PLWH

According to the NDOH (2015:73), PLWH and TB and young adults above 15 years of age weighing >40 kg should be initiated on the fixed combination dose (FDC) which contains Tenofovir 300mg, Emitricitabine 200mg and Efavirens 600mg. However, if the weight is less than 40kg then the client is managed by being based on the dosages prepared for children. In addition, if in the creatinine results the creatinine clearance is less than 50, FDC is contraindicated so the client is initiated on to Abacavir 300mg, Lamivudine 150 mg and Nevirapine 200mg because Tenofovir is contraindicated if the creatinine clearance is less than 50 mL/ min (NDOH, 2015:73).

2.6.1.5 Routine monitoring of PLWH and role of a PHC nurse

Monitoring of PLWH is essential to ensure continuity to care and to identify adherence barriers that may be present and drug failure which requires second line drugs for PLWH. According to the NDOH (2015:74), once the client is on HAART, the PHC nurse should monitor the client at certain intervals. At six months on HAART, the client is monitored for viral load suppression to establish compliance to HAART and poor response to HAART. At the first 12 months on treatment CD4 count is repeated to establish the client’s reaction to HAART then yearly if there is a need. Creatinine is also done at the first three months, six months and 12 months and repeated annually if on FDC which contains Tenofovir to establish the Tenofovir effect on the kidneys and if the Tenofovir is nephrotoxic, the PHC nurse should switch the client to another regimen that is free of Tenofovir (NDOH, 2015:75, NDOH, 2019:21).

2.6.2 Management protocol for HPT in PHC facilities

Management of HTN should always follow the diagnosis of HTN. A client is hypertensive only if the blood pressure has been measured on two occasions that are two days apart as hypertension cannot be diagnosed by one reading only. According to the NDOH (2017:73), if the blood pressure (BP) reading is less than 140/90 mmHg at every visit then BP must be checked again in five years' time, but if the BP has had any rise in the readings then it must be checked annually. In addition, if the BP is 140/90 mm Hg to 159/99 mmHg then the PHC nurse should assess the cardiovascular risk and if the risk is > 20% then the client should be diagnosed as hypertensive.

2.6.2.1 Non-pharmacological and pharmacological management of HTN

Once the client's blood pressure becomes greater than 140/90 mm Hg on separate occasions in the clinic, the client is started on high blood pressure care (NDOH, 2017:73) as per Primary Health Care 101 recommendations. According to the essential drug programme by the NDOH (2014:4.16; NDOH, 2018:4.19) and the Adult Primary Care guidelines (2017:81) that are currently used by PHC nurses, clients with HTN should be managed by the stepwise approach. Seven steps are followed. Initially it was five but currently seven steps are used. The Figure 2.4 shows the algorithm that is used by PHC nurses in the management of patients with HTN in the PHC facilities.

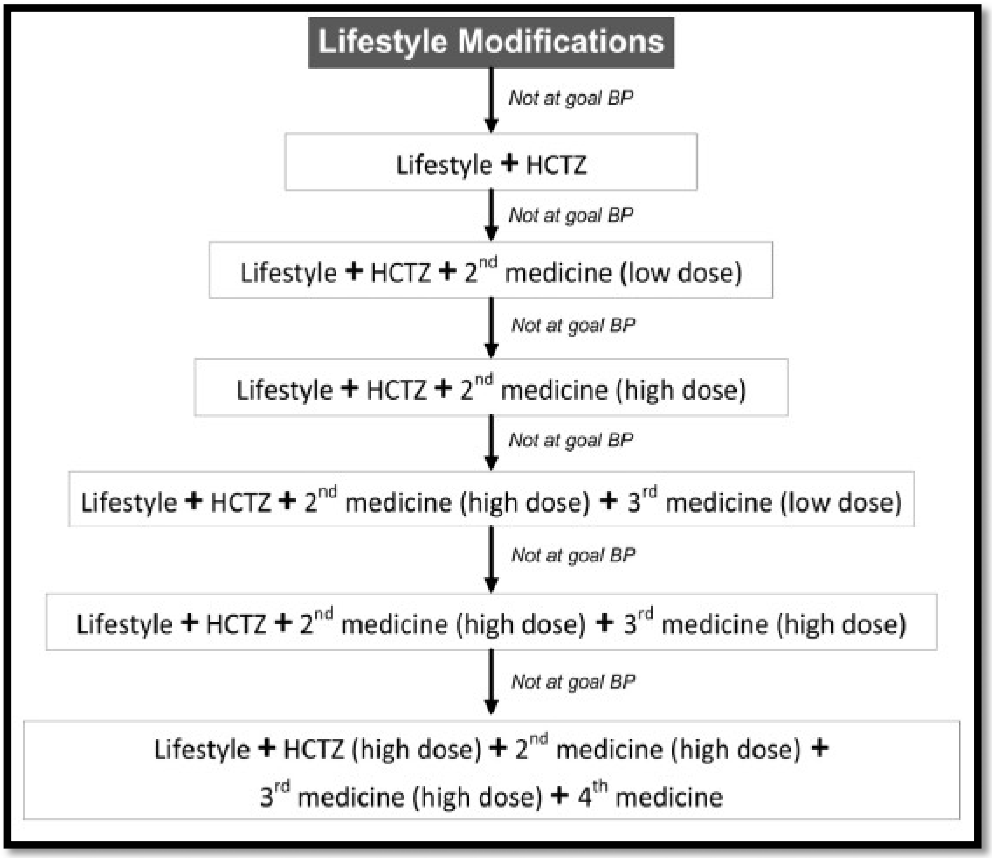


Figure 2.4: Stepwise approach for management of HTN in South Africa (NDOH, 2018:102).

1. Step one

If the systolic BP ranges from 140-159 mmHg and diastolic BP ranges from 90-99 mmHg then lifestyle modification is required in the form of limiting high salt in the diet, reducing weight, reducing number of cigarettes smoked a day and moderate exercise. The plan is to achieve a BP of <140/90 mmHg in three months.

2. Step two

If the systolic BP ranges from 140-159 mmHg and diastolic BP is 90-99 and lifestyle changes are unable to control BP in one month, continue emphasizing lifestyle changing and add 12,5 mg of Hydrochlorothiazide daily. In this step the plan is to achieve a BP of < 140/90 mmHg within one month.

3. Step three

If the plan that the PHC nurse wanted to achieve is not possible even if the client is compliant to medication, then the PHC nurse should continue with management and add Angiotension Converting Enzyme (ACE) –inhibitor; Enalapril 10 mg daily. The aim is to achieve a BP of <140 mmHg within one month on treatment.

4. Step four

If step three did not achieve the plan after compliance to treatment for a month, the PHC nurse should continue with management and add long acting calcium channel blocker such as Amlodipine 5mg daily. The plan is to achieve BP of < 140/90 mm Hg within one month.

5. Step five

If step four does not improve the BP even though the client is compliant to treatment, the PHC nurse continues with both the drug and non-drug management and adds Atenolol 50 mg daily. The plan is to achieve a BP < 140/90 mmHg within one month without side effects to medication.

If step 5 also fails in the PHC setting, the client should be referred to another level of care (NDOH, 2014:4.18). However, in the Essential PHC guidelines currently used (2018:4.21) the step wise approach has been amended to seven steps.

6. Step 6

In step six, the PHC nurse ensures that the PHC client continues with lifestyle modification and continues with Hydrochlorothiazide 12.5 mg, Enalapril 20 mg and increases the dose of Amlodipine to 10 mg.

7. Step seven

In this step, should step six fail, the PHC nurse increases the thiazide drug (Hydrocholorothiazide) and adds the fourth medication for HTN. The Hydrochlorothiazide is increased to 25 mg, and spironolactone 25 mg is doctor initiated in this step. The role of the PHC nurse is to refer the patient to the hospital if step seven fails (NDOH, 2018:4.21).

2.6.2.2 Routine Monitoring of HTN clients

According to PC 101 guidelines by the NDOH (2017:74) if the BP is controlled on treatment, the PHC should continue with the medication that is used then check the client in six months. The nurse has a role to take bloods for serum potassium concentration six monthly if the patient is on Spironolactone 25 mg or a creatinine level less than 30 mL/min (NDOH, 2018:4.17).

2.7 CHALLENGES EXPERIENCED BY PHC NURSES

This section will only focus on challenges because the study is planning to make recommendations to support PHC nurses in the PHC setting as clinicians nursing PLWH and HTN. PHC nurses are set to provide the initial point of care to patients in the community before they can even go to Hospital setting (Mash *et al.,* 2012:29). Despite the efforts of the PHC nurses in the management of patients in the clinics, they experience challenges in the PHC facilities. Maillacheruvu and McDuff (2014:2) highlight that PHC nurses may experience inequality between the private clinics and the public clinics. While the private clinics serve minor masses of the population, 60% of the budget is allocated to them, enabling them to have more equipment and sufficient staff. On the other hand, at public facilities, there are larger masses of the community and lack of staffing, and resources such as essential medication are a challenge. In addition, Maillacheruvu and McDuff (2014:5) argue that the second challenge experienced by PHC nurses is the increasing burden of chronic illness in the PHC setting, causing most of the patients to be seen at the clinics which then may cause stock outs and longer waiting times due to an increasing number of people living with chronic illnesses.

Similarly a study conducted by Hunter *et al.* (2017:112), which looked into the ideal clinic in South Africa and challenges in the implementation, revealed that in an audit that was conducted, PHC nurses experience a challenge in the essential drug supply that is unreliable, the infrastructure in some of the facilities is not conducive to seeing many patients and there are inadequate personnel to provide PHC services to the

South African population. In addition to the inadequate spaces to provide care to patients in the clinics experienced by PHC nurses in the South African clinics, long waiting hours are also a challenge due to the masses of the population being attended (Hunter *et al.,* 2017:112). To overcome these challenges, the NDOH has resorted to an initiative of the Ideal Clinic Realization and Maintenance (ICRM). The ICRM strives to improve the quality of health services provided in the PHC in order to meet the requirements in preparation for the National Health Insurance (Hunter *et al.,* 2017:112). According to the NDOH (2018:1) and Hunter *et al*. (2017:112), an ideal clinic is the clinic that has proper staff, sufficient and available essential medication and supply and good infrastructure and administrative processes, as well as adherence to protocols and policies to promote the provision of care to the large population of South Africa.

2.8 CONCLUSION

This chapter focused on a relevant literature review specifically on HIV and HTN. The literature studies provided an overview on trends in the burden of HTN and HIV in the world, nationally and regionally. In addition, the landscape of the PHC, management of HIV and HTN in PHC, the roles of PHC nurses in the management of HIV and NCDs, in particular HTN, and the challenges experienced by PHC nurses in South Africa were discussed. Furthermore, more of the literature control will be discussed in Chapter Five together with the study findings.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter discusses the research design and methods that were used in the study including the research setting, target population, sampling methods, data collection method and process and how data was analysed. Justification is also provided as to why the qualitative inquiry and descriptive phenomenology were selected and utilized in the study. Furthermore, qualitative rigour and the ethical considerations that the researcher upheld are discussed.

3.2 QUALITATIVE INQUIRY

In the study, a qualitative research approach was used as a lens for viewing the lived experiences of people living with HIV and HTN. According to Brink *et al.* (2012:121), a qualitative research approach refers to a broad range of research designs and methods used to study a phenomenon of social action and of which we don't have an understanding. In addition, qualitative research methods focus on the qualitative aspects of meaning, experiences, and understanding and these methods are used to study human experience from the viewpoint of the research participants in the context in which the actions take place. Furthermore, Burns and Grove (2011:73) argue that qualitative research is a systemic, subjective approach used to describe life experiences and give meaning to a phenomenon.

According to Brink *et al.* (2012:11), qualitative research has the characteristics that differentiate the approach from a quantitative approach, namely: a qualitative approach attempts to understand a phenomenon in its entirely; has few pre-conceived ideas and stresses the importance of events and circumstances; collects information without structured instruments; assumes that subjectivity is essential for understanding of the human experience; analyses narrative information in an organised manner and involves sustained interaction with the people being studied in their own language and on their own turf. Furthermore, De Vos, Strydom, Fouchè and Delport (2011:308) argue that a qualitative paradigm is concerned with understanding rather than explanations and with naturalistic observations rather than controlled measurements. In the study, the researcher used this approach to understand the everyday lived experiences of PLWH and HTN with regard to disease management using semi-structured interviews.

3.2.1 Justification for using qualitative inquiry

In this study, a qualitative research approach was used. Gray, Grove and Sutherland (2017:251) argue that a qualitative research approach is a systematic, subjective approach used to describe life experiences and give meaning to a particular phenomenon. In this study, the researcher used this inquiry to explore and describe the lived experiences of PLWH and HTN with regard to disease management, using semi-structured interviews. The researcher was the tool for collecting the information and analysing the lived experiences in order to describe the essence of the lived experiences of PLWH and HTN with regard to disease management. Amongst the research approaches involved in qualitative research, this study employed Husserl's descriptive phenomenology as the researcher was interested in identifying, describing and understanding the subjective experiences of PLWH and HTN with regard to disease management.

The single broad question which guided the study was 'What are the lived experiences of people living with HIV and HTN with regard to disease management?' Husserl's descriptive phenomenology was deemed appropriate as this method identifies the essence of a phenomenon and accurately describes it through the lived experience.

3.3 RESEARCH PARADIGM

Paradigms are defined as patterns of opinions, views or convictions and practices which control an investigation by providing a lens for viewing and explaining meaningful topic in a discipline (Weaver & Olson, 2006:460). This study was underpinned by constructivism in the research paradigm as a philosophical lens for viewing the lived experiences of PLWH and HTN. According to Weaver and Olson (2006:461), this paradigm explores an experience in the eyes of the participants as they are living through such experience. Supporting this, Chilisa and Kawulich (2012:9) argue that constructivism implies that to make sense of the world, one should look at those who experience it. In addition, in constructivism, essences and truths are co-created by a person’s synergy with the world. Constructivism implies that the meanings a person describes are not uncovered or found constructed through the lived experiences of a phenomenon in a distinct manner that is unique to different individuals experiencing the same phenomenon (Gray, 2013:20). Constructivists regard knowledge as being subjective, such that the meaning of the knowledge is socially constructed; generated by the individual who experiences a phenomenon based on their interaction with the world and that any truthfulness of the knowledge remains in the experiences being explored. It was thus found appropriate to use constructivism (Chilisa & Kawulich, 2012:10). Furthermore, Yilmaz (2013:313) argues that the paradigms for human explorations are distinguished in the manner they respond to as philosophical assumptions, namely: ontology, epistemology and axiology. Ponterotto (2005:130) states that the ontological inherent characteristic of the constructivist explorer concerning the assumptions is that the formulated reality is multiple, based on or influenced by personal feelings, or opinions and it is determined by the setting of the situation. In addition, epistemologically, the constructivists retain that the reality is socially formulated; thus the communication between the researcher and the participant is crucial for exploring and describing the lived experienced of living with HIV and HTN. Axiologically, the researcher should be conscious of and bracket predetermined knowledge and values (Wojnar & Swanson, 2007:175).

In this study, the ontological assumption was that the participants had unique lived experiences of living with HIV and HTN with regard to disease management. Epistemologically the assumption was that the researcher understood the lived experiences by communicating with the participants through the use of semi structured interviews and field-notes and through the continued engagement of in-depth interviews allow the meaning of the lived experience of the studied phenomenon to be co-created with the participants. Axiologically, the assumption was that the researcher had to bracket out knowledge on the management of HIV and HTN and be open to participants’ descriptions. This was done by making use of a reflective journal (see Annexure A) and not searching deeper on the experiences of PLWH and HTN.

3.4 PHENOMENOLOGY

In this study, phenomenology was the philosophical lens for exploring and describing the lived experiences of living with HIV and HTN during interviews guided by the semi-structured interview schedule. Phenomenology as the philosophical foundation undergirds the research methods of listening to individuals and analysing verbal and non-verbal communication to gain a more comprehensive understanding of their experiences (Gray *et al.,* 2017:65). Phenomenology is an approach to understanding people's everyday life experiences. In phenomenology, the researchers are interested in the essence of the phenomenon being experienced by the people (Creswell, 2013:76). In addition, Brinkman and Kvale (2015:30) argue that phenomenology is the term that points to an interest in understanding social phenomena from the actor's own perspectives and describing the world as experienced by the subjects, with the assumption that the important reality is what it is perceived to be.

In addition, Downing (2010:301) argues that in phenomenology, the researcher is interested in getting the meaning of the human experience as described by the participant and focuses on the meaning of lived experiences of the participants through the use of interviews to acquire information. Furthermore, LoBiondo-Wood and Haber (2010:102) state that the aim of phenomenology is to grasp the essence of the experience as the participant is spending his life. According to Creswell (2013:79), phenomenology is made up of two schools, namely: descriptive phenomenology by Edmund Husserl and the interpretive phenomenology (Hermeneutic) school by Heidegger.

3.4.1 Descriptive phenomenology

According to Phillips-Pula, Strunk and Pickler (2011:67), a mathematician named Edmund Husserl (1859-1938) is considered the father of modern phenomenology. In addition, Husserl believed that imaginative variations, acceptance of descriptions of experiences as related by study participants, assisted the researcher's efforts to grasp the essence of an experience and his focus was on the meanings and identifying essence or central themes of an experience as a way of further explaining knowledge. Gray *et al.* (2017:66) argue that Husserl posited that phenomena make up the world of experience and that the experiences cannot be explained by examining causal relations but need to be studies as the very things they are. Furthermore, the person experiencing his or her life must be the one to share the meaning of the experience and to describe the experience; the researcher must be open to the participant's worldview and must set aside personal perspectives, thus allowing meanings to emerge. Moreover, an assumption of Husserl's descriptive phenomenology is that individuals are free agents with the capability of influencing their environment, culture and the objects embedded within the phenomenon that is being experienced or lived; thus within this approach of phenomenology, Husserl recognises the influence of the person's context and influences from the environment (Lopez & Willis, 2004:728; Zahavi, 2004:42).

According to Giorgi, Giorgi and Morley (2017:180), phenomenology involves four steps: bracketing, intuiting, analysing and describing. Bracketing is a process of identifying and holding in abeyance preconceived beliefs and opinions about the phenomenon under study (Giogi *et al.,* 2017:180; Brink *et al.,* 2012:122; Botma *et al.,* 2010:190). Intuiting or epoché, the second step in descriptive phenomenology, occurs when the researcher remains open to the meaning attributed to the phenomenon by those who have experienced it (Giorgi *et al.,* 2017:180; Broomé, 2011:11). The analysis phase entails taking meaningful explanations, putting them together and making sense of crucial meanings. Lastly, the descriptive phase occurs when the researchers come to understand and define the phenomenon.

3.4.2 Hermeneutic Phenomenology

Hermeneutic (interpretative phenomenology) is a school of phenomenology by Martin Heidegger (1889-1976) that is interested in the experience of a person as it is lived. Heidegger puts emphasis on 'Daisen' which means 'Being in the World' (Shahbazian, 2015:6; Laverty, 2003:24). For Heidegger, in hermeneutic phenomenology the emphasis is on towards providing insight into details and apparently trivial facets within experience that may be taken for granted in life, with an aim of generating meaning and accomplishing a sense of understanding (Wilson & Hutchinson, 1991), as cited in Laverty (2003:24). In Heidegger's prospect, consciousness is not disconnected or separate from the world but it is a development of historically lived experience (Laverty, 2003:22). Furthermore, Hermeneutic phenomenology can be distinguished from descriptive phenomenology in that it does not employ a theoretical framework as a component of inquiry (Lopez & Willis, 2004:730).

3.4.3 Justification for the use of descriptive phenomenology

The single broad question that guided the study was ‘what are the lived experiences of people living with HIV and HTN?

Therefore, for the study to answer the question by exploring and describing the lived experienced of clients living with the co-morbidity of HIV and HTN, the researcher used Husserl’s descriptive phenomenology to get the essence of the described lived experiences and identify central themes as experienced by the research participants in their everyday life. This is because Rebar *et al*. (2011:182), argue that qualitative research questions seek to describe, understand, connect or relate, but do not seek to predict or manipulate. Therefore, for the research objective to be achieved, which is to explore and describe the lived experiences of living with HIV and HTN as they are experienced in the participant’s everyday lives, descriptive phenomenology was used for exploring the lived experiences.

Sloan and Bowe (2014:1295) argue that descriptive phenomenology is concerned with the interaction between the nature of the experience and the manner in which it is experienced. In descriptive phenomenology, the researcher makes an attempt to describe the lived experience of the participant, and to accomplish the description the researcher needs to adopt a phenomenological attitude called phenomenological reduction (Giorgi, Giorgi & Morley, 2017:180). Phenomenological reduction concerns its self with bracketing (Giogi *et al.,* 2017:180; Brink *et al.,* 2012:122; Polit & Beck, 2012:495; Botma *et al.,* 2010:190). Furthermore, Giorgi *et al.* (2017:180) and Broomé (2011:11) state that the phenomenological reduction also concerns itself with epoché or intuiting. Therefore, for the aim of the study, which was to explore and describe the lived experiences of PLWH and HTN with regard to the facilitative and inhibitory conditions to be achieved, the researcher had to employ Husserl’s descriptive phenomenology, adopting a phenomenological approach so as to get the essence of the lived experiences and to further use this essence in making recommendations for professional nurses in the management of the co-morbidity of HIV and HTN.

3.4.4 Bracketing

According to Carpenter (2007), bracketing is a process in which the researcher puts aside any pre-conceived beliefs and knowledge that the researcher knows about a phenomenon under study to allow a meaning to emerge. Chan, Fung and Chein (2013:1) argue that during the process of bracketing, the researcher holds aside the elements that define the limits of an experience. The purpose of bracketing is to avoid bias and to assure the veracity and validity of the research study based on the participants' experiences. To achieve this goal to the optimum interest of the participants under study, the researcher employed the Husserlian methodological stance of bracketing and intentionality, as the methodological approach. Specifically, the researcher "bracketed out" preconceived ideas, personal expectations resulting from previous work experience with patients living with HIV and HTN, to focus his mind towards the participants' phenomena with an intent to see it through their lenses (Weaver & Olson, 2006:461). This was assured by making use of a reflective journal (see Annexure A) for developing bracketing skills and asking open-ended questions during interviews guided by the semi-structured interview schedule (see Annexure B). The researcher also adopted a phenomenological attitude during the literature review by not searching deeper for experiences of people living with HIV and HTN so as to allow the experiences to emerge during the interviews.

3.4.5 Intuiting

According to Brink *et al.,* (2011:122), intuiting is the process that takes place when the researcher attempts to unfold and develop mindfulness of the lived experience. According to Streubert and Carpener (2011:81), intuiting warrants the researcher to be open to the meaning that the research participants affix to the phenomenon and becomes totally immersed in phenomenon under study with the help of participant's descriptions. The researcher applied and achieved intuiting by being the instrument for gathering information in the interview process. The researcher became the tool for data gathering and listened to each and every participant's description of living with HIV and HTN. The researcher then thoroughly studied the data as the researcher was transcribing and reviewing the data repeatedly in order to determine what the participants described as the essence of living with HIV and HTN.

3.5 STUDY SETTING

The study was conducted in the Sakhisizwe sub-district of the Eastern Cape. This setting was chosen due to the high prevalence of HIV and Hypertension based on the observation of the researcher that PLWH are also living with HTN as a co-morbid illness. The Sakhisizwe sub-district is one of six sub-districts in the Chris Hani municipality of the Eastern Cape. Figure 3.1 reflects the Chris Hani Municipality indicating the Sakhiswe sub-district.

Sakhisizwe sub-district

Figure 3.1: Map of Eastern Cape Municipalities

It is a rural area in nature, with few buildings, limited shops in town, people are involved in subsistence farming, the town is surrounded by the Tsomo river and mountains with trees and has a total population of 63 582 according to census in 2011 (StatsSA, 2011). The community of Sakhisiswe is homogeneous in terms of ethnicity and language in that all participants are *Xhosa* speaking. The sub-district has 13 fixed clinics and one mobile clinic. The PHC services offered include comprehensive chronic care, acute care, mother and child health care, family planning, mental health care, TB, HIV, and sexually transmitted infection (STI) management. The Sub-district reported a total of 4000 PLWH currently on HAART and approximately 2 400 individuals who are treated for hypertension. Figure 3.2 displays the map of the Sakhisizwe sub district within the Chris Hani Municipality.

Figure 3.2: Map of Sakhisizwe sub-district

3.6 POPULATION DESCRIPTION

A target population outlines characteristic elements that demonstrate significance to the research question formulated so that the study can have only those participants that meet the criterion of the researcher (Downing, 2010:302; Gray *et al.,* 2017:330). The target population of the study were adults living with HIV and HTN, accessing care from a PHC clinic in the Sakhisizwe sub-district in the Eastern Cape, and who meet the researcher's inclusion criteria.

3.7 SAMPLING

Sampling is defined as a procedure in which the researcher selects participants that have the elements of the inclusion criteria so that they can depict all the people with the same characteristics (Downing, 2012:303; Polit & Beck, 2012:275). In the study, purposive sampling was used as the researcher used individual selection in identifying the participants who have the characteristics that are needed for the phenomena in question and meet the inclusion criteria as explained by Downing (2012:303). The study's inclusion and exclusion criteria are the follows:

3.7.1 Inclusion criteria:

Inclusion criteria refer to typical features or elements that the research participant must have or own to be selected into a study population (Gray *et al.,* 2017:331). In this study, inclusion criteria were: (I) Adults over the age of 40 years (II) Adults with a diagnosis of HIV and HTN for more than one year and receiving HAART and hypertensive medication for more than one year. Advance in age in PLWH has been linked to development of HTN, such that several studies are in agreement that as PLWH age, the risk of NCDs increases. A Kenyan study by Cheppchirchir, Jaoko and Nyagol (2017:5), which explored the risk indicators and effects of HTN on disease progression of HIV/AIDS demonstrated that the frequency of HTN in HIV clients is related to known predisposing factors such as ageing. In the 297 participants, HTN diagnosis risk in PLWH was viewed according to age, such that clients with age 30-39 were nine; 40-49 years were 40 and 50 years and above were 20. This study revealed that as PLWH get older that is, 40 years and older, the prevalence of HTN increases. Similarly, a South African study by Manne-Goehler *et al*. (2017:7) demonstrated that the HTN prevalence was high in people aged 40 years and above. This trend is also evident in the literature by Medina-Thorne *et al.* (2012:23); Lloyd-Sherlock (2014:8) and Njelekela *et al.* (2016:1). Moreover, a study by Nkpornu (2017:175) supports the argument as it states that the risk of HTN prevalence increases with advance in age and it is two times higher in people aged 40 and above in contrast to people aged 30-39 and below. Furthermore, the National indicator data set (NIDS, 2017:23) permits people aged 40 years and older to be screened on daily basis for HTN prior to consultation in a PHC and Hospital setting. Therefore, the increase in age, in particular in people aged 40 years and older, is deemed as an appropriate age range to yield data from as this is the age where hypertension starts to be evident in most people on BP reading in PLWH.

3.7.2 Exclusion criteria

Exclusion criteria refer to elements that makes one not be used as a participant in a study (Gray *et al.,* 2017:331). In this study, exclusion criteria will include; (I) People living with HIV and more than one chronic condition e.g. DM, HTN and HIV, (II) Newly diagnosed clients for both HIV and HTN (less than one year), and (III) Visitors (once - off clients) in the clinics.

3.8 SAMPLE SIZE AND SATURATION

The sample size of the study was estimated at six to ten participants being guided by the principle of saturation. Data saturation in qualitative research refers to the gathering of qualitative data to a point where a sense of closure is obtained because the new data yields redundant or repetitive information. This occurs when no new analytic data arises anymore and the study provides maximum information on the phenomenon studied (Moser & Korstjens, 2018:11). Data saturation was reached in the ninth participant.

3.9 DATA GATHERING METHOD AND PROCESS

In this section, the researcher will describe the data gathering method and the process that was involved in obtaining data from the participants.

3.9.1 Data Gathering Method

The data gathering method that was used in this study was with semi-structured interviews. A semi-structured interview is a data collection method in which the researcher asks particular questions and makes use of probes to get more information (Brink *et al.,* 2012:158). The central question that guided the study was: can you please share with me your experiences of living with HIV and HTN with regard to disease management? Depending on the reply that the participant provided, the researcher used probes, which are prompting questions that encourage the participant to dwell more or to elaborate on the question asked. The researcher implemented this by making use of the semi-structured interview schedule that contained the probes that were used to stimulate responses to the participants (see Annexure B).

3.9.2 Data gathering process

In this study, a gatekeeper was used. According to Cresswell (2013) in Gray *et al.* (2017:277), gatekeepers are people who can provide access to the culture, facilitate the collection of data and increase the legitimacy of the researcher. In addition, this could be a nurse manager, or a nurse considered a unit's expert. In this study gate-keepers, started at Nelson Mandela University where the researcher obtained permission to conduct a study (see Annexure C), followed by ECDOH (see Annexure

D), and the District manager and Sub-district manager at the clinics where data was collected (see Annexure E).

The researcher identified all the participants living with HIV and HTN at the selected clinics where the study was conducted and then invited the eligible participants to participate as they came for their monthly chronic medication visits by explaining the study to them: the title, purpose, aim, benefits, risks and confidentiality of the study, and asked for their consent. The recruitment of the participants involved providing them with the information sheet explaining all the contents of the study (see Annexure H). The data gathering process took place in the morning so that clients could carry on with their activities soon after the interview. The interview process took place at the procedure rooms of the clinics where the participants attend because of the confidentiality nature of the rooms.

The semi-structured interviews were done in *Isixhosa* and took a minimum of 45 minutes to a maximum of one hour each and were then be transcribed verbatim in isiXhosa and were back translated into english to ensure validity. The semi-structured interview transcripts were presented back to the participants to ensure that the experiences described were what they meant during the interview. The researcher also asked for permission to do a follow-up interview should there be a need for follow up questions. There were no follow up interviews. The researcher during this process made use of a reflective journal, with field notes, and a tape recorder was used to collect information.

3.9.2.1 Field notes

In this study, the researcher made use of field notes during and after each interview. According to Groenewald (2004:15), field notes enable the researcher to reflect on what was happening during the interview. The researcher used field notes to record the verbal and non-verbal information during the Interview and these were used as a proof of the interview should the voice recorder stop working or the participant was not comfortable with the tape recorder (see Annexure H).

3.10 DATA QUALITY

3.10.1 Trustworthiness

In the study, the researcher maintained verification of qualitative rigour by means of Lincoln and Guba’s (1985) model of trustworthiness, which is made up the criteria of credibility, dependability, confirmability and transferability as discussed in Brink *et al.* (2012:172). Table 3.1 shows how each criteria of trustworthiness were applied in this phenomenological study.

3.10.2 Credibility

This is defined as criteria which determine whether the researcher has established confidence in the truth findings with the participants and context in which the research was undertaken (Botma, Greeff, Mulaudzi & Wright, 2010:233).

3.10.3 Dependability

This is defined as the reliability of the data collected from participants over time and over conditions (Polit & Beck, 2018:296).

3.10.4 Confirmability

This refers to the objectivity, the potential for congruence between two or more independent people about the data accuracy, relevance, or meaning. It is concerned with establishing that the data represent the information participants provided and that interpretations of those data are not imagined by the inquirer (Polit & Beck, 2018:296).

3.10.5 Transferability

This refers to the ability to apply findings in other context or to other participants (Brink *et al.,* 2012:173).

Table 3.1: Application of Trustworthiness

Criteria	Strategy	Method
Credibility	• Reflexivity of the researcher	• Keeping a journal so that all the field notes can also appear in the journal to ensure the truth value of the findings. The researcher kept a journal for writing the field notes during each interview.
	• Member checking	• This was ensured by transcribing the interviews and showing it to participants to make sure that what is typed is actually what they meant.
	• Prolonged engagement	• Credibility was ensured by spending time with the research participants so as to get the meanings they make of their experiences.
	• Peer examination	• Peer examination was done to ensure that the data findings were credible by having the supervisor go through the findings to ensure that they were credible.
	• Triangulation	• Data was collected by using semi-structured interviews, and by means of field notes.
Dependability	• Peer examination	• This was assured by having the supervisor go through the findings to ensure that consistency was maintained in collecting the data so that if it were to be done in another setting, similar results could be obtained.
	• Thick and dense description of research methodology	• This strategy was assured by properly describing the methodology process, starting from the design that was used to how the data was analysed to ensure that if a similar study were to be done, consistent results would be obtained.
	• Member checking	• This was ensured by transcribing the interview and showing it to participants to make sure that what was typed was actually what they meant.

Criteria	Strategy	Method
Conformability	• Prolonged engagement • Audiotapes and transcriptions • Audit trial	• This was assured by spending time with the participants in order to get a meaning from the data that was not biased. • The researcher sent the audiotapes to the supervisor and the transcripts so that the supervisor could confirm the meanings interpreted by the researcher. • An audit trail was done by updating the supervisor and having the supervisor verify every step of data analysis so that the study findings could be confirmable.
Transferability	• Selection of sampling • Data saturation • Thick or dense description • Triangulation	• This was assured by using purposive sampling so that the participants could have the same characteristics even if the study were to be done in another setting, so that it could be transferable. • Saturation was assured by interviewing the clients until they started to repeat the same information so that even if the study were to be done in another setting, the findings would be similar. • This was assured by describing all the findings through clear writing of the field notes and the data from the interviews so that transferability could be achieved. • Triangulation was assured by conducting the interviews and keeping the field notes to ensure transferability of the findings.

3.10.6 Pilot study

In this study, a pilot study was conducted. A pilot study is a smaller sample study performed with the same research population, setting, intervention, if any, and plans for data collection and analysis. The purpose of a pilot study is to determine whether the proposed methods are effective in locating and consenting subjects and in collecting useful data (Gray *et al*., 2017:54). The pilot interview was conducted with one participant; this was to ensure the researcher's process of interviewing and whether the probing inherent in the data gathering would yield the lived experience from the participants. The participant was identified from the selected clinic where the study was taking place. The participant met the inclusion criteria. The participant was approached prior to the interview and the study was explained to the participant and the ethical standards that would underpin the interview. The interview was audiotaped and it lasted for about 30 minutes. When the researcher left the field and arrived at home, the interview was transcribed verbatim. The analysis of the pilot interview showed that there was no problem in the interviewing process or with the depth of information gathered through probing from the interview schedule. The pilot interview thus was included in the sample of the main study.

3.11 DATA ANALYSIS

According to Creswell (2007:148), qualitative data analysis is the process of organizing the information from the interview transcriptions into codes and converging the codes into categories and themes then delineating the information into discussions. In this study, Giorgi's phenomenological method of data analysis guided the study, coding was done by the researcher and the supervisor. Giorgi's method consists of the following steps as cited in Pallikkathayil and Morgan (1991:197).

Table 3.2: Data analysis steps

Steps	Theoretical process	Application
One	Reading of the entire disclosure of the phenomenon straight through to obtain a sense of the whole	Reading repeatedly the transcripts after each interview to obtain emerging themes was conducted.
Two	Re-reading the same disclosure in a purposeful manner to delineate each time a transition in meaning occurs. This is done with the intention of discovering the essence of the phenomenon under study.	The researcher and supervisor met to review coding and categorisation of each transcript. Consensus was reached on whether information was clear or not.
Three	Examining the previous determined meaning units for redundancies, and clarification, or elaboration by relating meaning units to each other and to a sense of the whole.	The meaningful units /themes were examined and also those not related, and unique themes were noted.
Four	Reflecting on the meaning units and extrapolating the essence of the experience for each participant. Systematic interrogation of each unit is undertaken for what it reveals about the phenomenon under study.	Reflections were done on the identified categories and narrative capturing the essence of the phenomenon under study was formulated.
Five	Formalizing a consistent description of the structure of the phenomenon under study across all participants by synthesizing and integrating the insights achieved in the previous steps.	Common experience for the phenomenon was identified and relevant literature was used to support participant’s information.

3.12 ETHICAL CONSIDERATIONS

The researcher upheld the following ethical standards during the entire research process, these being the principle of beneficence, justice, respect for human dignity, right to privacy and confidentiality, anonymity and informed consent.

3.12.1 Principle of beneficence

Beneficence is an ethical principle that enforces the researcher to prohibit harm to research participants (Polit & Beck, 2018:79). In the study, the principle was assured by making recommendations that would ensure quality nursing practice to PLWH and HTN by RNs working in the PHC context, and debriefing was done after each interview. Secondly, this was assured by conducting interviews at a safe location that was free from any physical harm.

3.12.2 Principle of justice

The justice principle involves a sense of fairness in distribution or what is deserved (Miracle, 2016:223). In this study, justice was assured by ensuring that all the participants were represented in terms of gender balance, which is both genders were included. Furthermore, the study was open to use all races and ethnic groups in the study setting to ensure a fair selection of potential participants.

3.12.3 Principle of respect for human dignity

The principle of respect of human dignity was explained by right to self-determination and the right to full disclosure. Self-determination is defined as a principle in which research participants can decide to take part in the study or decline. It is non–mandatory (Polit & Beck, 2018:80). Full disclosure involves the researcher in explaining all the details of the research study to the participants, the non-compulsory right not to take part in the research, and possible harm and advantage of participation (Polit & Beck, 2018:81).

In this study, respect for human dignity was assured by ensuring that the participants were not being forced to be part of the study in any way. In addition, the researcher ensured that all participants in the study were aware that they could withdraw anytime they wanted to and that would not have any impact on the care rendered by the researcher to them at the clinic. Furthermore, the researcher ensured that the topic, aim, benefits, significance of the study were explained to the participants so that they could have the information prior to participation in the study. The researcher formulated an information sheet that was distributed to the research participants (see Annexure F).

3.12.4 Right to privacy

According to Gray, Grove and Sutherland (2017:168), privacy is a participant’s personal choice to decide the moment; the situation in which the details revealed to the researcher could be divulged or concealed to people. In this study, the right to privacy of the participants was protected by ensuring that no information was divulged without the knowledge of the participant. Secondly, privacy was ensured by making sure that no one besides the researcher was present during the interview and interviews were done in a secure location free from people coming in and out. In this study, the recordings from the interviews were saved on the password-protected laptop of the researcher that could only be accessed by the researcher and the supervisor. Lastly, privacy of the participants was assured by asking the participants to use pseudonyms instead of their real identities at the beginning of the interviews.

3.12.5 Right to confidentiality

Confidentiality refers to the researcher's process of making sure that any information the client shares is not revealed (Burns & Grove, 2011:117). In addition, Polit and Berk (2018:84) state that confidentiality is an agreement that the researcher will not divulge any information shared by the participant in any way. In the study, the right to confidentiality of participants was ensured by not mentioning or writing the participant's names on the interview transcripts (see Annexure I). Secondly, the names of the participants were mentioned during interviews, so that they could be addressed by their pseudonyms. Lastly, the names of the participants were not written in the dissertation.

3.12.6 Right to anonymity

Anonymity refers to the technique whereby the researcher ensures that any information shared during data collection is not connected to the participant (Polit & Beck, 2018:83). In this study, the right to anonymity of participants was ensured by not including the names of the participants in the interview transcripts (see Annexure I). In this study, anonymity was ensured by not writing any information that can be traced back to the participant such as surname and identity number.

3.12.7 Right to informed consent

Informed consent involves providing enough details about the study to the participants so that they could understand well enough, enabling the participants to be able to decide whether or not they wanted to be part of the study (Polit & Beck, 2018:83; De Vos *et al.,* 2011:117). In this study, the researcher ensured that all the participants involved in the study had agreed; that is, the researcher had explained the topic and purpose of the study and the participants voluntarily agreed to be part of the study by reading and signing the consent form (see Annexure G). In addition, clients who were illiterate or couldn't sign due to age received a verbal request from the researcher and the researcher ensured that all clients consented by signing or verbally accepting to be part of the study after having the title, purpose and aim of the study explained to them. The researcher formulated an information sheet and informed consent that would be signed by participants after informing the participants about the study.

3.13 DATA MANAGEMENT

All collected data in the form of written informed consent and all field notes and the reflective journal were stored in a locked cupboard, only accessible to the researcher. The transcribed data of the interviews and the audio recordings were stored in password-protected personal computers (PCs) - of the research supervisor and the researcher. All informed consent forms were stored in a locked cupboard of the researcher. All participants were requested to choose a pseudonym to ensure that their actual names were not written in the transcripts. All informed consent forms will be stored in a locked cupboard of the PRP. All information will be kept for a period of five years and all electronic information will be deleted from the hard drive and recycle bin of the researcher's PC and all hard copies of documents will be destroyed by shredding. The researcher will send the ECDOH the findings and will present the study findings at the Nelson Mandela University Faculty of Health Sciences Research conference. The researcher during this time will publish the study findings whilst waiting for the results.

3.14 CONCLUSION

In this chapter, the research approach, research design, theoretical and philosophical approach that underpinned the study, research setting, target population, sampling methods, data gathering method and process and how data was analysed were discussed. Furthermore, qualitative rigour, data management and the ethical considerations that the researcher would uphold were discussed.

CHAPTER FOUR

PRESENTATION OF RESEARCH FINDINGS

4.1 INTRODUCTION

The purpose of this descriptive phenomenological study was to explore and describe the lived experiences of people living with HIV and HTN with regard to disease management in Sakhisizwe sub-district, Eastern Cape. This chapter presents the findings of the inquiry and will include: (a) a sample description of the participants, (b) the description of Giorgi's phenomenological steps of data analysis and how it guided the analysis that is obtained in the study, (c) the presentation of the essential themes and (d) the exhaustive description of the central theme or essence of the lived experiences of living with HIV and HTN.

4.2 SAMPLE DESCRIPTION OF THE PARTICIPANTS

The aim of the study was to recruit participants who are living with HIV and HTN and have the experience of living with and managing HIV and HTN. With a sample size of nine participants, the researcher reached saturation of the essential meanings inherent in the descriptions of the lived experiences of living with HIV and HTN. The aspects that limited the availability of the participants was the number of co-morbidities that the participants were living with, such as those of HIV, HTN and DM, while the focus of the study was targeted only to participants who were living with HIV and HTN. Some of individuals were not eligible and were excluded because they were living with either HIV only or HTN only, and in some instances, individuals had been living with HIV and HTN for less than one year. This thus prevented them from participating in the study.

Table 4.1 Participants' demography

Pseudonym	Age	Gender	Highest level of education	Years of living with HIV and HTN			Number of depend-ents
				Years of living with HIV only	Years of living with HTN only	Years of living with HIV and HTN	
Bulelwa	44	Female	Grade 11	3	3	**3**	02
Nolubabalo	48	Female	Grade 12	9	9	**9**	03
Fumanekile	57	Male	Grade 9	18	4	**4**	04
Nosigniture	55	female	Grade 8	7	2	**2**	02
Sipho	55	Male	Grade 8	5	5	**5**	02
Zandile	41	Female	Grade 12	7	15	**7**	02
Siyanda	43	Male	Grade 6	5	2	**2**	01
Lelethu	46	Female	Grade 10	9	10	**9**	04
Vuyani	52	Male	Grade 10	15	10	**10**	02

4.2.1 Biographical description of the participants

The rigour of a qualitative study is actively supported and concluded on the basis of its thick description (Ponterotto, 2005:130). A thick description is defined as requiring a thorough and rich illustration of not only participants who experience the phenomenon but also of the scene in which those experiences occur (Morrow, 2005:251). Table 4.1 reflects the demographic characteristics of the study participants. All the participants met the inclusion criteria of the study, which was that they should be living with co-morbidity HIV and HTN for at least one year and be older than 40 years. The age range of the participants was between 40 to 59 years, with five participants being females and four being males. The average age of the participants was 49 years. All participants were from the *AmaXhosa* ethnic group and were all living within the catchment areas of the selected facility within the Sakhisizwe sub-district. All participants were Christians who attended different churches in their communities. In terms of educational status, none of the participants had completed educational training higher than Grade 12 and only two participants had completed Grade 12. On average, the participants had two dependents with the highest being four dependents, found among two of the participants. In terms of years living with HIV only, the sample included participants who were living with HIV for an average of nine years with a range of three to eighteen years, and were living with HTN only for an average of seven years with a range of three to fifteen years. In the sample of participants who were living with HIV only longer than living with the co-morbidity of HIV and HTN, there was an average of six years and in the sample of participants who were living with the co-morbidity of HIV and HTN there was a range of three to ten years. A full description of each participant is provided individually.

Participant 1: Bulelwa

Bulelwa is a 44-year-old female who is the mother of two children, a son and a daughter who are independent, and she also has two grandchildren. Bulelwa has never been married and has always resided in a rural area called Cala which is within the Sakhisizwe sub-district. She is not formally employed as she dropped out in Grade Eleven at school. She is working as a trader in the community selling vegetables and fruit. Bulelwa is a Methodist and has been living with the co-morbidity of HIV and HTN for three years as she was diagnosed with both these conditions in 2016.

Participant 2: Nolubabalo

Nolubabalo is a 48-year-old female who is the mother of three, two daughters and a son, and she also has two grandchildren. Nolubabalo has never been married and has always resided at Cala with her family. Nolubabalo is an Anglican and passed Grade Twelve but didn’t further her studies. Nolubabalo’s father believed that there was no point in sending a daughter to school because of a possibility of getting married and leaving home. Nolubabalo is a committed member of the community and is always considered when there are opportunities of employment besides being a domestic worker. The jobs include working at a Co-op company located within her catchment area. Nolubabalo also assists the Independent Electoral Commission (IEC) during voting periods and was previously a field worker in the project for the Reconstruction

Development Programme (RDP) in the catchment area and is also a facilitator for a water company in the community. Nolubabalo has been living with HIV and HTN for nine years.

Participant 3: Fumanekile

Fumanekile is a 57-year-old father of four children, two sons and two daughters. Fumanekile is married but his wife is no longer living with him as she left him a few years back. He stopped studying in Grade Nine and he went to work in the mines shortly after and returned to Cala in 2005. Fumanekile works as a community leader and is a breadwinner who has managed to send one of his daughters to University in the Eastern Cape. Fumanekile is an Anglican and has been living with HIV for 18 years as he was diagnosed with HIV in 1999 and diagnosed with HTN in 2016. Fumanekile has been living with HIV and HTN for four years.

Participant 4: Nosigniture

Nosigniture is a 55-year-old mother of two, one son and a daughter, and has one grandchild. Her daughter is married; Nosigniture lives with her son who has a mental illness so she takes care of her son. Nosigniture’s husband passed away in 2009 from an AIDS-related illness. The participant stopped attending school in Grade Eight. She is not working and depends on the disability grant of her son and social grant for her granddaughter. Nosigniture has been living with HIV for seven years, being diagnosed in 2012, and was diagnosed with HTN in 2017. Nosigniture has been living the HIV and HTN for two years.

Participant 5: Sipho

Sipho is a 55-year-old father of one son and lost another son before he was born. Sipho is married and living with his wife and son. Sipho stopped attending school in Grade Eight and works for the Expanded Public Works Programme (EPWP), which is the company that is responsible for maintaining gravel roads in the rural area. Fumanekile has been living with HIV and HTN for five years as he was diagnosed with HIV and HTN in the past five years.

Participant 6: Zandile

Zandile is a 41-year-old mother of two sons. She is a widow as her husband passed away in 2012 from a motor vehicle accident. Zandile is a Saint John's Christian member and dropped out of school in Grade Twelve. She did not further her education as she soon discovered a passion for business. Zandile is currently not working and depends on the social grant of her two sons. Zandile has been living with HIV for seven years and was diagnosed with HTN in 2003 when she was pregnant with her first son. She has been living with HIV and HTN for seven years.

Participant 7: Siyanda

Siyanda is a 43-year-old father of one son and is divorced. Siyanda dropped out of school in Grade Six and depends on small jobs he gets from roofing and tiling which is a skill he acquired when he was in Cape Town. He has been living with HIV for five years as he was diagnosed in 2014 and diagnosed with HTN in 2017. Siyanda has been living with HIV and HTN for two years.

Participant 8: Lelethu

Lelethu is a 46-year-old mother of three daughters and she has one grandchild. She is married but Lelethu's husband is residing in Gauteng Province for work purposes. Lelethu is not working and dropped out at school in Grade Ten. Lelethu depends on her husband who is a sole provider. Lelethu is currently living with her grandchild since her three daughters are still at school. Lelethu has been living with HTN longer than she has been living with HIV. She was diagnosed with HTN ten years ago and diagnosed with HIV nine years ago. Lelethu has been living with the co-morbidity of HIV and HTN for nine years

Participant 9: Vuyani

Vuyani is a 52-year-old father of two sons who were born before he got married. Vuyani is currently living alone as his wife has gone back home as he has not settled all the *lobola (pre-marriage customs)* arrangements. Vuyani previously worked in Cape Town but has returned to the Eastern Cape in 2004 when he was diagnosed with HIV. He depends upon the HIV fund he received when he came back to the

Eastern Cape. Vuyani has been diagnosed with HTN in 2010 and has been living with the co-morbidity of HIV and HTN for ten years

4.3 STRATEGY OF DATA ANALYSIS AND PRESENTATION

The researcher prior to data gathering had to do debriefing to allow the participants to feel at ease so that each interview could yield data for analysis.

4.3.1 Giorgi's (1985) phenomenological steps of data analysis

Before the researcher provides a detailed description of the data analysis procedure, it is crucial to provide a brief description and a reminder into the process of data gathering which was described in Chapter Three. Nine semi-structured interviews were conducted by the researcher utilizing a semi-interview schedule that had single broad questions. The researcher used the semi-structured interview guide in establishing rapport and enabling the participants to explain their lived experiences of living with HIV and HTN. The researcher made use of probes which further encouraged the participants to dwell more on their descriptions. The participants were encouraged to be honest and relaxed, and a conversation was held where they described their lived experiences of the phenomenon under study. The interviews lasted for 45 to 60 minutes and were conducted by the researcher. Following each interview, the researcher reminded the participants about the need to contact them for a follow up interview in order to discuss and make sure that the study findings reflected their experiences of living with HIV and HTN and where further elaboration might be needed. There were no follow up interviews. Table 4.2 details Giorgi's phenomenological steps and the application thereof that underpinned the data analysis.

Table 4.2: Data analysis steps

Steps	Theoretical process	Application
One	Reading of the entire disclosure of the phenomenon straight through to obtain a sense of the whole.	This involved reading repeatedly the transcripts after each interview to obtain emerging themes.
Two	Re-reading the same disclosure in a purposeful manner to delineate each time a transition in meaning occurs. This is done with the intention of discovering the essence of the phenomenon under study.	The researcher and supervisor met to review coding and categorization of each transcript. Consensus was reached on whether information was clear or not.
Three	Examining the previous determined meaning units for redundancies, and clarification, or elaboration by relating meaning units to each other and to a sense of the whole.	The meaningful units /themes were examined and those not related, as well as unique themes, were noted.
Four	Reflecting on the meaning units and extrapolating the essence of the experience for each participant. Systematic interrogation of each unit is undertaken for what it reveals about the phenomenon under study.	Reflections were done on the identified categories and narratives capturing the essence of the phenomenon under study were formulated.
Five	Formalizing a consistent description of the structure of the phenomenon under study across all participants by synthesizing and integrating the insights achieved in the previous steps.	Common experience of the phenomenon identified and relevant literature were used to support participant's information. This is detailed in Chapter Five of the study which is a discussions chapter.

A full description of the application of the data analysis steps is further provided and discussed below.

Step One: Getting the general sense of the whole

This step involved listening to the nine audio-recordings one by one and transcribing them verbatim. The audio-recordings were listened to and transcribed, then read for many times in order to get the sense of the disclosure. The researcher did this by reading each transcript over and over in order to make sense of the whole document.

During this process, the researcher's personal observations, knowledge and beliefs were set aside by recording in a reflective journal (see Annexure A). This was done to achieve the methodological stance of bracketing and also to allow new insights to be described by the participants in the research.

Step Two: Discriminating and extracting significant statements

This second step of data analysis entailed re-reading the transcripts again but now in a purposeful manner in order to get the meaning codes from the participant's own words. During this process, the researcher had to read each of the nine transcripts. Each transcript had a minimum of 20 pages and a maximum of 49 pages containing the pseudonym, the place of the interview and the time the interview was conducted. The use of a Microsoft Excel spread sheet enabled the research and supervisor to keep a log of each meaning unit and related excerpt that was identified during this step of the data analysis process (see Annexure J). This data analysis step yielded 704 meaning codes. Following the identification of the meaning codes, through the process of consensus between the researcher and the supervisors, similar meaning codes were grouped together to form categories.

Step Three: Formulation of the meaning units

This process of data analysis involved examining the previously determined meaning units for redundancies and clarification or elaboration, by relating meaning units to each other and to a sense of the whole. By doing the process, the meaning units /labels were examined, and those not related, as well as unique themes, were noted together and those that were outliers were noted. Nine meaning units were condensed from the 704 meaning codes. This was done by grouping from the 704 meaning codes those that were similar; the researcher and the supervisor met and those meaning units that had the same meaning and were related were labeled together. The researcher, after grouping the nine meaning units, identified those that were related to the research questions, and those that were unique and outliers which were not related to the research question were grouped as well.

Step Four: Formulation of the themes or essence

This step was done by reflecting on the meaning units and extrapolating the essence of the experience for each participant. Systematic interrogation of each unit was undertaken for what it revealed about the phenomenon under study. The meaning units that had the same meaning were grouped together in the Excel document and focus was placed on the phenomenon under the study which is the lived experiences of living with HIV and HTN. From the nine meaning units, five meaning units appropriately focused on the phenomenon of the study and narratives and capturing the essence of the study was formulated. This process allowed the themes and the sub-themes to emerge.

Table 4.3: Example of how one of the themes was formulated

Theme	Meaning units	Meaning codes	Excerpts from the data
1.Overcoming-illness-related stigma	Fear of being isolated by loved ones and the community	Social stigma Fear of contagion Fear of judgment Fear of disclosure Self-blame	*"They will isolate me, and maybe sometimes you think that I love cooking eh so It will happened that when im cooking, they will not eat the food"* (T1, L 189-91). *"I'm afraid that people will talk about me badly (kakubi)"* (T5, L 351). *"Maybe judge me and say hurtful things like I am silly because I have HIV"* (T7, L 627). *"I blamed myself because I knew the way I was carrying myself* (T7, 464)*"* *"I will have my separate spoon to eat"* (T1, L 155).

Step Five: Synthesis of transformed meaning units into a consistent description of the structure of the phenomenon under study

After all the meaning units were examined and formulated in the previous step, all themes were defined and portrayed into an exhaustive description of the phenomenon under study. In addition, common experience for the phenomenon was identified. This step is discussed further by Chapter Five of the study. Table 4.4 highlights the themes and the sub-themes that emerged from the process of data analysis.

Table 4.4: Presentation of themes and exhaustive description

Themes	Sub-themes
1. Overcoming illness-related stigma	• Anticipated stigma • Internal stigma • Received stigma/social stigma
2. Sources of support	• family support • peer support • health practitioner's support
3. Self-love: Taking ownership of the diseases	• Self-acceptance • Self-motivation
4. Creating transforming behaviours and self-care practices	• Making a plan • Coping with medication • Access to treatment • Grading of diseases • Pill burden • Unhealthy addictions

4.3.2 Theme One: Overcoming illness related stigma

The participants expressed that living with HIV and HTN was plagued with stigma related to their illness, in particular experiencing stigma that was related to the participant's HIV status. Participants experienced being judged and labelled with the virus by the people in the rural community. Various forms of illness-related stigmas emerged as a theme that participants experienced in various forms, and learning to overcome the stigma and discrimination formed part of the process participants experienced towards developing a new normal life as the lived experience of living with HIV and HTN in terms of their disease management. Participants experienced stigma as manifesting in three forms, namely anticipated stigma, internal stigma and social or received stigma. Participants identified that overcoming the various forms of stigma and discrimination was a process that varied for each participant and was dependent on their acceptance of their HIV or Hypertension diagnosis. The following excerpts highlight this statement further:

> *"This is where you need to give up and have self-acceptance, be happy and tell yourself that the condition is yours and you won't give it to anyone else and be left without it."*
>
> (T4, L259-61).

> *"I was scared that they will gossip and say things you see. I don't know this condition, it is not lucky."*
>
> (T1, L 641-2).

Based on the findings, the participants expressed that stigma is a serious issue in the rural setting; people fear being stigmatised, stigmatise themselves and are stigmatised by others in the community, based on HIV status or HTN diagnosis. However, the participants also expressed that towards developing a new normal of living with HIV status and HTN diagnosis meant that they had to learn to cope with the discrimination by not caring what others have to say about their HIV status. This quote reflects this further:

> *"Haike! No, I don't care about other people because even if they hear that I am sick, it won't go out and it's not like it goes out just because one knows that I am sick so what is going to scare me?"*
>
> (T2, L 273-5).

4.3.2.1 Sub-theme One: Anticipated stigma

Anticipated stigma was experienced in terms of participants expecting a negative behaviour or outcome from their family or significant others in light of living with HIV. Participants experienced anxiety of disclosing their HIV status due to fear of the reaction from their family or significant others. This is demonstrated in the following excerpts.

> *"I was afraid because I didn't know if they were going to accept."*
>
> (T6, L 122-3).

> *"I didn't tell her because I was scared that she will be shocked you see."*
>
> (T7, L 160).

Further to this, anticipated stigma was experienced in terms of participants envisaging being devalued or dehumanised due to their HIV status, which was often attributed to witnessing discriminatory actions meted out to other people living with HIV. Participants experienced fear of disclosing their diagnoses to their families and loved ones because of the fear of being stigmatized within their close circles. The selected quote reflects this:

> *"People especially family once they hear that one has a certain condition, you become a laughing stock to them without knowing the pain you are feeling."*
>
> (T3, L 123-5).

Moreover, some participants even took more time before disclosing to those closest to them, due to the anticipated fear of rejection and stigmatisation. This was noted as also contributing to delaying the process of accepting their HIV status. The selected quotes reflect the anticipated stigma experienced:

> *"it was not easy. It was not as I think I took about five months Trying to be strong."*
>
> (T1, L 173-4).

> *"I feared that he was going to say: sorry my sister, as I was also into this guy. I'm sorry my sister I don't deal with people like that."*
>
> (T1, L 418-20).

> *"I was afraid because I didn't know if they were going to accept; they will accept this condition or they will not accept it."*
>
> (T6, L 122-3).

4.3.2.2 Sub-theme Two: Internal stigma

Evident from the data analysis, the participants verbalized internal stigma which occurred within them and was directed by self. This type of stigma made them to experience feelings of self-blame with regard to the lifestyle and life choices that they had made and adopted before acquiring the illnesses. The following quotes reflect the internalized stigma:

> *"Eh maybe I will have my separate spoon to eat?"*
>
> (T1, L 154-5).

> *"I blamed myself because I knew the way I was carrying myself wrong you know is where I had HIV you see. Yes for not using a condom when sleeping with people you see. So those were the mistakes of alcohol even so you see. so that is why I'm saying I was not scared when it was said I have HIV because I knew that I was playing careless you know."*
>
> (T7, L 463-70).

The participants experienced feelings of regret towards a new normal of living with HIV and HTN and they started to stigmatise themselves to a point where they started to regret everything and how they had behaved in the past. The excerpt below explains this type of stigma further:

> *"I regretted my behaviour double; I regretted myself double."*
>
> (T5, L 560).

4.3.2.3 Sub-theme Three: Social stigma

Based on the findings of the study, the participants verbalised fear of being stigmatised by the people in the rural community because of their diagnoses. The participants experienced extreme anxiety of being stigmatised by their members of the community and being known that they are living with HIV. In addition, some participants towards a new normal of living with HIV experienced that when they are going in places where there are people, they would remove their medications from their containers because of the noise made by the pills which would make them known to the members of the rural community that they were using medication should they hear the sound and thus cause stigma to them. The following quotes reflect this further.

> *"Sometimes I put it inside the container and wrap it with a toilet paper so that it stops the movement that makes the noise."*
>
> (T9, L 734-5).

Furthermore, some of the participants verbalized that they feared how the negative remarks from the people in the community would make them feel when they discovered that they were living with HIV; hence they end up hiding their diagnoses. The following statements explain this further.

> *"I was scared that they will go on spreading to everyone that this one is sick, this and that."*
>
> (T2, L 1078-9).

In addition, some participants towards developing a new normal of living with HIV experienced fear of being identified by their illnesses and lose their worth in the community. The following quote explains this further.

> *"Maybe every person when looking at me will look and say this person is living with the virus."*
>
> (T1, L 159-60).

Moreover, some of the participants described that for them it was better to take the medication in places that are away from the people because of fear of being known and stigmatised based on the illnesses.

> *"No I take it in a private space the reason is because all people are living in secret about the conditions they are living with so I also don't want them to know, I'm glad that it's only my family that knows."*
>
> (T4, L 424-6).

4.3.3 Theme Two: Sources of support

Based on the findings of the study, the participants experienced that family support played a major role in helping them towards developing a new normal such that their support enabled the participants to accept their diagnoses, to accept themselves and to adhere to their medication. The following excerpts reflect this further.

> *"Yes my family, they said that if you take my pills, that is what we are saying nothing else, if you are taking your treatment the right way, you will be alright."*
>
> (T2, L 250-2).

> *"Ey my brother I don't want to lie, I received support from my family there is nothing that is beyond family."*
>
> (T6, L 455-6).

The participants expressed that because they live a rural community where stigma is a challenge, their families and loved ones were their source of strength who encouraged them and showed them love and advised them to continue to use their medication. The participants experienced support from their parents, who accepted them when they disclosed to them, from their siblings. The following quotes explain this further.

> *"She'd encourage me to cook on time so that I can eat your pills (Referring to her mother)."*
>
> (T2, L 380).

> *"Then my sister that I was living with made encouraged and made me strong."*
>
> (T9, L 125).

In addition, some of the participants verbalised that for them, their significant others, who include their wives and children, were their sources of support in living with two illnesses. Some participants verbalised that their partners played a role in supporting them and enabled them to cope with living with two illnesses. The quote reflects this further:

> *"It's my wife. She will say father of my child, take your treatment. After eating your porridge in the morning and late take your treatment and not forget it."*
>
> (T5, L 444-5).

4.3.3.1 Sub-theme One: Family support

The participants expressed that because they live a rural community where stigma is still a challenge, their families and loved ones were their source of strength who encouraged them and showed them love and advised them to continue to use their medication. The participants experienced support from their parents, who accepted them when they disclosed to them, from their siblings. The quotes reflect this further:

> *"Yes they do I told them and they said I must use my pills and take them (referring to her family)."*
>
> (T4, L 456-7).

> *"I told my mother first .yes then I told my husband."*
>
> (T6, L 117-9).

> *"I told my sisters all of them immediately even with them. Even my sister who is overseas, she also talks to me and encourages me and say this and this since she knows these things because it is said that they started there overseas because even with this one pill, I heard from her that it is on its way."*
>
> (T6, L249-52).

> *"He supports me and I support him or when he has arrived and I see that he is busy and it's time for him to take his pill, I bring it to him and put it in his hand and give him water to drink. I don't talk then I go back inside the house because other people do not know what I'm giving him."*
>
> (T8, L 431-4).

> *"By everything, she supports me; she encourages me and tells me not to lose hope. She encourages me to take my treatment and put me in the right path and I also listen to her."*
>
> (T5, L 528-30).

> *"They said I must take my pills you will live there is nothing, there is no problem and we will always love you (her children)."*
>
> (T8, L 383-4).

Some participants verbalised that their partners played a role in supporting them and who enabled them to cope with living with two illnesses.

> *"He is one of the people who have made me see myself."*
>
> (T1, L 426).

4.3.3.2 Sub-theme Two: Peer support

Evident from the data analysis, the participants verbalised that although their families and significant others supported them; support of their peers played a crucial role in enabling them to accept themselves and comply with the treatment of the two illnesses. In addition, the participants expressed that for them even when they were diagnosed; their peers were amongst the people who initially supported them. The excerpt explains this further:

> *"No I told my friends whom I chat with."*
>
> (T2, L 260).

Furthermore, the participants experienced the peer support through other patients whom they knew and just like them live with the chronic illnesses, and they received support from each other. Although the participants expressed that they didn't have support groups, they verbalised that they had each other and their support was one of the things that enabled them to cope with living with the two illnesses. The quote explains this further.

> *"They just said my sister we are living with pills since we were started in years ago because they started before me. We are still taking our pills they said and there is nothing as you can see us we are still walking and alive."*
>
> (T2, L 581-4).

Moreover, the participants expressed that they experienced support of their peers through their meaningful conversations when they are in the clinic for their monthly medication. The following quotes explain this further:

> *"Others as we are sitting at the clinic, others the person will say no if you eat treatment in the right way, there is nothing."*
>
> (T1,L 210-1).

Some of the participants expressed that they even reminded each other to continue taking their medication for their illness rather than being defeated by medication. The following quote explains this further:

> *"There are a lot that that I chat with, we even remind each other not be defeated by one pill, the one we take at eight."*
>
> (T4, L 694).

4.3.3.3 Sub-theme Three: Health practitioner's support

It emerged from the data that although the participants received support from their families and peers, the professional nurses in the clinic were also amongst the people whom they confided in and who provided support and encouragement to them and gave them hope towards developing a new normal of living with HIV and HTN. The participants verbalised that being in the rural area; they regarded the nurses as the influential people who have played a part in them coping with the two illnesses. In addition, the participants verbalised that for them, the nurses were also their source of support who encouraged them to accept themselves and who helped them to cope with the two illnesses through the education and counselling they provide in the clinic. The following quotes explain this further:

> *"To me it is treatment there is nothing else that id except that, and the On-going counselling by the nurses."*
>
> (T2, L 246-7).

> *"The thing that made me to accept was the on-going counselling and support I got where I take my medication"*
>
> (T3, L 200-1).

Furthermore, the participants expressed that the professional nurses in the clinic they attend are always welcoming and are the people who are always eager to assist them in coping with the illnesses and advising them. The following quotes explain this further:

> *"They sat down with me first and it was explained to that I must know that if we check and find that you have this and this, you mustn't be shocked you see You should accept and I said no problem check me everything that you want to check you see."*
>
> (T7, L188-91).

Moreover, based on the findings, the participants verbalized that the professional nurses in the clinic are their source of information and support and they are always displaying a positive attitude which makes it possible for them to confide in them. The quotes explain this further:

> *"The way nurses are treating us is well because would find out that the nurse compliments you and say you are beautiful, you are clean and your skin. Those encouraging words. Your skin is well. You are taking good care of yourself."*
>
> (T1, 526-9).

> *"At the clinic, the nurses talk to us. I'm always lucky have never had a problem that a nurse maybe talk to me in a bad way and cause me to have my blood pressure raised, they are always in the mood to help."*
>
> (T6, L 458-60).

The participants experienced support from the nurses through the way they communicate with them and through the way they always go an extra mile to make sure that they continue to take their medication both for HIV and HTN. The participants verbalised that although there is still stigma, the neutral place is the clinic with the nurses who are always consistent in the care they provide and their support. The quote explains this further:

> *"When I come here at the clinic, I'm helped by my nurses Whom I take treatment to then I gain strength."*
>
> (T5, L 530-32).

Evident from the data, the participants expressed that the support of nurses is what enabled them to accept themselves and their diagnosis, thus facilitating the process of living with two chronic illnesses. The participants explained that the nurses are what enabled them towards a new normal.

4.3.4 Theme Three: Self-love: Taking ownership of the diseases

The third theme that emerged from the data analysis of taking ownership and loving yourself is what enabled the participants to cope with living with HIV and HTN. The participants experienced self-acceptance and motivation as a means of coping towards developing a new normal with HIV and HTN. This is demonstrated by the development of self-encouragement in the management of the two illnesses. The following quotes explain this further:

> *"No things that helped me to cope with this treatment is one knowing that if I don't take my treatment, the condition will be worse so I need to careful and go and take treatment so that, instead of the condition worsening, it will be better."*
>
> (T3, L 286-9).

> *"But I knew that I will manage it with these pills, with this Treatment."*
>
> (T4, L 398).

Furthermore, the participants verbalized that indeed accepting and living with two illnesses is a process that required them to develop self-coping skills. The participants had to develop self-love as a way of coping. The following quotes explain this further:

> *"This is what I found out that if you love yourself no (hayi), no.one can say you are living with these conditions."*
>
> (T1, L 256-7).

> *"You have to love yourself, which is very important."*
>
> (T4, L 620).

4.3.4.1 Sub-theme One: Self-acceptance

Evident from the data, self-acceptance for the participants meant that for them to be able to live with the two illnesses they had to first accept themselves as the people who are living with the two illnesses. The following excerpts explain this further:

> *"I accepted that then. I felt strong because knowing that it is a condition that is present in people and it is not only in me only."*
>
> (T3, L 85-88).

> *"This is where you need to give up and have self-acceptance, be happy and tell yourself that the condition is yours and you won't give it to anyone else and be left without it."*
>
> (T4, L 259-61).

Furthermore, the participants verbalized that these conditions are for the people; hence they had to accept them and take ownership of the illnesses, which enabled them to cope and manage them. The quotes explain this further:

> *"It was like a gift given to me, I just accepted it like that because it is a condition for people."*
>
> (T5, L 90-1).

> *"I had to be strong like a man because this is the condition for people."*
>
> (T5, L 96-7)

In addition, the participants expressed that they experienced self-acceptance by first accepting the two illnesses and taking ownership of them to be able to live with both of them and take their medication. The quotes explain this further:

> *"I accepted. I don't have stress."*
>
> (T4, L146).

> *"A person must accept first of all. If you don't accept You won't live."*
>
> (T1, L 550).

Moreover, instead of denying the illnesses, the participants experienced a sense of ownership of their diagnosed illnesses and started to love and accept themselves as a way of coping. The quote reflects this further:

> *"I said let me accept myself because if I don't accept myself, I will not be able to focus on those pills."*
>
> (T8, L 124-5).

4.3.4.2 Sub-theme Two: Self-motivation

Based on the data analysis, the participants described that self-motivation is what enabled them to cope and take their medication for the two illnesses. Participants expressed that they experienced this by encouraging themselves to continue to adopt appropriate behaviour, adhering to medication and becoming responsible towards their management of the two illnesses. The quotes reflect this further:

> *"I told myself that if I don't take my treatment it is the end of my life."*

(T8, L 330-1).

> *"I knew that if it is said I must use my treatment maybe all will be well because what causes a problem is when it is said you have something and not use treatment."*
>
> (T9, L 156-7).

The participants experienced motivation in themselves and self-determination which helped and enabled them to continue to live and take their medication. Furthermore, the participants verbalised that in order for them to continue living with the two illnesses, they had to remain motivated and take their medication. The excerpts reflect this further:

> *"And I told myself that there is nothing that will make me not to take my pills."*
>
> (T2, L 377-8).

> *"The thing is I knew that I was going to live if I take this treatment that I am told by the Drs (referring to nurses)."*
>
> (T5, L 115-6).

4.3.5 Theme Four: Creating transforming behaviours and self-care practices

Based on the data analysis, the fourth theme that emerged is making healthy life choices: HIV is better than HTN. The participants expressed that in order to continue to live with the two chronic illnesses; they had to start taking good care of themselves towards developing a new normal of HIV and HTN. This meant that the participants had to change the way they were eating and follow instructions given. The quote below explains this further:

> *"When you have these conditions, you don't drink alcohol, you don't smoke cigarette, yes and you need to be a person who love drinking water the food must not have excess of fat, and a lot of salt."*
>
> (T3, L 423-35).

4.3.5.1 Sub-theme One: Making a plan

It emerged from the data that in order for the participants to take care of themselves; there was a need to develop a plan that would facilitate that they managedtheir two chronic illnesses well. The participants expressed that the plan included preparing their meals prior to the time of taking the medication so that they could be able to take their medication at their specified times, which is in the morning and in the afternoon in order to accommodate their anti-hypertensive drugs and anti-viral drugs. In addition to this, the participants experienced that to manage these two illnesses required them to adopt a healthy lifestyle, which means that the diet that they consumed should be the one that has the necessary nutrients needed by the body. The quotes explain this further:

> *"I eat healthy food; fruits and veg, meat and so on."*
>
> (T2, L 706-7).

> *"Another to eat the right way, to eat veg and fruit, it is very important in the body."*
>
> (T6, L 656-8).

Furthermore, the participants in the making the plan verbalised different time frames for taking the medication ranging from the morning for their HTN medication and eight and nine for their HAART medication. The time frames enabled the participants to manage the two illnesses by taking the medications at their stipulated times that is suitable for them. The selected quotes reflect this further:

> *"In the morning i take the one that is white in colour; sometimes I take the one that is pink. You see when I have taken the pink one; it is the one that really helps me."*
>
> (T4, L 500-2).

> *"No I wake up and take my treatment for pressure in the morning after eating porridge yes then I take the other pill at night."*
>
> (T8, L 372-5).

However, even though the participants decided on the stipulated times, they expressed that initially they experienced difficulties which included forgetting their stipulated times. The participants experienced that for the plan to work and for the diseases to be managed, it was essential for them to follow the instructions of their health providers by taking their treatment at the correct times. The following excerpts explain the statements further:

> *"To keep the directions you are given because the only thing that will make you live long is to care about taking your treatment."*
>
> (T3, L 662-3).

> *"It was said that I should take it on the same time."*
>
> (T5, L 723-4).

> *"You don't need to disobey when it is said take your pills."*
>
> (T4, L 563).

4.3.5.2 Sub-theme Two: Coping with treatment

The participants expressed that achieving self-care meant that one has to take one's medication everyday as the conditions are chronic and require daily intake of the medication. This means that the participants needed to practise good adherence to both medications for HIV and HTN. The quotes reflect this further:

> *"I leave home at 07h00 and by 06h30 maybe I would've already been up and by 06h55 I swallow my pill before going out."*
>
> (T2, L 611-3).

> *"I know that at nine I must go and take my pill."*
>
> (T6, L 420).

Therefore, the participants experienced coping with their treatment by remaining compliant and committed to their chronic medication for both HIV and HTN.

4.3.5.3 Sub-theme Three: Access to treatment

Based on the data analysis, the participants expressed that towards a new normal, one must access care which is not always within reach to them. The participants verbalised that being in a rural area and having one clinic meant that they had to access medication at that one clinic. In addition, the participants experienced that achieving self-care for themselves meant that they had to travel a long distance to receive medication for their chronic illnesses as the clinic is far. The following excerpts reflect this further:

> *"The clinic is far when you think that you woke up early to go the clinic, you are afraid of hiking and arrive there that there are a lot of people and you are the last one."*
>
> (T6, L 709-11).

Some participants expressed that due to the distance being far from where they live, it made them at times to be reluctant to go the clinic and end up missing their appointment dates. The quote explains this further:

> *"The clinic is very far from where I am staying it is far that is what sometimes makes us to miss our dates because it is far then we end up being lazy to go to clinic. The distance is long, even if you are thinking about going there and think yho! It is far to go to the clinic.so we fail on our dates and not take treatment, this is what is a challenge."*
>
> (T7, L 563-70).

Furthermore, the participants experienced waiting long waiting hours in the one clinic that services them in order to get the chronic medication for their chronic illnesses. In addition to this, they had to wait for long waiting hours as the clinic that is providing care is serving different catchment areas. The quotes explain this further:

> *"Sometimes you would come and arrive and see that it is full in the clinic."*
>
> (T2, L 362-3).

> *"Then you arrive you see people who are already there then I have to wait a long time to be seen."*
>
> (T6, L 728-40).

The participants also verbalised that while self-care is essential for them to manage the two illnesses, being in the rural community makes it impossible when the climatic conditions change such as rain to access the one rural clinic where one has to cross the river in order to access. The participants experienced that when it rains, they are unable to access care at one clinic that is located in their catchment area as they have to cross the river that becomes full. The excerpts reflect this statement further:

> *"When ilwalwa (the river) is full, no one is able to pass it even the cars."*
>
> (T4, L 883).

> *"The river affects me when there is a rain; it becomes full and being unable to pass and go to the clinic. it becomes a problem"*
>
> (T8, L 484-93).

The inability to access the treatment meant that for others the self-care of adhering to treatment is affected because when the river becomes full, they are unable to pass and go to the clinic which then affects their adherence to medication.

4.3.5.4 Sub-theme Four: Grading of illnesses

Evident from the data, the participants experienced grading of their illnesses. The grading was marked by the comparison that the participants made regarding their illnesses in terms of which one is life threatening and serious as compared to the other. Some participants expressed that HTN for them was more serious than HIV therefore requiring more care. The quotes reflect this statement further:

> *"What shocked me was the pressure mostly because I said HIV doesn't quickly take a person and it doesn't kill a person if you take treatment."*
>
> (T2, L 1008-10).

> *"But I saw that by looking, HIV is better than pressure that I have because with pressure, it does go down or anything, I try to eat things I am told to eat but it is always high."*
>
> (T1, L 143-6).

Some of the participants experienced that HIV is a more life-threatening condition than HTN; hence they had to first manage it. The quotes reflect this further:

> *"It is because. It is better with pressure because it is said that with it is better. With this illness, people are scared of it." (Referring to HIV)*
>
> (T1, L 631-2).

> *"I felt that if I accepted the big one, I will see that pressure will be managed just like I will manage the big one with treatment that I get from the doctor."*
>
> (T5, L 297-9).

The experiences varied in each participant and the grading displayed how a condition is given more attention than the other which then affects the way in which one is caring for and managing the two illnesses. The participants expressed that living with the co-morbidity of HIV and HTN brought about change in their lifestyles. The participants expressed the transition by their experiences of having to adopt a different lifestyle towards developing a new normal which included being diagnosed with HIV first and starting to take treatment for managing that condition. The quote reflects this further:

> *"Yes because I didn't a have condition to treat."*
>
> (T5, L 224).

In addition, the participants also experienced the transition by being diagnosed with the two illnesses at the same time. The participants verbalised their experiences of the transition of not taking medication for any illness to taking medication for two chronic illnesses for managing and controlling the illnesses. Some of the participants experienced the transition by the number of pills they had to take towards a new normal. The quote reflects this statement further:

> *"So I was given a third pill for pressure which has a role of removing fat in the blood."*
>
> (T1, L 460-1.

In addition, the participants verbalised the change by having to adjust their lifestyle when it came to meal preparation in order to take medication for HIV and HTN. The quote reflects this statement further:

> *"Once it is eight or around eight, i say oh my God, it is time, I try to hurry up and get even if it is small bread to eat or a small apple I must hurry so that I can eat my treatment."*
>
> (T1, L 342-44).

4.3.5.5 Sub-theme Five: Pill fatigue

Evident from the data, the participants expressed the transition in the lifestyle through the use of the medication for the two chronic illnesses. The participants verbalised that due to the number of tablets they have to take, some experienced treatment fatigue due to the number of the pills that they had to take a day for HIV and HTN. The quotes reflect this statement further:

> *"I started the time the pills were more, they were still more than one it was four different kinds. I used to take others at the same time others I would separate them and take them at different time."*
>
> (T5, L 312-5).

Furthermore, some of the participants verbalised that when one of the conditions was not controlled, more pills were added which then caused the pill fatigue. The excerpts explain the statement further.

> *"I was changed because I was eating one pill for high blood pressure so now I am eating two pill."*
>
> (T1, L453-4).

> *"Ey taking many pills was tiring because I had to make sure that I eat and there is something in the stomach then rest and then feel after a while that the body is right then I would be able to walk around."*
>
> (T9, L 340-2).

Participants experienced different views with regard to coping with the treatment for two illnesses. Some participants expressed that living with the two illnesses and taking two medications was not tiring. The excerpts explain this statement further:

> *"I don't see them that way because the one for pressure I take it in the morning and it does its work."*
>
> (T3, L 302-3).

> *"No those pills are not too much. Hayi they are not. Look I take them at eight daily then is this one I take in the morning, the ones for high, they are small, there are no pills there Not at all (tu). They are not many."*
>
> (T4, L649-53).

4.3.5.6 Sub-theme Six: Unhealthy addictions

The participants verbalised the experience of change in the lifestyle of adopting unhealthy addictions as a way to coping and towards developing a new normal of living with HIV and HTN. The change was verbalised as developing an addiction to smoking and heavy alcohol intake which they experienced as a barrier towards the lifestyle. The participants expressed that adopting the addiction had a negative impact on their health which caused a challenge in the management of the two chronic illnesses. The excerpts below explain the statement further:

> *"I do drink alcohol but I don't smoke. No I do drink alcohol. Yes I sometimes have that problem when I drink alcohol day before going to clinic you know and my blood pressure becomes high you know. So this is where I suspect that I am using alcohol heavily sometimes I've seen that my pressure becomes high when I have used alcohol heavily."*
>
> (T7, L 516-18).

> *"What is a challenge for me is a cigarette only, it is the only challenge."*
>
> (T9, L 673).

4.3.6 Exhaustive description of the essence of living with HIV and HTN

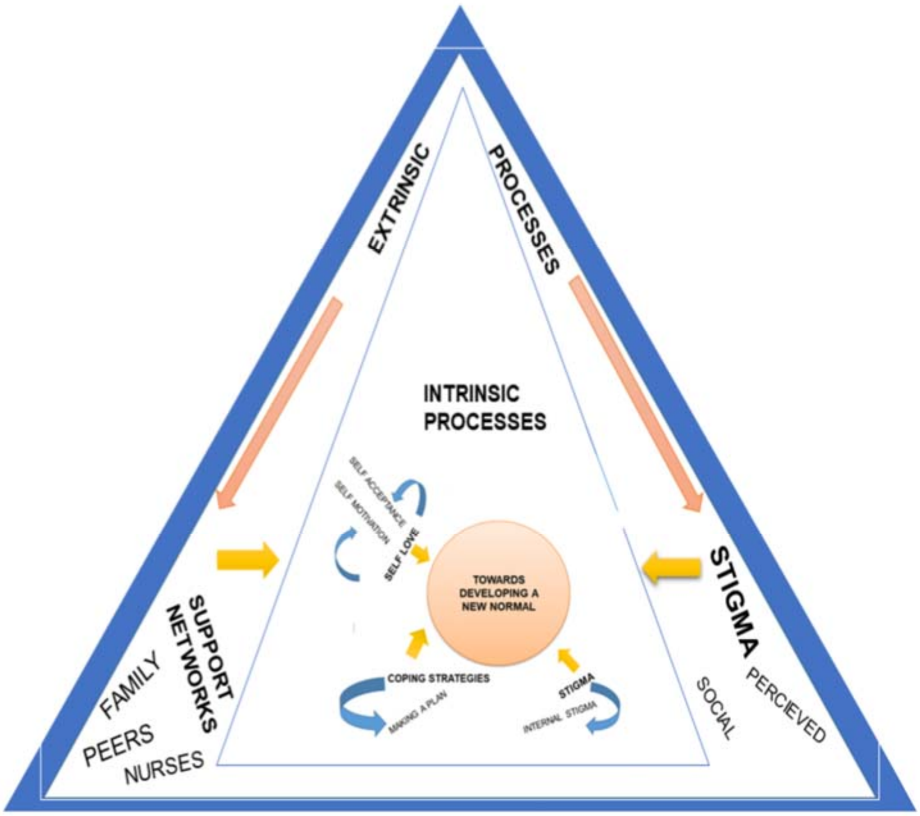


Figure 4.1: Thematic Representation of the Study Findings

The central theme that emerged that underpinned the essence of the lived experiences of living with HIV and HTN was the process towards developing "a new normal”. This is reflected in the thematic representation of Figure 4.1. A triangle was deemed appropriate as it is the scientific symbol that denotes change. The two triangles that are boxed within each other were used to show the extrinsic and intrinsic processes. In a similar manner the process towards a new normal for the participants was underpinned by change. The circle in the thematic representation denotes the process towards developing a new normal of living with HIV and HTN that the participants experienced. The small curved arrows under intrinsic processes represent the characteristics that each internal influence was made of. The yellow arrows pointing at the circle represent how the intrinsic and external processes enabled the participants to develop towards a new normal. The long arrows in the representation inside the triangle represent the external factors, these being stigma and a support system in the change towards developing a new normal.

Towards developing a new normal is the essence of the lived experiences of PLWH and HTN and it is a process that does not simply take place but rather one must undergo a change in one’s life towards a new normal. This process of living with HIV and HTN began with the participant developing self-acceptance that he/she is living with the two illnesses. This process involves having to admit that one is living with two illnesses and entails that one has to develop self- acceptance that he or she is HIV positive and hypertensive as well. The participants who were living with these two illnesses on diagnosis had to first develop self-acceptance that he or she was living with the two chronic illnesses. This process was unique as the participants demonstrated that in their experiences. This experience of living with HTN and HIV was unique, such that for some participants they had to first go through the denial phase before accepting. The participants verbalised that they had to first deny that they were living with the two chronic illnesses because of the nature of the two chronic illnesses. This was because of their perceived susceptibility that influenced this. This was influenced by the lack of education regarding the illness; thus they were unclear about the likelihood of living with HIV and HTN. The participant’s experiences were different in such a way that after being diagnosed, it was dependent on the participants to immediately accept the illnesses or to take time to accept and adjust to the change. For the participants, this process of living with HIV and HTN was differentiated, such that some participants immediately started to accept the illnesses and continued to experience living with the two chronic illnesses. However, for some participants the experience was not easy and they had to take time to first reflect on the experience and how they might have acquired the two illnesses before finally accepting and managing the two illnesses.

The process of living with HIV and HTN was facilitated by two domains, these being the internal and the external influences. For the internal influences and thus moving towards developing a new normal, it meant that one must have self-love. Because this process of living with HIV and HTN is occurring within a person, it is intrinsic; hence the person must first have self-love. This is demonstrated by how the participants described that the most important thing following accepting is self-love. Self-love entailed the participants had to first have self-acceptance and self-motivation. This meant taking ownership of the two illnesses before anything can take place. Self-acceptance meant that the participant had to first accept the change that is taking place and to do that they must acknowledge that they are living with the two illnesses. This experience of self-acceptance for the participants meant that they must first accept that they are living with the two illnesses and it is then that they will feel motivated to manage the two illnesses and disclose them their significant others. This process entailed the experience of disclosing to the loved ones about possessing and living with these two chronic illnesses. This experience was intrinsic and was dependent on the person, if he or she was willing to disclose his or her illnesses. The participants experienced this change differently as some immediately disclosed to their loved ones while others kept it from them. This experience of disclosing entailed the thinking process of either being rejected by the significant others or accepted. It is only when the person has accepted the change in his life and has been accepted that self-motivation kicks in.

Self-motivation is the internal drive to manage the two illnesses and it is intrinsic. It determines whether the person will or will not manage the diseases properly and continue with the treatment. The participants experienced self-motivation only after they had accepted their illnesses. Once the person has that internal drive, self-care takes place. Self-care is a process of caring for one’s self after having undergone the acceptance and disclosure phase. This process determines whether or not the person will manage the illness well or will totally default on treatment. The participants experienced self-care by adjusting their lifestyles in order to accommodate the two illnesses. The participants experienced perceived benefit by establishing ways that would facilitate living with two chronic illnesses. This is demonstrated by the participant’s descriptions of the importance of eating healthily and taking medication. The participants experienced this by adopting a healthier lifestyle such as preparation of the food and healthy eating. This experience enabled the participants to make a plan regarding how they would manage the two illnesses with regard to their chronic treatment. Following this, the participants experienced that to manage these two illnesses, it was needed to remain compliant with the treatment both for HIV and HTN. This process was facilitated by establishing time frames for taking the medication. The participants experienced this by taking the medication for HTN in the morning after they had prepared their morning meals then following that they had to prepare healthy meals that would facilitate the medication for HIV being taken at night. These cues to actions that the participants adopted facilitated living with HIV and HTN.

This process entailed establishing and sticking to a regular time for taking the medication for HIV. So it is only after a person has consumed a healthy diet that they have to stick to this time for taking the medication and following the nurse’s instructions. This experience entailed that one must choose a time for taking the medication which was differentiated and was dependent on the schedule of the participants. The participants discovered to achieve the management of HIV in the afternoon, the medication must be taken at either at seven, eight or nine. This experience of taking the medication was not always an easy task because towards developing a new normal is a change in one’s life, thus accommodating the two illnesses. Some of the participants had different experiences regarding this, such that initially they would forget their medication and the time for taking the medication due to this change that they were unfamiliar with of living with and managing two chronic illnesses. It is through this internal motivation and self-efficacy that the participants had to travel for many hours to go to their one far clinic and wait long hours to be seen and managed for their two illnesses. It is with this intrinsic drive that some participants had to go to their nearest hospitals when the river on the way to the clinic was full just to obtain their medication and remain adherent to their medication both for HIV and HTN. The long distance to the clinic, long waiting times in the clinic and the river which was a challenge when it had rained were described as the perceived barriers which the participants experienced of living with HIV and HTN.

Towards developing a new normal involved also in a way of overcoming an internalised stigma that was guided by self. The participants experienced an internal stigma and this had the influence on how they saw themselves. Towards developing a new normal involved initially having to overcome the stigma internally and start to regret how things had unfolded. The participants experienced this by the development of self-blame regarding how they had adopted certain attitudes and risky behaviours in the past such as multiple partners. The participants were also surrounded with unhealthy addictions such as smoking and alcohol consumption which they described as perceived barriers to living with HIV and HTN. The participants also experienced grading of their illnesses based on the perceived seriousness of living with HIV. Some participants perceived HIV as more serious and life-threatening, whereas some of the participants perceived HTN to be more serious than HIV; thus management of the two was not treated the same by the participants.

This process towards developing a new normal was also influenced by external influences that were different from the internal influences, these being support network and overcoming an illness related stigma and discrimination. Regarding support network, the participants experienced this through the support of their significant others such as their parents, spouses, children, siblings and partners and essentially of the nurses at the clinic who provided support and encouragement to the participants. The support of these influential figures in the participants' lives ensured and facilitated that the participants had people beside them who would remind them of taking their chronic medication and assist them in preparing their meals to ensure that they take their medication. The role of support for the participants was crucial as it facilitated that encouragement and determination had a purpose rather than of one's life coming to an end. Towards a new normal meant that there are people who continually provide advice, encouragement and counselling to ensure that the two illnesses are managed well and the illnesses are well managed. The support network played a major role which facilitated the process towards a new normal. The support networks also played a role as the participants described them as being beneficial in their process of developing towards a new normal. This included being reminded to take their medication daily and support to help them continue on their treatment for HIV and HTN.

The second aspect which was external is overcoming an illness-related stigma, in particular for HIV. This external process involved the perceived stigma of living with HIV which had the influence of determining whether or not the person should disclose the conditions. The participants experienced extreme fear of being stigmatized by their families, and the rural community at large. The participants experienced the fear of being rejected by their families and their partners because of living with the two illnesses. This external process is the reason why other participants delayed disclosing because of the fear of being discriminated against, and being judged and labelled by their HIV status. This process was not easy for the participants in their descriptions, such that even regarding taking the medication, the participants had to take them in secrecy and hide the medication because of the fear of being stigmatized. It is with the support of their loved ones that the participants achieved this stereotype and started to experience the sense of being free regarding living with HIV and HTN. This process of overcoming the stereotype created an enabling condition that facilitated the participants' experience of becoming able to take their medication without any fear, thus towards a new normal coming into existence.

4.4 SUMMARY OF THE CHAPTER

This chapter entailed the description of the participants that took part in the study, together with the description of how each of Giorgi's five phenomenological steps were applied to yield the emergent themes. Four essential themes, together with their sub-themes that emerged in the data analysis, were described and the participants' excerpts were used to broaden the findings related to the phenomenon under study. Finally, an exhaustive description of the essence of living with HIV and HTN was described fully.

CHAPTER FIVE

DISCUSSION OF FINDINGS

This chapter will discuss the main findings of this phenomenological study of the lived experiences of PLWH and HTN. Given the study is phenomenology; literature review was restricted and limited in Chapter Two so as to achieve the methodological stance of bracketing (Lopez & Willis, 2004:727; Chan e*t al.,* 2013:4, Hamill & Sinclair, 2010:20). This chapter will discuss the findings and integrate them with literature so as to achieve literature control. The study had four themes that emerged and will be discussed below.

5.1 THEME ONE: OVERCOMING ILLNESS RELATED STIGMA

The findings of this study demonstrated that PLWH and HPT experienced three forms of stigma, being the social, internalised and perceived stigma. According to Rueda *et al.* (2012) as cited in Idemudia, Olasupo and Modibo (2018:2), stigma occurs in three courses, which are internalised, enacted and perceived. Internalised stigma is the state or way in which a person who has a condition accepts negative beliefs and features internally that are related to the illness that he or she possess and starts to stigmatise him/herself. Enacted or social stigma is the state in which the person experiences judgements and stigmatisation from other people. Perceived stigma is the way in which a person anticipates being stigmatised by other people because of the illness he suffers from.

In a South African study that was conducted by Idemudia *et al*. (2018:1) which compared stigma experiences in patients living with HIV and HPT in Limpopo Province, stigma amongst people living with chronic illnesses was found to present. In the study, the research findings revealed that PLWH experienced social stigma from other people as compared to other people living with HPT. In addition, another study which was conducted in Kwazulu-Natal by Treffry-Goatley *et al.* (2016:15), stigma is regarded as something that exists and is real in particular amongst PLWH. Furthermore, McNeish (2016) in a study on stigma killing South Africans living with HIV supports that stigma in Africa is real amongst PLWH.

While stigma is reported to be real in South Africa, trends of stigmatisation and discrimination among PLWH have been noted and reported in an African study which explored the barriers and facilitators to interventions improving retention in HIV care in Sub-Saharan Africa (Hall *et al.,* 2017:5). In the study it was reported that PLWH experienced stigma which disrupted retention on HAART which is responsible for prolonging life (Hall *et al.,* 2017:5). Furthermore, an international study conducted by Friedland *et al.* (2018:116), which measured intersecting stigma among key populations living with HIV, they reported on increased levels of stigma in the Cameroons as compared to other countries. All the findings support that PLWH experience stigma and discrimination. The findings of the studies relate to this study in such a way that the participants of the study experienced stigma as the barrier of living with HIV and HTN.

5.1.1 Sub theme 1.1: Anticipated stigma

In the findings of this study, the participants verbalised that they experienced anticipated stigma from their families and the rural community. In an HIV stigma index conducted by the Human Sciences Research Council (HSRC) (2015:20); and Idemudia *et al.* (2018:5), the participants living with HIV were also reported to experience high levels of anticipated stigma and a large number of PLWH experienced anticipated stigma in a form of fearing gossiped about and fear of being rejected based on their HIV status. Similarly, In a Sub-Saharan study conducted by Chan and Tsai (2016:6), 50% of the participants were reported to support the experience of anticipated stigma despite the HAART expansion. Furthermore, an International study conducted by Fongkaew *et al.* (2014:71) supports the findings that PLWH experience anticipated stigma from their peers and the community they reside in. In addition, another international study conducted by Scrithanaviboonchai *et al.* (2017:5) on the stigmatising attitudes towards PLWH in Thai, they reported that 76.9% of PLWH experienced anticipated stigma. Krishna, Bhatti, Chandra and Juvva (2005:489), in a study which explored experiences of families living with HIV/AIDS, noted that the participants in the study expressed how they experienced fear of being stigmatised by their family members and the community based on their HIV status. Moreover, Angwenyi *et al.* (2018:9), who explored patients' experiences of self-management and strategies for dealing with chronic conditions in rural Malawi, reported on how participants experienced anticipated stigma as a result of the people's awareness of their HIV status that drove them to take medication to clinics that are far from their communities because of the fear of being stigmatised and discriminated against. The findings of this study are consistent with the findings of other studies that have been conducted, suggesting that anticipated stigma is experienced by PLWH.

5.1.2 Sub-theme 1.2: Internal stigma

In the findings of the study, the participants experienced internal stigma in the form of self-blame and regret. Similarly, a South African study conducted by Idemudia *et al.* (2018:5) which compared stigma in chronic illnesses of HIV and HTN, revealed that PLWH had high levels of internal stigma. In addition, a report on a study conducted in the Eastern Cape in the Oliver Tambo district by the Eastern Cape AIDS Council (2016:12) pointed out that due to stigma, 35.1% clients blamed themselves for having HIV while 26.1% were embarrassed about living with HIV. Furthermore, an international study conducted by Baugher *et al.* (2017:2600) in the United Kingdom supports that PLWH reported internal stigma and the prevalence of internal stigma was 79.1%. Moreover, a study conducted by Albright and Fair (2018:3), which explored the trajectory to self-acceptance among PLWH, cited that participants described how they suffered from self-blame because of their past behaviours which had led them to acquire HIV. The findings of this study are consistent with the findings of other studies that have been conducted that PLWH experience internal stigma that manifests in self-blame and regret.

5.1.3 Sub-theme 1.3: Received stigma

In the findings of the study, the participants verbalised to have experienced social stigma from the members of the rural community they reside among. Similar to the study findings, in a study conducted by Treffry-Goatley *et al.* (2015:15), it was reported that PLWH as a chronic illness experience social stigma. In addition, studies that have been conducted by Bezebhe *et al.* (2014:5) and Govindasamy, Ford and Kranzer (2012:2063), which explored barriers and facilitators to Anti-retroviral drug therapy, demonstrated that the participants experienced social stigma which is characterised by fear of being judged by their families and the community because of medication for HIV; hence, this led to participants taking medication away from the people because of non-disclosure and fear of being stigmatised and judged. Further to this, an African study conducted by Tafuma *et al.* (2018:4) reported that social stigma was experienced by PLWH which was manifested by negative comments and name calling towards PLWH, due to their HIV status. The findings are consistent with the findings of the study where some of the participants took their medication in secrecy because of fear of being stigmatised by the rural community and their families because of living with the chronic illness. Furthermore, Hardon *et al.* (2007:18) highlighted that PLWH reported that they were isolated by their community members due to their HIV status which caused them not to disclose to their peers and colleagues. Moreover, Skinta *et al.* (2014:588) described how participants experienced social stigma with regard to dating on the internet as a result of being HIV positive and this led the participants to be unable to establish relationships because of their HIV status.

5.2 THEME TWO: THE ROLE OF SUPPORT SYSTEMS

The findings of the study demonstrated that PLWH and HTN experienced support towards developing a new normal from different influential figures, these being their parents, spouses, partners, children, peers and health care practitioners. A South African study conducted by Hill, Maman, Groves and Moodley (2015:5), which explored the role of the social support among PLWH, found that family support was reported to play a huge role in caring for HIV. Furthermore, an African study conducted by Osamor (2015:30) highlighted that social support played a role in treatment adherence such that 74.8% of people living with hypertension reported a role played by a family. In addition, Mosheke, Bond and Merten (2013:8), explored the self-care practices and experiences of PLWH not receiving antiretroviral therapy in an urban community of Lusaka, Zambia. In the study, support networks such as family, peers and health care providers, were reported to play a crucial role and provided a pleasant experience in the management of chronic illnesses, in particular amongst PLWH. The findings of this study are consistent with other studies by Hill *et al*. (2015:5); Osmor (2015:30) and Mosheke *et a*l. (2013:8) that have been conducted on the crucial role played by support systems in the management of HIV and HTN.

5.2.1 Sub-theme 1.1: Family support

In the findings of the study, the participants experienced support from their loved ones that being their parents, significant others and children, and this played an important role in the management of HIV and HTN. In a study conducted by Treffry-Goatley (2016:12), participants described how their families played a part in supporting them regarding treatment intake. In another study by Hill *et al.* (2016) the participants reported that their families supported them regarding the management of HIV. Bazebhe *et al.* (2014:5) reported that the participants who were interviewed in the study revealed that they had disclosed to their family, friends and partners about their illnesses who facilitated acceptance and adherence to their chronic HAART medication. Furthermore, Conroy *et al*. (2017:1245) also found that PLWH received more support from their partners, which facilitated adherence. In addition, Dehab *et al.* (2008:4) further highlighted that family support amongst the participants was the key facilitator to taking medication which was displayed by frequent reminder by family members on taking of medication for HIV. Furthermore, Skinta *et al.* (2014:588), in a phenomenological study which explored shame, self-acceptance and disclosure in the lives of gay men living with HIV, noted that participants had reported that family support was amongst the things that enabled them to cope with living with HIV. Iwelunmor *et al.* (2006:10) in the study that explored family systems in South Africa, found that family support was amongst the facilitating factors that were experienced by PLWH through love, support and affection received from family members of PLWH. In addition, a study conducted by Krishna *et al.* (2005:498) also found that support was one of the factors that facilitated well-being of the participants and the participants expressed receiving support from their families, knowing very well that they were living with HIV. Moreover, Angwenyi *et al.* (2018:10) further highlighted that family support among patients living with HIV and a co-morbidity played a crucial role in the management of the chronic illnesses by the patients.

In contrast to the role of the social support amongst people living with chronic illnesses, in a study conducted by Hardon *et al.* (2007:18), it was reported that PLWH experienced being mistreated and abandoned by their significant others after they had disclosed to them about their HIV status. Krishna *et al.* (2005:495) further highlighted that while PLWH were supported by their partners, they were not sexually active with them as they feared that they would get infected if they engaged in sexual encounters; hence, focus was shifted towards abstinence and raising children together rather than engaging in sexual practices.

5.2.2 Sub- theme 1.2: Peer support

The findings of the study reported that PLWH and HTN experienced support from their friends. A South African study conducted by Iwelunmor *et al.* (2006:7) highlighted how some of the participants described peer support as important in the management of a chronic illness of HIV and for sharing feelings. Similarly, an African study conducted by Osamor (2015:31) reported that 50% of the participants experienced support of friends, especially with regard to taking their medication. Furthermore, an international study on support systems which was conducted by *Grodensky et al.* (2015:12), reported that support was received in friends and family rather than in partner relationship for women living with HIV. Moreover, Bazebhe *et al.* (2014:5) reported that the participants that were interviewed for the study revealed that they had disclosed to their family, friends and partners about their illnesses who facilitated acceptance and adherence to their chronic HAART medication.

5.2.3 Sub-theme 1.3: Nurses support

In the findings of the study, nurses working in Sakhisizwe clinics were reported to have played a major role in supporting patients living with HIV and HTN, especially with regard to treatment compliance and on-going counselling. In a South African study conducted by Treffry-Goatley (2016:12), some of the participants amongst family members highlighted the support of nurses with regard to HIV testing and treatment support. Similarly, a South African study conducted by Iwelunmor *et al.* (2006:6) also highlighted how nurses provided support to patients in terms of management for HIV. In addition, the study revealed that the case managers and the professional nurses responsible for their medication provided support to them through education and counselling regarding the management of the chronic illness of HIV (Bezebhe *et al.,* 2014:6). Furthermore, another African study conducted by Russell *et al*. (2016:6) reported that the professional nurses in the clinic provided support to the patients and had positive attitudes towards the patients. Moreover, Vedanthazn et *al.* (2016:219) further stated that the participants expressed that the nurses in the health care facilities demonstrated a positive attitude towards the patient because of their period of interaction with the clients which then facilitated the treatment compliance of HTN clients to their treatment. Similarly, Angwenyi *et al. (*2018:11), noted that the participants in the study reported how the health care practitioners in their clinics were providing education to them regarding diet that they should adhere to for HIV and HTN.

Contrary to the study findings, in a study conducted by Adams and Zamberia (2017:299), the participants that were interviewed expressed that the nurses in the public hospital had lack of empathy and they treated them like they were nobody and there was no support when they came for HIV care. Another qualitative study which assessed self-management support needs of patients with chronic diseases in a South African Township conducted by Dube *et al.* (2017:26) demonstrated that the health care providers had a negative attitude that was not supportive to patients with chronic illnesses such as HIV and HTN such that if a client had a high blood pressure, they just said the client would die instead of providing counselling and proper health education. Similarly, Tafuma *et al.* (2018:3) in a study also revealed that the participants expressed that the nurses had bad attitudes towards the clients in the districts where the study was conducted. Krishna *et al.* (2005:490) also highlighted that the participants verbalised how they were treated unfairly and received a negative attitude from the nurses as a result of their HIV status. The participants verbalised that the nurses would get irritated even when they tried to communicate with the nurses in the health care facilities, showing that the nurses did not provide support to them.

5.3 THEME THREE: SELF LOVE; TAKING OWNERSHIP OF THE DISEASES

In the study, self-love was experienced by PLWH and HTN in overcoming illness related stigma. The self-love that the participants experienced was made up of self-acceptance and self-motivation. In a South African study conducted by Earnshaw *et al.* (2018:2546), the participants also revealed that acceptance of the illness and the use of medication are what enabled them to cope with the chronic illnesses. The study also demonstrates with regard to self-acceptance, some of the participants did not initially accept the diagnoses for HIV. In addition, the findings demonstrated that motivation of accepting and continuing with treatment was facilitated by extrinsic factors such as prolonged life expectancy and living for their children (Earnshaw, 2018:2548). Similarly, in the current study, most of the participants verbalised that motivation in them was facilitated by the fact that if they took their medication, they would live longer. In addition, some participants verbalised that they were motivated to cope and manage their illnesses because HIV is a condition for people and that they had seen most people living longer while having it. Furthermore, Dube *et al.* (2017:27) revealed that some of the participants that were interviewed verbalised that the participants living with HIV expressed that self-love meant that one must learn to accept the diagnosis and acceptance is what enabled them to cope with their chronic illness. The findings demonstrated that the participants had internal motivation based on other people who had been living with and managing the chronic illnesses for years without any problems.

Furthermore, a study conducted by Alexias *et al.* (2016:588), which looked at the embodiment and biographical disruption in people living with HIV/AIDS (PLWHA) demonstrated that some of the participants verbalised HIV as an essential part of their lives. Similarly, the findings demonstrate that the participants finally developed self-love and acceptance of living with HIV as a chronic illness. Furthermore, Lakshmi (2017:2), in his study, reveals that some of the participants that were interviewed demonstrated acceptance of the condition as their life’s fate as a way of coping and living with the chronic illness. The findings are consistent with the findings of the study where some of the participants developed self-love and acceptance with regard to living with two chronic illnesses and they took the illnesses as part of their new way of living.

5.3.1 Sub-theme 1.1: Self-acceptance

In the findings of the study, the participants experienced self-acceptance which enabled them to overcome the stigma related to their illness and cope with the illnesses. Anderson and Spencer (2002:1346) revealed that the participants that were interviewed in their acceptance of the condition and themselves verbalised that HIV/AIDS was just like any normal chronic condition that is controlled by taking medication. In addition, in a study conducted by Albright and Fair (2018:6), it was revealed how PLWH had developed self-acceptance to their chronic illness of HIV through interaction with other people with HIV and also by coming to terms with their diagnosis as a part of their lives. Furthermore, another study conducted by Skinta *et al. (*2014:591), found that self-acceptance was seen as the coping strategy which enabled the participants to normalise their HIV status and shift away from letting the diagnosis define their lives. Moreover, in a study conducted by Horter *et al.* (2017:56) which explored acceptance, denial and linkage to care in Swaziland, self-acceptance of HIV was seen as the facilitating condition that enabled the participants to cope with living with HIV. The study findings revealed that initially the participants had experienced denial of HIV status but with the help of social support and also seeing other PLWH, it became easier for the participants to develop self-acceptance of their chronic illness. These findings are consistent with the findings of the study where some of the participants referred to HIV as the condition for people which displayed the normalisation of HIV from being a deadly disease to a chronic manageable illness.

5.3.2 Sub-theme 1.2: Self-motivation

Participants in the study findings reported how self-motivation enabled them to continue managing their chronic illness and taking their medication. A study conducted by Russel *et al.* (2016:6) demonstrated that despite the difficulty of living with HIV, self-motivation in taking a treatment played an important role in the management of a chronic illness. Further to this, an African study conducted by Vedathan *et al.* (2019:319), which explored the barriers and facilitators of HTN, revealed that self-motivation by HTN facilitated adherence to their medication. The study findings revealed how participants experienced self-motivation which enabled them to cope with living with HTN as a chronic illness. Monroe *et al.* (2013:3), on self-motivation, further reported that the participants experienced self-motivation in their treatment for HIV and HTN because they feared complications that they would suffer if they remained non-adherent to their chronic medication. These studies are consistent with the findings which displayed that having the intrinsic motivation was essential when managing the two chronic illnesses.

5.4 THEME FOUR: CREATING TRANSFORMING BEHAVIOURS AND SELF CARE PRACTICES

The findings of this study revealed that self-care as the major theme meant that the participants had to make a plan that would help them to cope and manage the chronic illnesses. In a phenomenological study which explored the cognitive representations of AIDS by Anderson and Spencer (2002:1346), the participants living with AIDS expressed that for them to live longer they had to eat the right way and take their medication for HIV/AIDS.

5.4.1 Sub-theme 1.1: Making a plan

The findings are similar to the findings that were revealed in the study where the participants expressed that self-care for them meant that they had to take their medication on a daily basis and at stipulated times and also consume food that has the necessary nutrients needed by the body as their cues to action. Similarly, a study by Adams and Zamberia (2017:300) further explained self-care when the participants were revealed to have a positive insight that taking HAART meant that they had to consume a proper diet and refrain from alcohol. In addition, Mendes *et al.* (2015:584), in a study which explored the self-care comparison of hypertensive patients in primary and secondary health care services, revealed that the HTN participants that were involved in the study were using artificial seasoning such as spices which in meals had an effect of elevating their BP readings. Further to this, it was reported that the majority of the HTN participants had minimal physical activity despite the importance; however, the majority of the participants were not smoking or had stopped prior to and on treatment and were not consuming alcohol. In addition, Neminqani, El-Shereef and Thubiany (2015:1710) who explored the hypertensive patients: self-care management practices in Al-Taif, averred that about 41.1% of hypertensive patients stopped smoking when they were on treatment for HTN and remained adherent to their HTN medication as prescribed and were attending their health facilities on stipulated dates. A study conducted by Angwenyi *et al.* (2018:11), reported that the participants that were involved in the study had a high awareness regarding food restrictions, especially those living with HTN, and PLWH were reported to consume a nutritious diet and following the diet plan as per their health provider’s instructions. Furthermore, Ding *et al.* (2018:2174) in a cross-sectional study in China which explored the integrating factors associated with hypertensive patients’ self-management using structural equation modelling, reported that the HTN patients had a low knowledge of the disease; however, with regard to diet management, the participants had high social efficacy with regard to the diet they consume while managing HTN. Moreover, in a study conducted by Mosheke *et al.* (2013:6) it was reported that in making a plan for management of HIV as a chronic illness, participants experienced this by consuming a healthier diet, and also by engaging in safe sexual practices with their partners, as well as reducing the number of sexual partners they had. The study findings are consistent with the studies that have been conducted on HIV and HTN management where the participants that were interviewed also stated the same regarding self-care practices.

5.4.2 Sub-theme 1.2: Coping with medication

The findings of this study reported that coping with medication was associated with adherence to medication for both HIV and HTN. A study conducted by Nguyen *et al.* (2017:7) on adherence to medication for HTN demonstrated that people living with HIV had high adherence to treatment and were following their health practitioners' advice and instructions. Increase in age was also a factor associated with good compliance to HTN treatment. Furthermore, a South African study conducted by Azia, Mukumbang, van Wyk (2016:3), on the the barriers to adherence to antiretroviral treatment in a regional hospital in Vredenburg, Western Cape, South Africa, demonstrated that factors related to side effects and lack of transport money to go to their far clinics and stigma, was amongst the influences which contributed to poor adherence. Moreover, Dehab (2008:3) further stated that compliance to treatment for chronic illness, in particular HAART, and the positive effect it had on the patients, encouraged them to continue taking their medication and thus remaining adherent to the treatment by not defaulting. In addition, Nguyen *et al.* (2017;8), in a study which explored adherence to HTN medication, reported that adherence to medication for HTN was facilitated by the awareness of the complications of not taking medication and non-adherence was caused by side effects as a result of taking the medication. In addition, age was one of the factors which facilitated adherence among HTN patients and they experienced this by following the instructions of the health care practitioner.

Contrary to the findings of the study, In a study conducted by Nashilongo *et al.* (2017:573) which assessed adherence to anti-hypertensive medication in PHC in Namibia, it was reported that patients on chronic medication had a sub-optimal level of adherence evidenced by missing one or more follow up visits, with the majority of the participants experiencing non-adherence to their chronic medication. Moreover, Tafuma *et al.* (2019:3), in study that was conducted, also reported that while HIV is a chronic manageable illness, some of the participants reported to have defaulted on HAART due to the burden of taking the medication that inhibited medication compliance.

5.4.3 Sub-theme 1.3: Access to treatment

The findings of this study demonstrated that towards developing a new normal of HIV and HTN, the participants experienced barriers to the care which were stumbling blocks in accessing care at the PHC clinics. The recent literature also reveals that the participants that are living with chronic illness, although they take their medication, access to their chronic medication is described as a challenge as they have to wait longer periods to be seen by health care workers in the clinics and also due to the far distance to the clinics. This is demonstrated by a study conducted by Dube *et al.* (2017:25) where the participants expressed that they have to wait for longer times to be seen by the professional nurses in the clinic. The study findings are similar to those of other studies conducted by Knight, Schatz and Mukubang (2018:5) and Tafuma (2018:4), where the participants expressed that the distance to the clinic is far and they have to wait for longer times to be seen by professional nurses in the clinics. In addition, Dahab *et al.* (2008:4) reported that the participants reported that one of the barriers to management of HIV was the long waiting times before they are attended by health care practitioners. Furthermore, Hardon *et al.* (2007:15) in an African study which was conducted it was reported that participants experience long waiting hours when they go for their chronic medication, one being HAART which caused them to be seen later by health care practitioners. It was highlighted that the far distance of over 50 kilometres to the health facilities where the participants got their treatment was a challenge to them; hence, this became a barrier to the management of their chronic illnesses (Hardon, 2007:12). Moreover, Nashilongo *et al.* (2017:573) also reported that long distances to the clinic were experienced. The findings of the recent studies by Dube *et al*. (2017:25) and Knight *et al.* (2018:5) are consistent with the findings of this study where barriers to care, particularly in terms of distance to the clinic, and the waiting time to be attended by the professional nurses was experienced.

5.4.4 Sub-theme 1.4 Grading of diseases

The findings of this study highlighted that the participants that were interviewed experienced grading of their co-morbid illness. While self-care for the participants is demonstrated in several ways, some the participants displayed comparisons in the chronic illnesses based on which one is better and more life threatening between HIV and HTN, which then affected self-management of the two chronic illnesses. This grading of diseases was similar in other recent studies such as a Kenyan study that explored the lay beliefs about hypertension among HIV-infected adults in Kenya (Temu *et al.,* 2017:1)., HTN was considered to be more serious than HIV; hence, management was focused on HTN by clients thus perceived seriousness was identified. Similarly, in a study which assessed the randomised controlled trial of a pictorial aid intervention for medication adherence among HIV-positive patients with comorbid diabetes or hypertension by Monroe *et al.* (2017:205), PLHW and an NCD placed and practised adherence on HAART as compared to other co-morbid illnesses, indicating that HIV was seen as more serious than other chronic co-morbid NCDs. Furthermore, Monroe *et al*. (2013:3) described how participants experienced grading of illnesses of HIV and HTN when they described that HIV was not a life threatening condition but it was the HTN that was deadly as compared to HIV; hence, this facilitated the participants to take their medication for HTN. Moreover, Smith *et al.* (2013:4) who explored information, motivation and behavioural skills for early pre-Art engagement in HIV care among patients entering clinical care in Kwazulu-Natal, reported that self-motivation was high among PLWH towards HAART care. The findings suggested that PLWH experienced self-motivation regarding caring for HIV. The participants experienced self-motivation, as supports networks were insufficient to assist them. The findings are consistent with the findings of this study where some of the participants expressed that HIV is better that HTN and focused on HTN as being more serious than HIV.

In this study, findings revealed that living with HIV and HTN brought a change in the participants' lifestyles. This change was in the form of transition from previously not taking medication to taking medication for HIV and HTN. In this change, some of the participants reported that poly-pharmacy was an issue as they were taking more than two tablets while others did not see it as a problem towards the management of HIV and HTN.

5.4.5 Sub-theme 1.5: Pill burden

The findings of the study revealed that some of the participants that are living with HIV and HTN experienced pill burden which was evidenced by their description on their experience of taking more than one medication for the treatment of HIV and HTN. A study conducted by Temu *et al.* (2017:5) reported that patients living with HIV and HTN verbalised that poly-pharmacy was a problem due to the number of pills that one has to take for living with HIV and HTN. This is demonstrated in other studies by Gleason, Luque and shah (2013:749); Ahn *et al.* (2019:1) and Mantejano, de Miguel and Bernardino (2018:189). Further to this, another study conducted by Cohen, Meyers and Davis (2013:1) reported that patients with a single treatment regimen had higher adherence to medication and lesser hospitalisation as compared to patients with more than one pill. The current study also has similar findings where some of the participants expressed that living with two chronic illnesses causes them to take more pills. In support, Sutton, Ahuja, Magangoli and Joseph (2016:16), in their study on the effect of pill burden on adherence to HIV antiretroviral, reported that PLWH with many pills had lower adherence as compared to PLWH on a fixed combination dose. Moreover, a study conducted by Nachenga *et al.* (2014:1301), which explored low pill burden and once-a-day antiretroviral therapy regimens for HIV, revealed that poly-pharmacy was associated with non-adherence while low pill count was associated with high adherence to treatment. However, some of the participants expressed that living with HIV and HTN for them was not associated with poly-pharmacy. Furthermore, in a study by Buscher, Haartman, Kallen and Giodarno (2012:355), participants that experienced higher compliance to treatment were those with a single medication as compared to those with two or more medications for chronic illnesses. The findings demonstrate that people with more than one medication struggle to adhere to their medication due to the number of pills they have to take compared to PLWH taking one medication, or one medication for HTN.

5.4.6 Sub-theme 1.6: Unhealthy addictions

In the findings of this study, some of the participants experienced barriers to living with HIV and HTN such as alcohol and smoking, which had an effect on their medication intake. According to a study by Azia *et al.* (2016), PLWH were reported to be engaging in alcohol consumption and smocking while on HAART. Furthermore, Dehab *et al.* (2008:3), in a study conducted on the barriers and enablers of HIV treatment adherence, highlighted that the use of alcohol by PLWH was one of the barriers they experienced in living with HIV. In addition, a study conducted by Ikeda *et al*. (2013:3), which assessed association of blood pressure and HTN with alcohol consumption in HIV-infected white and non-white patients, highlighted that alcohol consumption was higher among PLWH and HTN, which in turn affected blood pressure readings that were higher. In addition, a study conducted by Ataro, Ashenafi, Fayera and Abdosch (2018:185), which assessed the magnitude and associated factors of DM and HTN among PLWH receiving HAART, found that PLWH and HTN had reported the experience of engaging in unhealthy addictions such as alcohol consumption, smoking and chewing Khat while on treatment for both HIV and HTN. Moreover, in a study conducted by Freiburg and Kraemer (2010:247), PLWH were reported to have experienced alcohol dependence and consumption while on treatment. The findings are consistent with the findings of this study, indicating that PLWH and HIV experience unhealthy lifestyles while on treatment which becomes a challenge to how they manage their co-morbid illnesses.

5.5 SUMMARY OF THE CHAPTER

This chapter entailed the discussion of the findings of this study which emerged in Chapter Four. The chapter discussed four emergent themes of the lived experiences of PLWH and HTN with regard to disease management. The findings of this study were supported by literature studies that have been conducted to achieve literature control. In this chapter, a deep literature review was conducted without bracketing the experiences of living with HIV and HTN so that literature control could be achieved.

CHAPTER SIX

RECOMMENDATIONS, STRENGTHS AND LIMITATIONS AND CONCLUSION

6.1 INTRODUCTION

The previous chapter focused on the discussion of the research findings with the support of literature on the studies that have been conducted and related to the topic in order to achieve literature control and remain true to the phenomenological method. By remaining true to the phenomenological method, the researcher must undertake a transcendental phenomenological attitude by means of transcendental reduction. This is done by bracketing any pre-conceived knowledge that the researcher has on the lived experiences that are being investigated (Giorgi, 2017:178; Abakpa, Agbo-Egwu & Abah, 2017:394). In addition, for one to remain true to the phenomenological method, the researcher must utilise imaginative variation whose role is to detect essential attributes of a phenomenon. This occurs when the researcher remains open to the meaning attributed to the phenomenon by those who have experienced it (Giorgi *et al.,* 2017:180; Broomé, 2011:11). It enabled the researcher to identify findings that support the findings and also unique findings that this study discovered about the experiences of living with HIV and HTN in the Sakhisizwe sub-district, in the Eastern Cape. Before beginning this chapter, it is imperative to highlight that the third objective of the study was to make recommendations on the management of HIV and HTN by professional nurses in the PHC setting. This chapter will focus on the following (a) recommendations for clinical practice, research and nursing education, (b) strengths and limitations of the study and (c) conclusion.

6.1.1 Process that guided the emergence of the recommendations

A recommendation in research refers to a crucial suggestion concerning the best course of action in a certain situation, whose aim is to provide a guide that will resolve a certain situation and result in a favourable or beneficial outcome. In addition, the recommendation should be based on the data from research (Copland, 2016:1). The recommendations for the management of HIV and HTN by professional nurses were generated by focusing on the experiences that the participants described of living with HIV and HTN. A study by Chenitz and Swanson (1986:13) in conveying trustworthiness of recommendations that emerge from research findings, argued that the evidence generated from research must have (i) Fittingness, (ii) understanding of ability, (iii) generality (being able to be transferred). In addition, Chenitz and Swanson, in ensuring trustworthiness, state that fitting suggests that themes, recommendations must be the ones that are indicated by the data and are readily applicable to the data (Chenitz & Swanson, 1986:13). Furthermore, Cohen and Crabtree (2008:334) argue that qualitative research findings should be connected, understandable and clear and the relationship between the data and the interpretation should be coherent. The experiences that were described emerged in the Chapter Four where the essential four themes and their 14 sub-themes were described. Following that, an exhaustive description of the essence of living with HIV and HTN was formulated. The emergent themes and exhaustive description describing the essence of the lived experience of living with HIV and HTN guided the recommendations on the management of HIV and HTN. Being embedded in the research data, each theme was assessed in terms of recommendations that could be yielded from the theme towards the PHC nurses' role in the management of HIV and HTN. Figure 6.1 reflects the recommendations that were formulated and the themes each recommendation is based on.

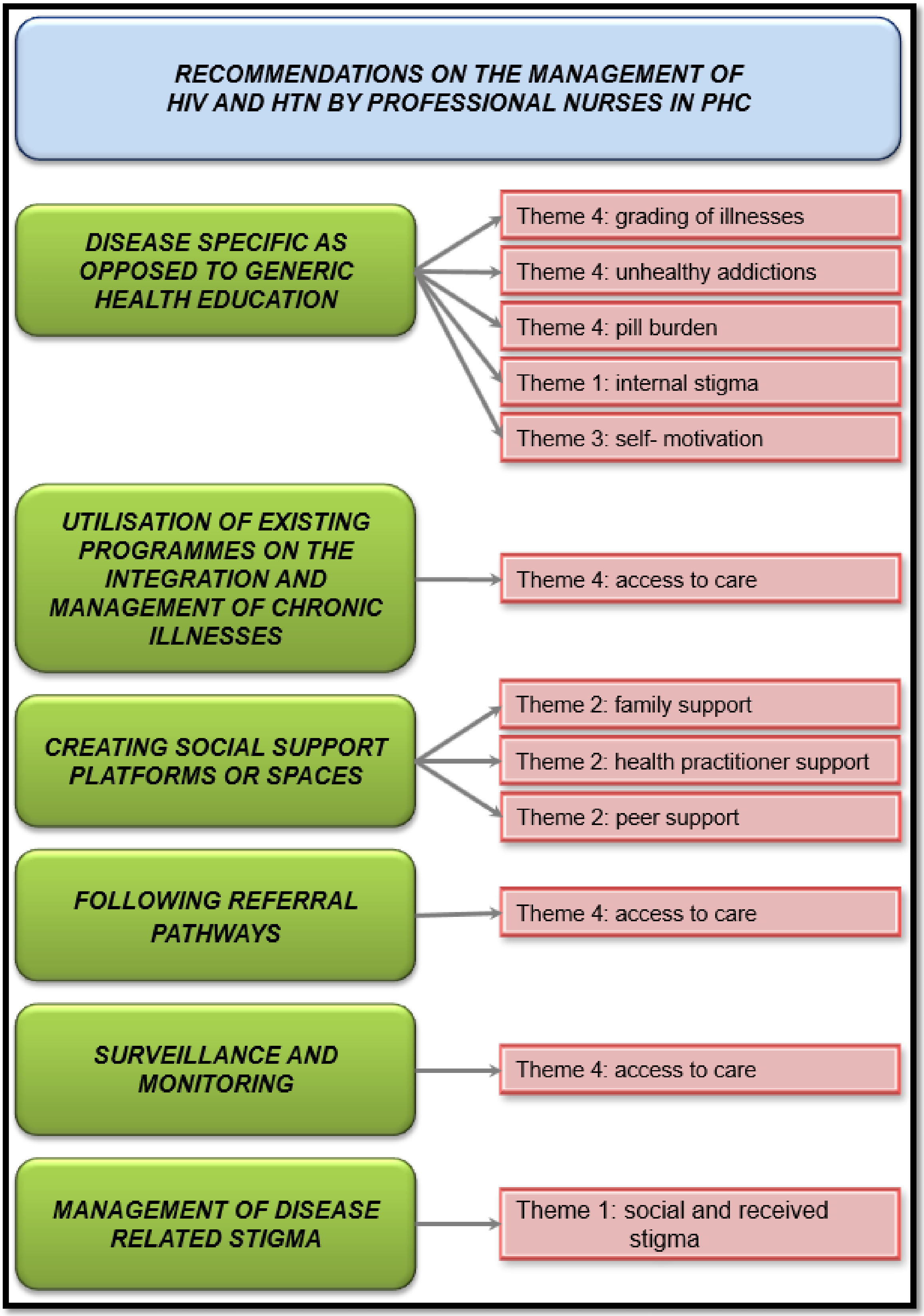


Figure 6.1: Representation of recommendations for nursing practice

6.1.2 Recommendation on the management of HIV and HTN by professional nurses in the PHC setting

This study recommends that the recommendations that will be described will assist the professional nurses in the PHC in the management of HIV and HTN. Six clinical recommendations were formulated to support professional nurses in the management of HIV and HTN in the PHC setting as per Figure 6.1. The recommendations are for disease specific as opposed to generic health education; utilisation of existing programmes on the integration and management of chronic illnesses; creating social support platforms or spaces; recommendations on referral pathways and recommendations on surveillance and monitoring. Each of the recommendations that the study has offered will be discussed fully below.

6.1.2.1 Disease specific as opposed to generic health education

This study recommends that PHC nurses should re-enforce the disease specific health education to PLWH and HTN. This recommendation further specifies that often health education is provided in a very generic manner, while the findings of this study highlighted the need for patients living with the co-morbidity of HIV and HTN to receive disease-specific health education; thus, the need for tailoring health education that is specific to the patients' needs and disease profile. In particular to the experiences of living with HIV and HTN, this study noted that patients were often feeling overwhelmed initially with processing a second diagnosis of a chronic illness and started to grade the diseases of HIV and HTN - placing one disease of greater importance to the other. This study further showed that this perceived grading of illnesses stemmed from the attention the diseases were given by their health care provider. In many instances, HIV management was given greater importance in terms of medication compliance or symptom screening by the PHC nurse. Thus, this recommendation requires PHC nurses to place both chronic illnesses on the same level rather than grading them, to ensure that the self-management of both HIV and HTN as chronic illnesses is dealt with the same level of priority and effort in terms of medication and disease management.

This study recommends that the PHC nurses should educate the PLWH and HTN on the proper lifestyle modification to ensure viral load suppression and a healthy lifestyle, such as reducing alcohol intake and smoking to smoking patients. The proper lifestyle practices will ensure that viral load remains undetected and blood pressure is within normal levels. The PHC nurses can provide information on the symptoms of each disease, and what patients can expect in terms of living with the co-morbidity of both diseases. PHC nurses should also build/cascade the health information provided so as not to overwhelm patients with information overload. The PHC nurses can also provide information regarding the monitoring of viral load among PLWH and HTN.

This study recommends that the PHC nurses should standardise the education to the patients on adherence to HTN and HAART medication to avoid additional medication that can cause poly-pharmacy by developing an adherence plan with them on diagnosis. The WHO (2015) highlights that health care should be patient centred, and health care providers need to provide individual tailored health education; thus, despite patients living with the same co-morbidity, each patient will present with unique characteristics, and nurses need to be skilled and able to provide health education that is aligned to the patients’ unique needs of how they are experiencing the disease.

This study recommends that PHC nurses should educate PLWH and HTN about the importance of self-love and self-acceptance to ensure that internalised stigma is reduced. This can be done by on-going counselling to the patients about the chronic nature of the illnesses and that possessing them is not the end of the world.

This study recommends that the PHC nurses should educate the PLWH and HTN about the importance of remaining motivated and taking medication both for HTN in the morning and HIV at night to ensure that the patients living with a co-morbidity are retained on treatment and their viral loads and blood pressure readings are normal and suppression is achieved.

6.1.2.2 Utilisation of existing programmes on the integration and management of chronic illnesses

This study recommends that the PHC nurses should monitor and register stabilised PLWH and HTN on treatment to spaced fast lane appointments which is a two-months’ supply of chronic treatment, six monthly prescriptions such as the utilisation of centralised chronic medication dispensation and a distribution (CCMDD) programme and adherence clubs. These programmes will ensure that PLWH and HTN that are stable on their treatment do not have to travel long distances to go to the clinics and wait long hours to be seen by professional nurses.

Spaced fast lane appointments: A spaced fast lane appointment is the system in the facilities in PHC where all the patients that are stable are given two months treatment supply instead of just one month. This is implemented when the professional nurse has observed an improvement in the patient's conditions. This study recommends that PLWH and HTN should be seen after two months by professional nurses provided that they remain adherent to their medication and their medication supply will be issued for two months.

Repeated six-monthly prescriptions such as CCMDD: with this programme, all the stable clients will be seen by professional nurses after six months in the clinic to monitor their blood pressure, creatinine and viral load, and whether these readings are satisfactory after the six months. Their chronic medication prescription will be signed for six months to ensure that after every two months, they receive messages to collect their medication either at the clinic, churches or local halls. The role of the PHC nurse would be to ensure that the patients receive their medication timeously by delivering the medication parcels to the pick-up points suitable for the patients.

Adherence clubs: The adherence club is a club that is formulated by a professional nurse for all stable clients to ensure that they meet and have the same cohort for taking bloods, checking blood pressure. With this programme, the PHC Nurse can group the patients according to their catchment areas so that they can be seen after six months in their area.

This study recommends that the PHC nurses should establish nearest pick up points for the CCMDD clients such as churches in the patient's catchment areas so that they can avoid the long distances for collecting their medications from the clinics. The multiple pick up points will ensure that the patients do not have to go to the clinic to take their medication every two months but they can either be dropped off at their local shops, churches or even pharmacies to reduce the waiting time and walking long distances to the clinics. The findings of this study revealed that the PLWH and HTN experience a challenge of access to care in terms of rivers that become full due to climatic conditions, as well as waiting hours that are long and distances that are far from the clinics. When PLWH and HTN are supported through their adherence clubs they can view the chronic illnesses as manageable diseases; thus, in instances where the disease is managed, medication hubs can be created to promote access to patients, especially instances such as those of this study, where in rural areas access to the PHC clinic is often further than 5 km. These medication hubs could enable patients to access their care, in the long term, and such medication hubs could be built in places where social support and anti-stigmatising campaigns and behaviours would be encouraged; thus these illnesses will become sensitised and conscious to the community.

6.1.2.3 Creating social support platforms or spaces

This study recommends that the PHC nurses should ensure that PLWH and HTN have the proper support in their homes and in their surroundings to facilitate treatment intake. This can be done by PHC nurses ensuring that the care is not individualised by asking relatives to support PLWH and HTN. Community health workers can be utilised through home visits to facilitate that patients are supported in their families.

This study recommends that the PHC nurses should strengthen their counselling role in patients living with HIV and HTN to improve compliance to their treatment through on-going counselling and support and displaying a caring attitude to all PLWH and HTN. This study recommends that the PHC nurses should improve their attitudes when caring for patients with HIV and HTN so that they can be able to be motivated, ask for health related advice and follow instructions given by the nurses.

This study recommends that the PHC Nurses should utilise mobile technology such as Whatsapp support for patients living with HIV and HTN where they will be added by a professional nurse using pseudonyms in order to facilitate support amongst the patients. This will also enable patients who are still undergoing the process of letting go of internal stigma and disclosure, especially to living with HIV, to be connected on an online support space. In addition, given the number of mobile devices available in the country and coverage thereof, the use of mobile support groups, such as that through WhatsApp or bulk messaging in this recommendation will enable nurses to network patients to connect with one another. Directory of services and common or frequently asked questions (FAQs) can also be part of this social support base, thereby creating greater ownership of the management of these diseases to the patients.

This study recommends that the PHC nurses should encourage PLWH and HTN to disclose to their significant others so that they can be supported in terms of their emotional well-being and also to facilitate that they adhere to treatment. Disclosure of the patients to their families and/or partners will facilitate support in terms of reminding them to take medication in the morning and in the afternoon for HAART.

This study recommends that the PHC nurses should allow PLWH and HTN to support each other in the community when one of them is not adhering to treatment. This can be done by creation of support groups in the patients' catchment areas that will ensure that all patients on treatment support each other in terms of the management of chronic illnesses.

This study recommends symptom management support bases facilitated by a nurse that also enables patients to connect and to also create more connectivity with patients and a way of monitoring and providing additional care from the nurse to a collective group.

This study recommends creating care plans that are culturally relevant and patient centred. This could be linked to the fact that each client journeys differently with their acceptance of living with HIV and HTN and thus the nurse needs to be mindful of tailoring nursing care that is aligned to the cultural need of the patient, also in terms of the working hours of the patient which may be linked to symptom management and pill burden.

This study recommends that the PHC nurses can link the experiences of patients towards the process of developing a new normal through the various processes embedded in the themes by having a short learning training. The training for nurses will enable and equip PHC nurses on the psychological and the supportive aspects to support the patients living with a co-morbidity.

This study recommends PHC nurses to organise a community-based family support groups or information sessions that are led by the PHC nurses. In the groups, the PHC nurses during routine visits with their clients who are not necessarily living with

HIV/HTN routinely can engage on whether that client has family members that have HIV/HTN and then build within their consultation skills and mechanisms of how the family member can be supported. It can also be in the form of nurses asking the patient who has HIV/HTN to bring/invite their family members to come for the consultation of family support sessions that are being facilitated by the PHC nurse to help them to better support their family member living with the co-morbidity.

For lifestyle, this study recommends that the PHC nurses can build symptom management mentoring that is facilitated by the PHC nurses. In this mentoring, PLWH and HTN can be supported to cope with the symptoms they experience rather than use unhealthy habits to cope with the co-morbidity

This study recommends that the PHC nurses can create care plans that are culturally relevant and patient-centred. The care plans could be linked to the fact that each client journeys differently with his or her acceptance of living with HIV and HTN and thus the nurse needs to be mindful of tailoring nursing care that is aligned to the cultural needs of the patient, in addition to considering terms of the working hours of the patient being linked to symptom management and pill burden. The care plans can ensure that medication is taken at specific times suitable for patients without disruption of activities in daily living.

6.1.2.4 Recommendation on referral pathways

This study recommends that the PHC nurses should arrange with local hospitals to provide the patients with their chronic medication when they are unable to go to their clinics due to changes in climate, such as rain, that cause them to be unable to attend their nearby clinic. This will facilitate adherence to treatment despite challenges of accessing nearby clinics. The study findings revealed that PLWH and HTN struggle to attend clinics due to access to care that is not within reach. This study recommends that the PHC nurses collaborate with nearby hospitals close to the patient’s catchment areas so that they can supply medication to them when they are unable to attend the clinics due to different barriers to access being experienced.

6.1.2.5 Recommendation on surveillance and monitoring

This study recommends surveillance and monitoring in terms of the PHC nurse developing clear strategies of how this cohort of patients will be regularly monitored outside of their PHC visit that is usually focused on routine screening and medication receipt. In this recommendation, the PHC nurses can collaborate with the WBOT teams and even go as a facility to areas out of reach of the facility to ensure that during outreach programmes, the PLWH and HTN on treatment can be monitored in their catchment areas for blood pressure and viral load monitoring instead of going to the clinics. The PHC nurses can create rosters as to when each catchment area will be visited so that the CHWs can mobilise to ensure that all eligible patients are seen.

6.1.2.6 Recommendation on the management of disease-related stigma

This study recommends that the PHC nurses can organise workshops for the communities within the areas where the clinics are located. In the workshops, the community and the family members of the PLWH and HTN can be educated about the chronic nature of HIV and HTN to minimise stigma. The people in the community can be educated about how they can be sensitive to the feelings of the PLWH and HTN and be capacitated on the chronic nature of the illnesses when one is on treatment. The PHC nurses can also educate about the pharmacological management of the treatment used and benefit of the treatment.

6.1.3 Recommendations for nursing education

This study recommends that the nursing students in their final year should be exposed to the management of HIV and HTN by PHC nurses in the facilities. This can be done by outsourcing a practising clinician that can introduce the students on the DOH guidelines that are currently used and the programmes specifically for HIV and HTN so that they can be able to facilitate the management of the patients living with HIV and HTN to ensure that the students enter the field with a pre-requisite knowledge. This includes the programmes that are currently used in PHC such as CCMDD, spaced fast lane appointments and adherence clubs.

Another recommendation is that the student nurses' exit outcomes can include an additional component in the community health nursing that focuses on the management of patients living with co-morbidity.

6.1.4 Recommendations for further research

This study recommends that the research on the lived experiences of living with HIV and HTN should be done on a wider sample and in different provinces so as to get the essence of the experiences of living with two chronic conditions on a wider scale. In addition, this study recommends that further research should be done on the role of social support in the management of chronic illnesses with regard to self-acceptance and adherence. This study recommends further research on the effect of social stigma in the management of HIV in the rural areas of the Eastern Cape.

This study recommends that further research should be done on the lived experiences of people living with more than two illnesses such as HIV, HTN and DM. Furthermore; this study recommends further research on the experiences of family members caring for a loved one living with an NCD and communicable disease. The study recommends further research on the lived experiences of people being infected by their spouses with HIV. This study recommends further research on the knowledge and perceptions of professional nurses on the implementation of adult basic care guidelines in the management of patients with chronic illnesses. Moreover, the study recommends further research on the attitudes of professional nurses with regard to the limited trainings on the management of HTN and HIV in their sub-districts

6.1.5 Summary of the recommendations

The recommendations to support the PHC nurses in the management of HIV and HIV and HTN were made. The recommendations emerged from the findings of the study and were discussed fully. In addition, recommendations for nursing research and the nursing research this study recommends were made.

6.2 STRENGTHS AND LIMITATIONS OF THE STUDY

6.2.1 Strengths

The strengths of the study were facilitated by the research methodology and research approach that underpinned the study. In addition, the strengths lay in the use of an exploratory methodology such as that of phenomenology that enabled each participant to share their unique experiences and through this to draw generalised recommendations for the management of HIV and HTN for PHC nurses. Further, because this study was on the patients and not the health care providers, it means that the findings and the recommendations that have been made from the findings are underpinned greatly to the patients' needs and what they will require from their PHC nurses to make the management of the co-morbidity more manageable.

The use of qualitative research design enabled the nurse to be the instrument for data gathering which allowed more data to be yielded during interviews. In addition, the use of a semi-structured interview guide and probes enabled the researcher to obtain more information in terms of the lived experiences of living with HIV and HTN as the patients would dwell more in their descriptions when probes were used. The use of descriptive phenomenology enabled the researcher to obtain the everyday experiences of PLWH and HTN as experienced by the participants.

6.2.2 Limitations

This study only focused on a smaller sample of nine participants, in one sub-district, and in one district. Therefore the study findings reflected the lived experiences of the patients of the selected setting. In addition, the study was conducted only in one province so it looked only at the Eastern Cape rather than the entire South African Provinces where patients are living with NCDs and communicable diseases. Furthermore, the study was conducted only to participants that were homogeneous in terms of ethnic group. This meant that the researcher could not generalise the study findings to other areas outside the Eastern Cape and different homogeneous ethnicity. However, it is of importance to know that qualitative research studies are not intended to be representative and do not look at generalising findings but rather to ensure that the findings can be transferable to another setting if the same methods can be utilised again, thus achieving trustworthiness.

6.3 CONCLUSION

The use of Husserl's descriptive phenomenology as it was deemed appropriate to explore the lived experiences of PLWH and HTN was effective in achieving its purpose. Phenomenology as a lens enabled the researcher to see through the life world of the participants in the rural areas of the Eastern Cape. In my knowledge, this is the first study to explore the lived experiences of people living with HIV and HTN in the rural Eastern Cape with regard to disease management. In addition, this is the first study to make recommendations to support the PHC nurses in the management of the co-morbidity of HIV and HTN.

Furthermore, the aim of the study which was to explore the lived experiences of PLWH and HTN with regard to disease management was achieved. The research question of the study was answered. This was answered by the central theme that emerged which was the essence of the lived experiences of PLWH and HTN towards developing a new normal. The objective which explored the inhibitory and facilitative conditions of patients living with HIV and HTN experience was explored and described. The last objective, which is to make recommendations to support professional nurses working in the PHC, was achieved. Moreover, the study concludes that the lived experiences of PLWH and HTN based on the findings were different; participants described each one of them as they coped towards developing a new normal of HIV and HTN.

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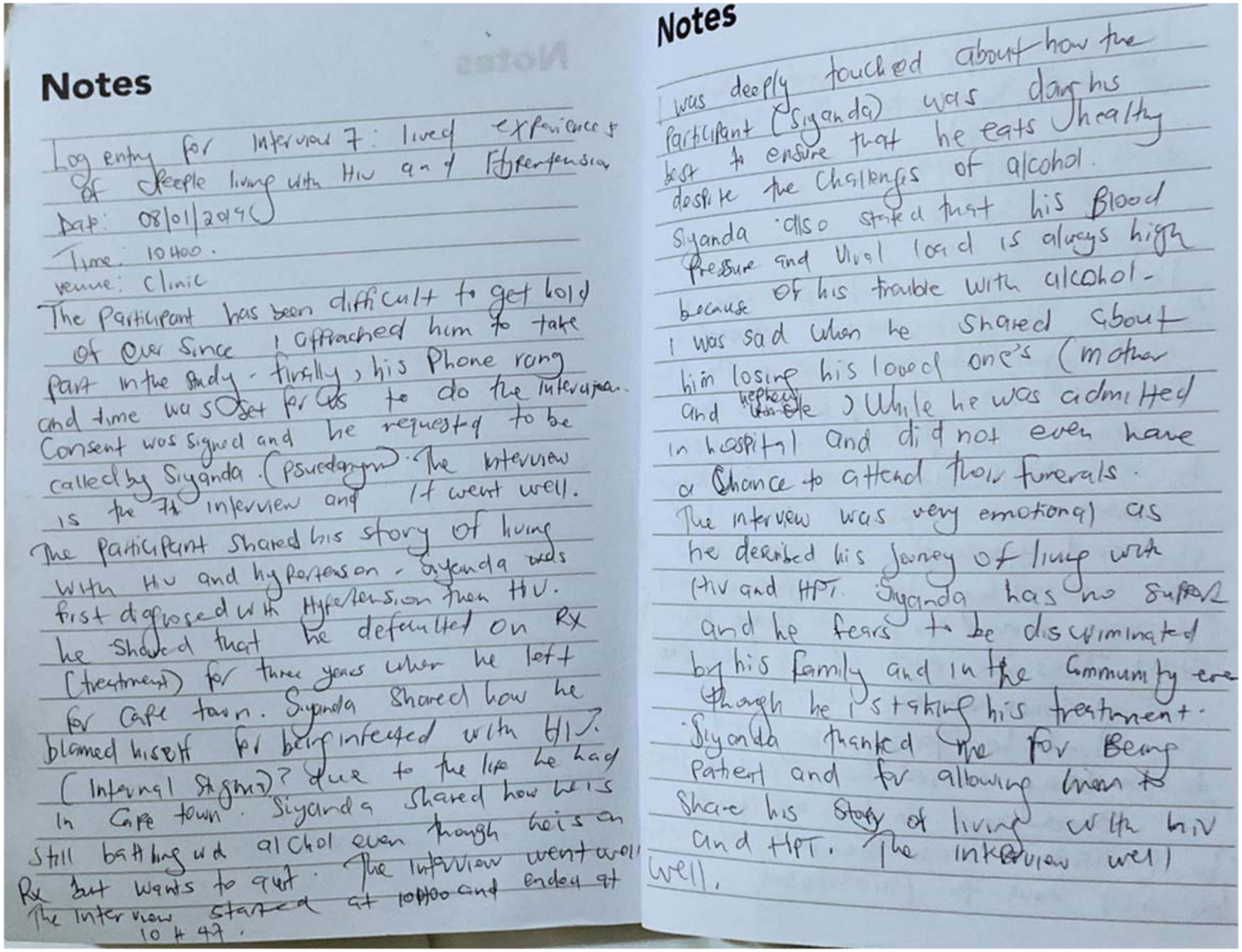
ANNEXURE A: REFLECTIVE JOURNAL



Notes

Log entry for Interview 7: lived experiences of people living with HIV and Hypertension

Date: 08/01/2019

Time: 10H00.

venue: clinic

The participant has been difficult to get hold of ever since I approached him to take part in the study. finally, his phone rang and time was set for us to do the interview. Consent was signed and he requested to be called by Siyanda. (pseudonym). The interview is the 7th interview and it went well.

The participant shared his story of living with HIV and hypertension. Siyanda was first diagnosed with Hypertension then HIV. he shared that he defaulted on Rx (treatment) for three years when he left for Cape town. Siyanda shared how he blamed hiself for being infected with HIV. (Internal Stigma)? due to the life he had in Cape town. Siyanda shared how he is still battling with alchol even though he is on Rx but wants to quit. The interview went well

The interview started at 10H00 and ended at 10H47.

Notes

I was deeply touched about how the participant (Siyanda) was doing his best to ensure that he eats healthy despite the challenges of alcohol.

Siyanda also stated that his Blood Pressure and Viral load is always high because of his trouble with alcohol.

I was sad when he shared about him losing his loved one's (mother and nephew ~~uncle~~) while he was admitted in hospital and did not even have a chance to attend their funerals.

The interview was very emotional as he described his journey of living with HIV and HPT. Siyanda has no support and he fears to be discriminated by his family and in the community even though he is taking his treatment.

Siyanda thanked me for being patient and for allowing him to share his story of living with HIV and HPT. The interview well well.

ANNEXURE B: SEMI-STRUCTURED INTERVIEW SCHEDULE

The researcher will contact the participants in advance and explain the purpose of the interview

The researcher will obtain permission from the participants

The researcher will schedule an appointment with the participants and agree on the appointment date

The interview place will be confidential, clean, and free from distractions

On the day of the interview

1. Greetings and brief introduction

Good morning, my name is Lwandile Tokwe, as I have mention when we last met; I am a Master of Nursing student at Nelson Mandela University doing a research on the experiences of people living with HIV and HPT.

2. Establishment of rapport

I would like to thank you first for taking time to share your experiences with me. As I have mentioned when we last met, today's discussion is to get to understand your experiences of living with both HIV and HPT. Are you still comfortable with this? Please feel free to stop me at any time of the interview. As I have also mentioned what we are discussing will be used collectively for me to better understand how people are living with HIV and HPT, cope and manage, therefore I will not use your name however you can choose a fake name I can use to identify you during this interview. Would you like me to do that now? I also need to keep a record of this information therefore; I will be recording the interview on this device. Are you still happy? This will only be heard by me and later I will type it all out and both me and my supervisor will go through it to better understand your experience. I will also bring this typed interview so that you can confirm that the information you will be sharing during the interview is what you meant.

3. General information and biographical information

Let’s start by telling me about yourself;

- How old are you?
- When were you diagnosed with hypertension?
- And when were you diagnosed of HIV?
- Did you start the medication immediately?
- Tell me a little bit about what that was like for you?
- How did you initially feel about the diagnosis?

4. Broad question

Now that you are living with HIV and hypertension for more than one year, can you please share your experiences of living with both HIV and hypertension especially in terms of how you manage the disease and treatment?

5. Probes

What are the facilitative conditions you experience of living with HIV and hypertension with regard to disease management?

What are the barriers that you experience of living with HIV and hypertension with regard to disease management?

6. Conclusion

Thank you so much for sharing with me your experiences. Is there anything you would like to add? I will appreciate it if you would allow me to come back for a follow up interview should I have additional questions for you. Are you happy? Thank you once again.

ANNEXURE C: NMU ETHICAL CLEARANCE

NELSON MANDELA
UNIVERSITY

PO Box 77000, Nelson Mandela University, Port Elizabeth, 6031, South Africa mandela.ac.za

Chairperson: Research Ethics Committee (Human)
Tel: +27 (0)41 504 2235
charmain.cilliers@mandela.ac.za

Ref: [H18-HEA-NUR-007] / Approval]

27 September 2018

Prof J Naidoo
Faculty: Health Sciences

Dear Prof Naidoo

LIVED EXPERIENCES OF PEOPLE LIVING WITH HIV AND HYPERTENSION WITH REGARD TO DISEASE MANAGEMENT IN THE EASTERN CAPE

PRP: Prof J Naidoo
PI: Mr L Tokwe

Your above-entitled application served at the Research Ethics Committee (Human) for approval.

The ethics clearance reference number is **H18-HEA-NUR-007** and is valid for one year. Please inform the REC-H, via your faculty representative, if any changes (particularly in the methodology) occur during this time.

An annual affirmation to the effect that the protocols in use are still those for which approval was granted, will be required from you.

We wish you well with the project.

Yours sincerely

Prof C Cilliers
Chairperson: Research Ethics Committee (Human)

Cc: Department of Research Capacity Development
Faculty Officer: Health Sciences

ANNEXURE D: EC DOH APPROVAL

Province of the
EASTERN CAPE
HEALTH

Enquiries: Zonwabele Merile Tel no: 083 378 1202
Email: zonwabele.merile@echealth.gov.za Fax no: 043 642 1409

Date: 12 October 2018

RE: Lived experiences of people living with HIV and hypertension with regard to disease management in the Eastern Cape. (EC_201810_002)

Dear Mr L. Tokwe

The department would like to inform you that your application for the abovementioned research topic has been approved based on the following conditions:

1. During your study, you will follow the submitted amended protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.

2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.

3. The Department of Health expects you to provide a progress update on your study every 3 months (from date you received this letter) in writing.

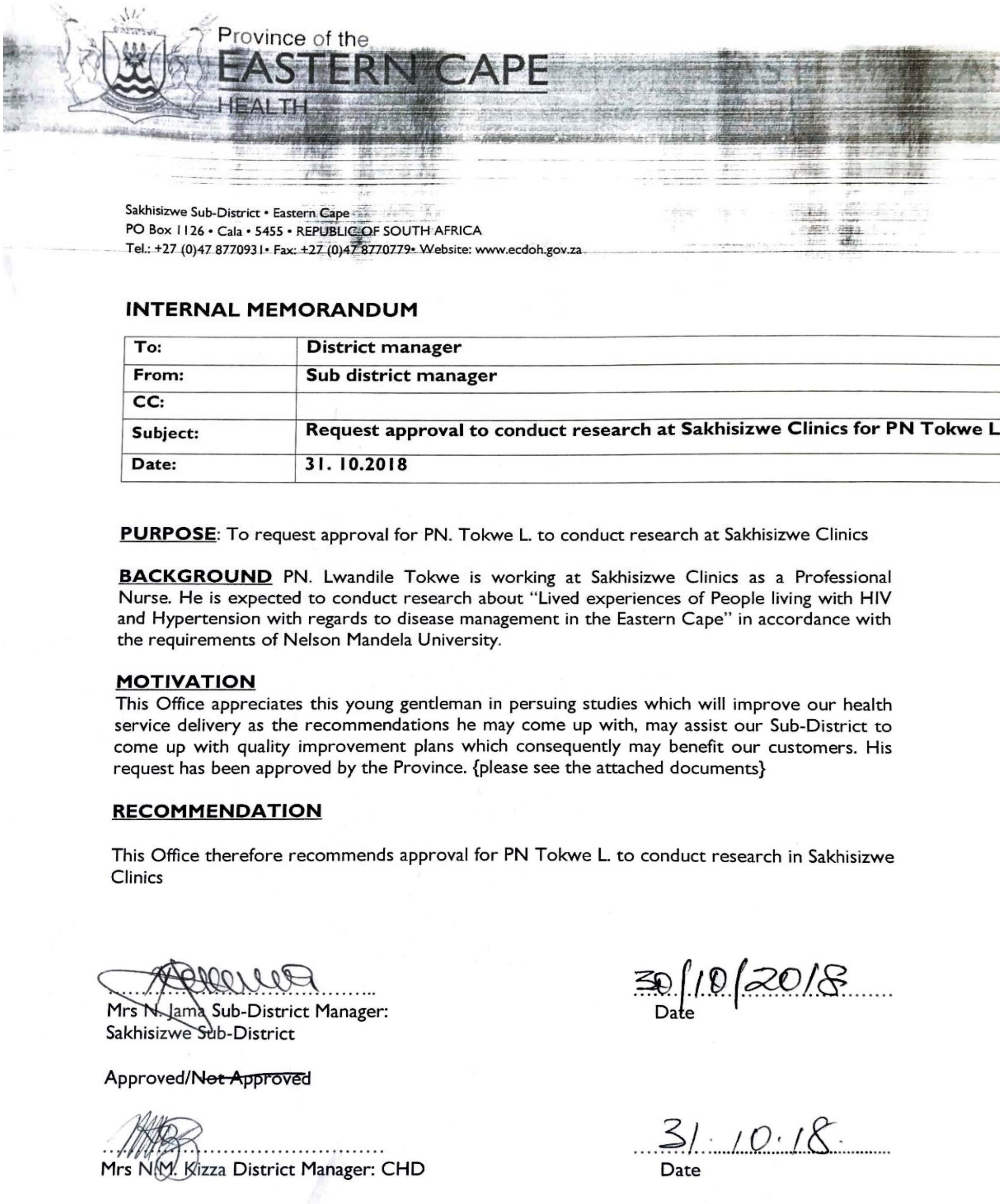
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Eastern Cape Health Research Committee secretariat. You may also be invited to the department to come and present your research findings with your implementable recommendations.

5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE

ANNEXURE E: SUB-DISTRICT AND DISTRICT APPROVAL



Province of the
EASTERN CAPE
HEALTH

Sakhisizwe Sub-District • Eastern Cape
PO Box 1126 • Cala • 5455 • REPUBLIC OF SOUTH AFRICA
Tel.: +27 (0)47 8770931• Fax: +27 (0)47 8770779• Website: www.ecdoh.gov.za

INTERNAL MEMORANDUM

To:	**District manager**
From:	**Sub district manager**
CC:	
Subject:	**Request approval to conduct research at Sakhisizwe Clinics for PN Tokwe L**
Date:	**31. 10.2018**

PURPOSE: To request approval for PN. Tokwe L. to conduct research at Sakhisizwe Clinics

BACKGROUND PN. Lwandile Tokwe is working at Sakhisizwe Clinics as a Professional Nurse. He is expected to conduct research about "Lived experiences of People living with HIV and Hypertension with regards to disease management in the Eastern Cape" in accordance with the requirements of Nelson Mandela University.

MOTIVATION

This Office appreciates this young gentleman in persuing studies which will improve our health service delivery as the recommendations he may come up with, may assist our Sub-District to come up with quality improvement plans which consequently may benefit our customers. His request has been approved by the Province. {please see the attached documents}

RECOMMENDATION

This Office therefore recommends approval for PN Tokwe L. to conduct research in Sakhisizwe Clinics

……………………………………… 30/10/2018……
Mrs N. Jama Sub-District Manager: Date
Sakhisizwe Sub-District

Approved/~~Not Approved~~

……………………………………… 31.10.18.
Mrs N.M. Kizza District Manager: CHD Date

ANNEXURE F: INFORMATION SHEET FOR PARTICIPANTS

NELSON MANDELA
UNIVERSITY

Title of the research study: **Lived experiences of people living with HIV and hypertension with regard to disease management in the Eastern Cape**

Researcher: Mr L. Tokwe, Master of Nursing (Research) student, RN, B Cur
Supervisor: Prof. J.R Naidoo, RN, PhD

Brief introduction and Purpose of the study: You are kindly invited to take part in this research study. The purpose of the study is to explore and describe the lived experiences of people living with HIV and hypertension with regards to disease and treatment management

Outline of the procedure: You are kindly requested to participate in an in-depth interview where you will be asked questions regarding your lived experience of living with the comorbidity of HIV and hypertension. The interview will take 45-60 minutes each and it will be conducted in a private room and the conversation will be recorded.

Risks or discomforts to the participants: There is a risk involved however, should the questions trigger a need for a psychological assistance, a standby Psychologist will be contacted, and the researcher is also a Registered psychiatric nurse who is trained in counselling of clients and debriefing will also be done immediately after the interviews.

Benefits: The study findings will be used to make recommendations, specific to the management of a comorbidity of HIV and hypertension to Professional nurses in the PHC context. Therefore, the study will be of benefit to you in the management of your comorbid illnesses by Registered Nurses.

Reason why the participant may withdraw from the study: Your participation is voluntary; you are under no obligation to participate but it will be highly appreciated if you decide to participate. Should you withdraw, your withdrawal will have no impact on the health care you receive.

Remuneration: You will not get paid for your participation in this study

Cost of the study: None

Confidentiality: The interviews will be recorded and any information that is gathered will not be divulged. Anonymity of participants will be assured by not having your personal details published.

Research related injury: There will be no research related injury during the course of the study.

If you have any problems or queries, please contact the persons below

Mr L.Tokwe 073 333 9231

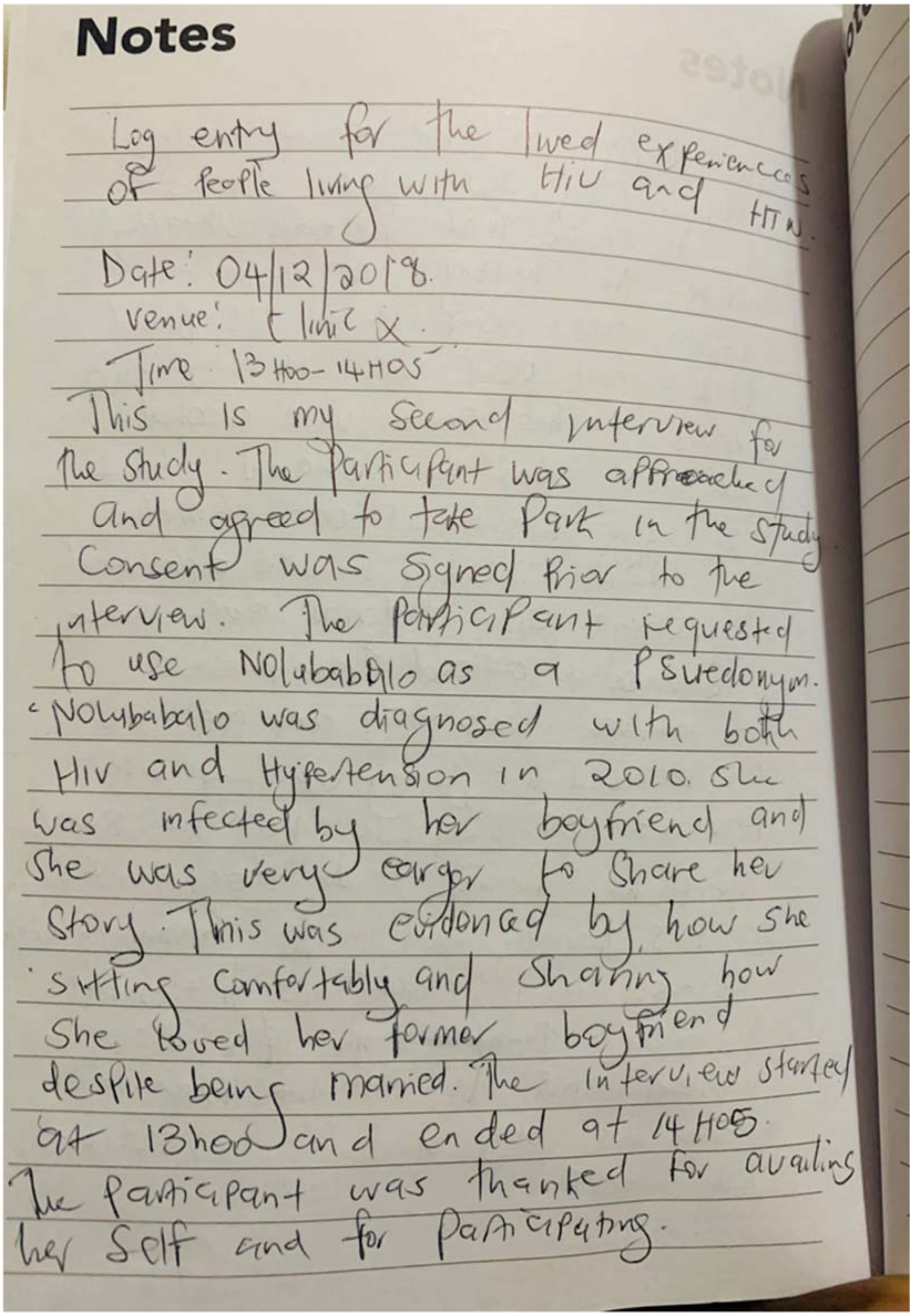
ANNEXURE G: INFORMED CONSENT

RESEARCHER'S DETAILS			
Title of the study	Lived experiences of people living with HIV and hypertension with regard to disease management Eastern Cape		
Principal investigator	Lwandile Tokwe		
Address **Postal code**	Upper Lafuta Clinic Upper Lufuta A/A Cala 5455		
Contact telephone number (Private number not advisable)	0733339231		
A. DECLARATION BY THE PARTICIPANT OR ON BEHALF OF THE PARTICPANT			
I, THE PARTICIPANT ANDTHE UNDERSIGNED		**FULL NAME**	**INITIAL**
IDENTITY NUMBER			
NAME OF THE INSTITUTION			
A1. HEREBY CONFIRM AS FOLLOWS			
I THE PARTICIPANT WAS SELECTED TO PARTICIPATE IN THE ABOVE MENTIONED STUDY			
THIS IS BEING UNDERTAKEN BY		LWANDILE TOKWE	

THE FOLLOWING ASPECTS HAVE BEEN EXPLAINED TO ME, THE PARTICIPANT		
2.1 PURPOSE	The purpose of the study is to explore and describe the lived experiences of people living with HIV and Hypertension with regards to disease and treatment management. Further to this, the findings of the study will be used to make recommendations, specific to the management of HIV and HPT by RN's in a PHC context.	**INITIAL**
2.2 PROCEDURES	I understand that the researcher expects me to answer the question that will asked	**INITIAL**
2.3 RISKS	I understand the research study may cause risk of emotional discomfort and distress due to questions of my everyday experiences of living with HIV and hypertension and that should there be questions that trigger the need for a psychologist, such service will be rendered. I also understand that should I require other means of counselling other than a psychologist; cultural or spiritual leaders will be made available for the services and such will be paid by the researcher should it be necessary.	**INITIAL**
2.4 POSSIBLE BENEFITS	I understand that the benefits expected to accrue to me as participant is the improvement in quality of nursing care provided by PHC nurses in the clinics. I also understand that participation will enable me to reflect on the coping skills and experiences of living with HIV and hypertension.	**INITIAL**
2.5 CONFIDENTIALY	I am aware that the interviews will be recorded and my information shared with the researcher will not be disclosed to any person and that my identity will not be revealed at a time of publication of the study	**INITIAL**
2.6 REMUNERATION	I understand that the will be no payment for my participation in the study	**INITIAL**

2.7 VOLUNARY PARTICIPATION/REFUSAL/DISCONTINUATION	My participation is voluntary	**INITIAL**
THE INFORMATION WAS EXPLAINED TO ME/ THE PARTICIPANT BY		
Lwandile Tokwe		
I was given time to ask questions and all my questions were answered		**INITIAL**
4. No pressure was exerted to me by the researcher to consent and to participate in the study. I understand that I may withdraw at any time without any change in the care I receive in the clinic		**INITIAL**
5. Participation in this research won't result to any additional cots to me		**INITIAL**
SIGNED/ CONFIRMED (INSTITUTION) ON 2018	**SIGNITURE OF THE PARTICIPANT**	
B. STATEMENT BY THE INVESTIGATOR		
1. I, LWANDILE TOKWE; declare that I have explained the information given in this document to:	**NAME OF THE PARTICIPANT**	
2. He/she was given enough time to ask questions; Yes No		
3. The interview was conducted in English Yes No		
4. I Have detached the copy of annexure D and handed to the participant		
5. Signed / confirmed at on 2018		
6. Signature of the interviewer		

ANNEXURE H: FIELD NOTES



Notes

Log entry for the lived experiences of people living with HIV and HTN.

Date: 04/12/2018.
venue: Clinic X.
Time 13H00-14H05

This is my second interview for the study. The participant was approached and agreed to take part in the study. Consent was signed prior to the interview. The participant requested to use Nolubabalo as a psuedonym. Nolubabalo was diagnosed with both HIV and Hypertension in 2010. She was infected by her boyfriend and she was very eager to share her story. This was evidenced by how she sitting comfortably and sharing how she loved her former boyfriend despite being married. The interview started at 13h00 and ended at 14H05. The participant was thanked for availing her self and for participating.

ANNEXURE I: INTERVIEW TRANSCRIPT

Interview 8

Participant H (LELETHU)

Date: 8/12/19

Setting: Clinic procedure room

Time: 13h00-13h45

R: good afternoon Ma'am how are you?

P: I am good how you are

R: I am also good. My name is Iwandile Tokwe, you know me, and I'm a nurse at your clinic. I would like to thank you for your time that you have given me so that we can sit down so that we can chat. Ma'am im a student doing Masters at Nelson Mandela University. So I was given permission by the Sub-district to continue and do this research that I am doing in people who are living with HIV and high blood pressure, the one you call pressure. I want to understand how it is for you to be living with these two conditions and the things you have faced as you are living with these two conditions. You see

P: yes

R: what is your name Ma'am?

P: my name is Lelethu

R:oh okay Lelethu. Okay How old are you Ma'am?

P: I am 46 years old

R: 46 years this year?

P: yes in this year

R: 46 oh okay okay. Are you married Ma'am?

P: yes I am married

R: oh okay okay. How long has it been since you've been married?

P: I married in 1999

R: can you please try and raise your voice

P: in 1999..

R: oh in 1999 *(Researcher moving chair close to the participant*) let me also move closer so that we can hear each other. Oh so you have been married since 1999 until now?

P: yes

R: oh okay. Do you have children?

P: I have children, they are three

R: ohhh.. what are their names?

P: Anelisa, Sinovuyo and Aphiwe

R: oh Anelisa, Sinovuyo and Aphiwe. How old are they?

P: 1993. 1999, 2001

R: mhhh.okay .the last was was born in 2009?

P: 2003

R: oh 2001..oh well they are old. Do you have grandchildren?

P: I have them

R: mhhhh….how many are they?

P: I have one

R: ohhh.from your older child?

P: yes

R: oh okay Ma’am. That is better. Eh you studied up to which level at school?

P: I studied up to standard 8 (*ndaphela kwibanga lesibhozo)* Then I dropped out because of situation of parents who lost their jobs

R: mhhh…mhhhh..When was that?

P: it was a strike of 1995 for Vat. I was studying in Gauteng

R: mhhh…I have chosen you because you are living with these two conditions, that is HIV and high blood pressure. Do you hear me Ma’am?

P: yes

R: eh Ma’am,when did you know that you have high blood pressure?

P: it was in 2010

R: 2010.. mhhh how old were you then?

P: haike I cannot rememeber because im not counting

R: mhhh..but it was in 2010?

P: yes

R: it was found that you have high blood pressure?

P: yes high blood pressure

R: mhhh..what are the things that you noticed for you to suspect that you have high blood pressure?

P: I used to be dizzy, have headache

R: mhhh

P: I said at request to be checked for high blood pressure

R: where?

P: at Clinic

R: mhhh..and then what happened?

P: and then they said my blood pressure is high but I must go and come back next week

R: mhhh.. to be checked again?

P: yes to be checked again so that they can find out if there wasn’t something that made me sad

R: the time you went to that clinic?

P: yes to have this headache and dizziness

R: mhhh..

P: then I went in the following week

R: ,mhhh

P; it was high again

R:mhhh did you feel dizziness and headache?

P: I was not feeling dizziness but I had headache

R:mhhh…

P: they gave me pills for the pressure, Ridaq, the yellow one

R: so you were started on Ridaq?

P: yes

R: how did you feel Ma’am after finding out that you will use treatment since you were not using any treatment?

P: I told myself that it is my life and I will live a long life if I take my treatment, if I don't take it, it will be increased to a high level and find myself having episodes of fits maybe

R: mhhhh..but the time you are told, you were not shocked or sad by that?

P: no I was not sad

R: mhhh...why because you were expecting it maybe or what?

P: it is because I used to saw people with pressure that they become better if they take their pills then if they are not taking pills and it arrives to 200 and something…they die

R: oh okay

P: then I told myself that im in the safe hands

R: mhhh..mhhhh so after finding out that you have pressure, did you accept the condition?

P: I said let me accept myself because if I don't accept myself, I will not be able to focus on those pills

R: mhhh..When you were told you have pressure Ma'am, what are the things that you were told to do at the clinic?

P: it was said that I shouldn't put too much salt in my food. This is what they said

R: mhhhh…

P: I was that person who when I was eating pour uncooked Aromat on top of the food

R: and spices and raw salt

P: they said I must stop doing that again and I stopped it

R: mhhh..So would you say your pressure was caused by the way you were eating and not by things that maybe made you unhappy?

P: I didn't have anything that made me unhappy, so I suspected the way I was eating

R: mhhh.. Then who did you tell when you found out you have this high blood pressure?

P: I told my husband

R: okay. So would you say accepting high blood pressure helped you to tell your husband about it?

P: I said to myself hiding it won't help anything because he will see my pills and ask what condition they treat. Then I would be the same as a person who is dishonest now

R: mhhh mhhh…so you have been living with high blood pressure since 2010?

P: yes

R: oh okay Ma'am. Then when did you find out you also have HIV?

P: HIV. I don't remember the year. My husband was coming back home and we were training for HIV/AIDS and home-based in all and counselling in another area. My husband arrived and there was a funeral here in the area, I knew that he was going to come with the person who was going to be buried.

R: oh

P: when it was 01ham at night, I heard my phone ringing

R: your husband's phone?

P: my husband was calling

R: okay

P: please open for me. I opened the door, since I have already been educated about HIV and everything, we did our greetings, we hugged each other and it was nice. I said my husband before we can sleep together; we need to sit down in this time we living in

R: mhhh

P: because times have changed, it’s not the same as before. Then he was in shock. I said to him, there is nothing shocking about this matter because it is needed that for both of us to be true to each other

R: mhhh mhhh

P: so that if there is a problem, we cannot both pass away and leave children with no parent to raise them. His answer was, I have pills that I am taking

R: mhhh

P: I was afraid of telling you. I asked him since when have you been taking this pills? He said I have two years

R: mhm mhm mhm

P: I said in these two years you have been hiding yourself?

R: every times your husband was coming back home?

P: every time he was coming back he was hiding himself. He said I used to guard you when you went out here in the room or doing something that you were doing in the kitchen and guard you

R: they he would take his pills?

P: then I would run and take pills. I was afraid of telling you this even though I wanted to. I asked him that he is aware that he had also infected me?

R: oh so you are telling him that?

P: yes. I said maybe I also have it then. This is good. No one is fighting with anyone here, I will go to the clinic and at clinic I will request to be tested

R: mhhh

P: he was going to a funeral and late he was leaving now so he was not going to sleep here at home

R: mhhh

P: he said I should call him, but I said no he should call me because I wanted to know that I didn’t hurt his feelings

R: oh okay

P: because it happens that you talk to someone about a thing and you end up hurting them and be afraid of saying that they are hurt

R: mhhh

P: I said to him that he should call me and ask how I went at clinic

R: mhhh

P: I said you see in these two years if it was not two years or you were saying you are not taking ARVs, you are taking Bactrim and haven’t started on treatment, and maybe it was two months not two years, I would say I’m in window period then after three months I would need to be tested again and again after another three months if it is not seen or now. The decision I am taking is that you and I must use a condom for our safety. So he left

R: mhhh

P: then in the morning, he called and asked how things went in the clinic. I said I have it my husband (referring to HIV), he asked again and I said I have it. I am positive, what were you expecting when we were continuing sleeping

R: and he was not saying anything

P: and you were no talking. No I was afraid, he said. That made him to come back home in the second week. He took me for two years to move with him to Gauteng because he was saying that I was going to leave him

R: mhhh

P: I said to him, I will leave you and say I will spread it to who because if you don’t forgive yourself and I don’t forgive myself we will be unhappy and we will be thin

R: mhhh

P: and if you will say when you have running tummy, you have headache it is because of HIV, you will be thin. I told my husband that I will not die because of this condition

R: mhhh

P: it will control me and I will control it. I took Bactrim and I took Bactrim I think for about a year

R: mhhh

P; and I was changed to ARV's.

R: Wait Ma'am, the time your husband is telling you that he is HIV positive and has been taking treatment for two years not telling you; how did you fell about that?

P: because there was nothing I could do, my sadness would be my sickness; better let me go and look for a place that I going to helpful to me

R: mhhh then in your family how did your acceptance of the condition help you?

P: it helped me to be able to tell my sister who comes after me about this condition. She also got a chance to tell me that she is HIV positive, and that she was afraid of telling me. Then I told my other sister again, who is the fourth one

R: so would you say acceptance helped you to be able to tell other people?

P: it helped me, even if someone is sick and I know that person is positive, I know how to tell them that they this is how they should do things when they are HIV and when I'm done I make them an example about me, but I tell them not to go around and tell people about, it should stay between us because I will not tell people that I was here

R:mhhh mhhh so Ma'am what can you say are the things that have helped you to be able to live with this conditions up to this far?

P: things that have helped me to be alive even now, I would say are my pills for pressure and (ARVs) to be able to live with these conditions

R: mhhh and what?

P: and aspirin

R: mhhh.. didn’t acceptance didn’t help you?

P: it helped me to because I started with accepting and I told myself that if I don’t take my treatment it is the end of my life

R: mhhh.. So if you are at home, do you still hide your treatment if there are other people because you fear that they will find it then talk about you?

R:mhhh so you don’t wish other people to know about you conditions?

R: mhhh.. so other people don’t know ?

R: so they encouraged you

R: mhhh how?

they able to support you?

R: mhhh.. then Ma’am when you told your sisters that you are HIV positive and you have pressure, were they able to support you?

P: they were able to support me

R: mhhh how?

P: they said it is not the end of the world a person can live 30 years even 40 years with these conditions if they take their treatment the right way

R: so they encouraged you

P: yes. Even when im at home, and they see that I am busy maybe there is an event, they are able to remind me that it it is time to take pills because the phones are usually with the kids without even saying that but by just making a gesture indicating time with hands. By doing that, I know, and quickly go and take my pills because I already know what it means

R: mhhh.. so other people don’t know ?

P: other people do not know and I don’t want them to know

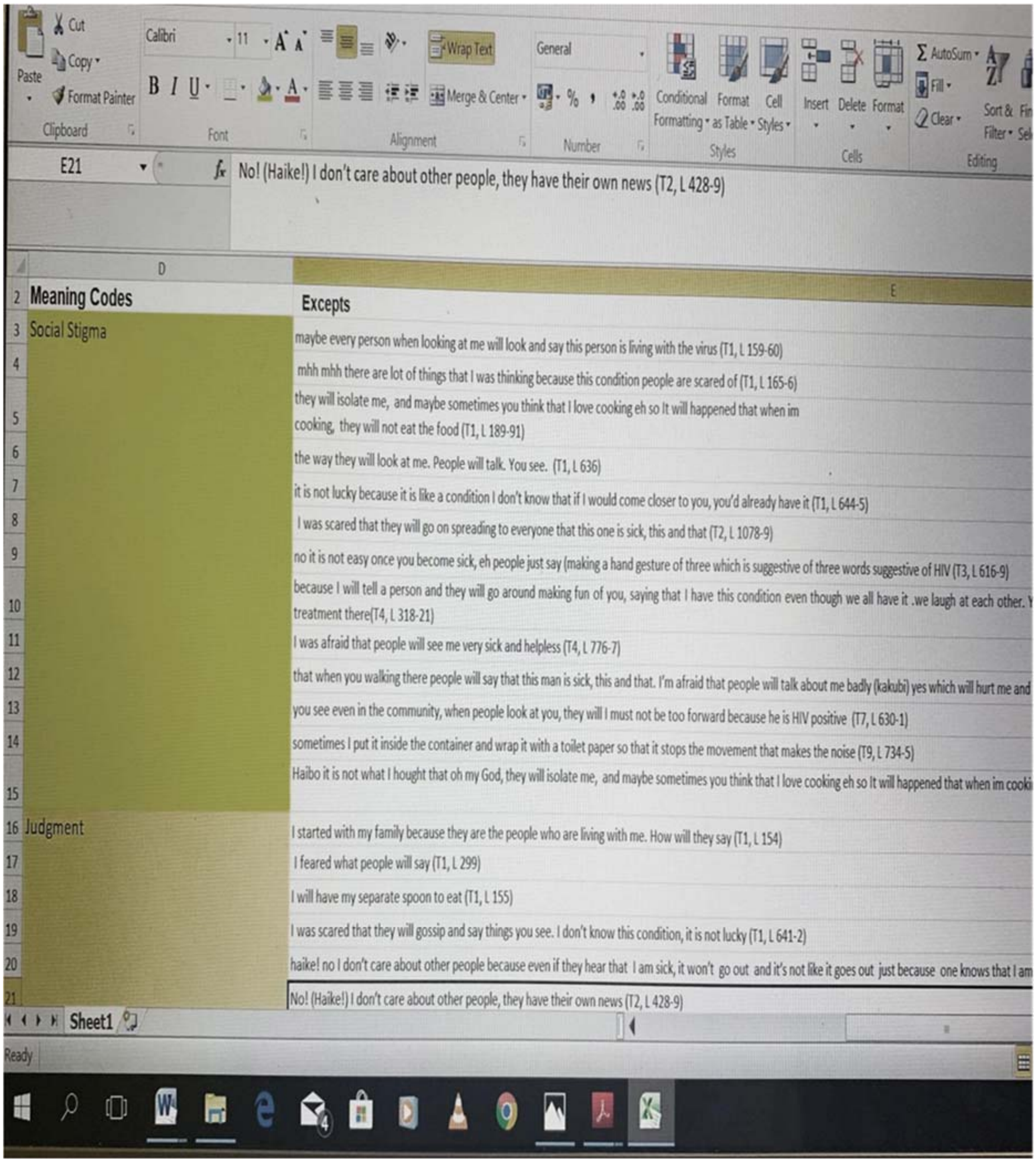
R:mhhh so you don’t wish other people to know about you conditions?

P: No I don’t wish so because other people judge a person or judge you and say you see this one, or make a mistake by telling a friend that I have this condition and spread it .That eats you inside because the person you told your problem tells it to other people

R: mhhh.. So if you are at home, do you still hide your treatment if there are other people because you fear that they will find it then talk about you?

R: thank you Ma’am for your time

ANNEXURE J: MICROSOFT EXCEL SPREAD SHEET



E21 No! (Haike!) I don't care about other people, they have their own news (T2, L 428-9)

	D	E
2	**Meaning Codes**	**Excepts**
3	Social Stigma	maybe every person when looking at me will look and say this person is living with the virus (T1, L 159-60)
4		mhh mhh there are lot of things that I was thinking because this condition people are scared of (T1, L 165-6)
5		they will isolate me, and maybe sometimes you think that I love cooking eh so It will happened that when im cooking, they will not eat the food (T1, L 189-91)
6		the way they will look at me. People will talk. You see. (T1, L 636)
7		it is not lucky because it is like a condition I don't know that if I would come closer to you, you'd already have it (T1, L 644-5)
8		I was scared that they will go on spreading to everyone that this one is sick, this and that (T2, L 1078-9)
9		no it is not easy once you become sick, eh people just say (making a hand gesture of three which is suggestive of three words suggestive of HIV (T3, L 616-9)
10		because I will tell a person and they will go around making fun of you, saying that I have this condition even though we all have it .we laugh at each other. treatment there(T4, L 318-21)
11		I was afraid that people will see me very sick and helpless (T4, L 776-7)
12		that when you walking there people will say that this man is sick, this and that. I'm afraid that people will talk about me badly (kakubi) yes which will hurt me and
13		you see even in the community, when people look at you, they will I must not be too forward because he is HIV positive (T7, L 630-1)
14		sometimes I put it inside the container and wrap it with a toilet paper so that it stops the movement that makes the noise (T9, L 734-5)
15		Haibo it is not what I hought that oh my God, they will isolate me, and maybe sometimes you think that I love cooking eh so It will happened that when im cooki
16	Judgment	I started with my family because they are the people who are living with me. How will they say (T1, L 154)
17		I feared what people will say (T1, L 299)
18		I will have my separate spoon to eat (T1, L 155)
19		I was scared that they will gossip and say things you see. I don't know this condition, it is not lucky (T1, L 641-2)
20		haike! no I don't care about other people because even if they hear that I am sick, it won't go out and it's not like it goes out just because one knows that I am
21		No! (Haike!) I don't care about other people, they have their own news (T2, L 428-9)

ANNEXURE K: LETTER TO DEPARTMENT OF HEALTH

NELSON MANDELA
UNIVERSITY

Po Box 77000, Nelson Mandela University, Port Elizabeth, 6031, South Africa

03 October 2018

DEPARTMENT OF HEALTH
BISHO

Dear Sir/Madam

RE: PERMISSION TO CONDUCT A RESEARCH STUDY AT SAKHISIZWE SUB-DISTRICT

My name is Lwandile Tokwe; I am a registered Master of Nursing (Research) student at Nelson Mandela University in the Department of Nursing Science in this Academic year of 2018. I would like to request a permission to conduct my research study at the clinics of Sakhisizwe Sub-district. The research study is conducted under the supervision of Professor J.R.Naidoo, an Associate Professor at the Nelson Mandela University in the Department of Nursing Science.

The title of my research study is: *Lived experiences of people living with HIV and hypertension with regard to disease management in the Eastern Cape.* The study will be qualitative using a phenomenological approach.

The objectives of the study are to:

- Explore and describe the lived experiences of people living with HIV and HPT in the Sakhisizwe Sub-district, Eastern Cape
- Explore and describe the facilitating and inhibitory conditions experienced by people living with HIV and HPT with regard to disease management in the Sakhisizwe Sub-district, Eastern Cape
- To make recommendations on the management of HIV and HPT by RN’s in the PHC setting

For the researcher to be able to achieve the objectives of the study there is a need to conduct interviews at the clinics of Sakhisizwe Sub-district which will be 45-60 minutes each. The data will be gathered using semi-structured interviews with a single broad question. The participation to the study will be voluntary and the clients will have the freedom to withdraw anytime in the study and their withdrawal will not affect the care provided to them at the clinics. The participant's confidentiality, anonymity will be assured by not linking their names to the information they will provide including writing their names on the transcriptions.

The proposal will be presented at the Departmental Research committee in the Department of Nursing Science then on approval it will be forwarded to the Faculty Post Graduate Research Committee for Ethical clearance. The study may have research related risks or ethical concerns, but you can contact my supervisor Prof J.R Naidoo for any concerns. The proposal for the study is attached at the back of the letter

Thanking you

Yours faithfully

Lwandile Tokwe (Mr), RN	Joanne.R. Naidoo (Prof), RN, PhD
Master of Nursing (Research) student	Research supervisor
Email:s213313774@mandela.ac.za	Email:joanne.naidoo@mandela.ac.za
Cell number: 073 333 9231	Telephone: 041 504 1403
__________________________	__________________________
Researcher's signature	Supervisor's signature
__________________________	__________________________
Date	Date

ANNEXURE L: LETTER TO THE DISTRICT MANAGER

NELSON MANDELA UNIVERSITY

Po Box 77000, Nelson Mandela University, Port Elizabeth, 6031, South Africa

19 OCTOBER 2018

THE DISTRICT MANAGER
CHRISHANI DISTRICT
QUEENSTOWN

Dear Sir/Madam

RE: PERMISSION TO CONDUCT A RESEARCH STUDY AT SAKHISIZWE SUB-DISTRICT

My name is Lwandile Tokwe; I am a registered Master of Nursing (Research) student at Nelson Mandela University in the Department of Nursing Science in this Academic year of 2018. I would like to request a permission to conduct my research study at the clinics of Sakhisizwe Sub-district. The research study is conducted under the supervision of Professor J.R.Naidoo, an Associate Professor at the Nelson Mandela University in the Department of Nursing Science.

The title of my research study is: *Lived experiences of people living with HIV and hypertension with regard to disease management in the Eastern Cape.* The study will be qualitative using a phenomenological approach.

The objectives of the study are:

- Explore and describe the lived experiences of people living with HIV and HPT in the Sakhisizwe Sub-district, Eastern Cape
- Explore and describe the facilitating and inhibitory conditions experienced by people living with HIV and HPT with regard to disease management in the Eastern Cape
- Explore and describe the inhibitory conditions experienced by people living with HIV and HPT with regard to disease management in the Eastern Cape
- To make recommendations on the management of HIV and HPT by RN's in the PHC setting

For the researcher to be able to achieve the objectives of the study there is a need to conduct interviews at the clinics of Sakhisizwe Sub-district which will be 45-60 minutes each. The data will be gathered using semi-structured interviews with a single broad question. The participation to the study will be voluntary and the clients will have the freedom to withdraw anytime in the study and their withdrawal will not affect the care provided to them at the clinics. The participant's confidentiality, anonymity will be assured by not linking their names to the information they will provide including writing their names on the transcriptions.

The proposal will be presented at the Departmental Research committee in the Department of Nursing Science then on approval it will be forwarded to the Faculty Post Graduate Research Committee for Ethical clearance. The study may have research related risks or ethical concerns, but you can contact my supervisor Prof J.R Naidoo for any concerns. The proposal for the study is attached at the back of the letter.

Thanking you

Yours faithfully

Lwandile Tokwe (Mr), RN	Joanne.R. Naidoo (Prof), RN, PhD
Master of Nursing (Research) student	Research supervisor
Email:s213313774@mandela.ac.za	Email:joanne.naidoo@mandela.ac.za
Cell number: 073 333 9231	Telephone: 041 504 1403
____________________________	____________________________
Researcher's signature	Supervisor's signature
____________________________	____________________________
Date	Date

ANNEXURE M: LETTER TO THE SUB-DISTRICT DISTRICT MANAGER

NELSON MANDELA
UNIVERSITY

Po Box 77000, Nelson Mandela University, Port Elizabeth, 6031, South Africa

19 OCTOBER 2018

THE SUB-DISTICT MANAGER
SAKHISIZWE SUB-DISTRICT
CALA
5455

Dear Sir/Madam

RE: PERMISSION TO CONDUCT A RESEARCH STUDY AT SAKHISIZWE SUB-DISTRICT

My name is Lwandile Tokwe; I am a registered Master of Nursing (Research) student at Nelson Mandela University in the Department of Nursing Science in this Academic year of 2018. I would like to request a permission to conduct my research study at the clinics of Sakhisizwe Sub-district. The research study is conducted under the supervision of Professor J.R.Naidoo, an Associate Professor at the Nelson Mandela University in the Department of Nursing Science.

The title of my research study is; *Lived experiences of people living with HIV and hypertension with regard to disease management in the Eastern Cape*. The study will be qualitative using a phenomenological approach.

The objectives of the study are:

- Explore and describe the lived experiences of people living with HIV and HPT in the Sakhisizwe Sub-district, Eastern Cape
- Explore and describe the facilitating and inhibitory conditions experienced by people living with HIV and HPT with regard to disease management in the Sakhisizwe Sub-district, Eastern Cape
- To make recommendations on the management of HIV and HPT by RN's in the PHC setting

For the researcher to be able to achieve the objectives of the study there is a need to conduct interviews at the clinics of Sakhisizwe Sub-district which will be 45-60 minutes each. The data will be gathered using semi-structured interviews with a single broad question. The participation to the study will be voluntary and the clients will have the freedom to withdraw anytime in the study and their withdrawal will not affect the care provided to them at the clinics. The participant's confidentiality, anonymity will be assured by not linking their names to the information they will provide including writing their names on the transcriptions.

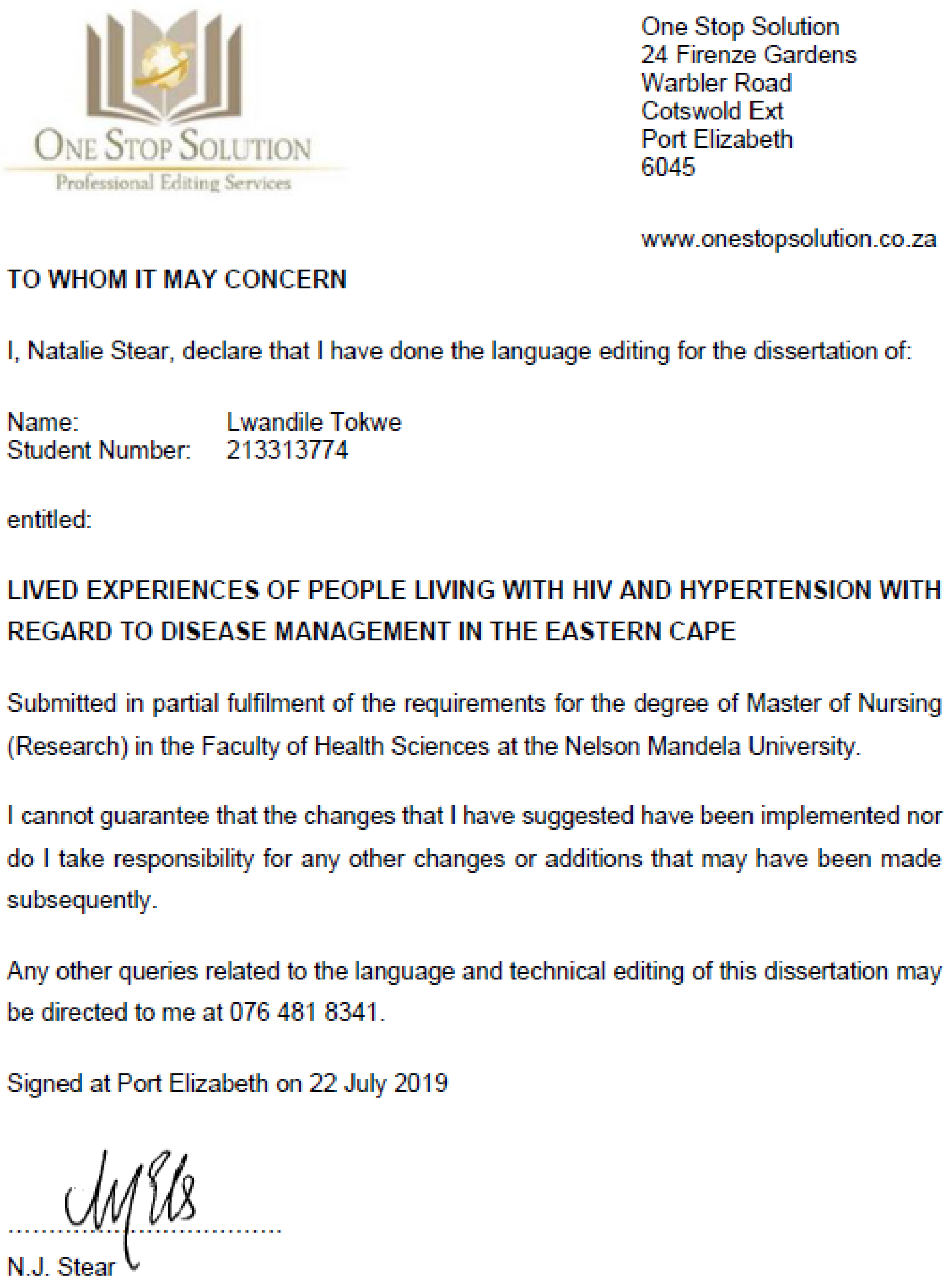
The proposal will be presented at the Departmental Research committee in the Department of Nursing Science then on approval it will be forwarded to the Faculty Post Graduate Research Committee for Ethical clearance. The study may have research related risks or ethical concerns related to the study, but you can contact my supervisor Prof J.R Naidoo for any concerns. The proposal for the study is attached at the back of the letter.

Thanking you

Yours faithfully

Lwandile Tokwe (Mr), RN	Joanne.R. Naidoo (Prof), RN, PhD
Master of Nursing (Research) student	Research supervisor
Email:s213313774@mandela.ac.za	Email:joanne.naidoo@mandela.ac.za
Cell number: 073 333 9231	Telephone: 041 504 1403
______________________________	______________________________
Researcher's signature	Supervisor's signature
______________________________	______________________________
Date	Date

ANNEXURE N: LETTER FROM THE LANGUAGE PRACTIONER



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TO WHOM IT MAY CONCERN

I, Natalie Stear, declare that I have done the language editing for the dissertation of:

Name: Lwandile Tokwe
Student Number: 213313774

entitled:

LIVED EXPERIENCES OF PEOPLE LIVING WITH HIV AND HYPERTENSION WITH REGARD TO DISEASE MANAGEMENT IN THE EASTERN CAPE

Submitted in partial fulfilment of the requirements for the degree of Master of Nursing (Research) in the Faculty of Health Sciences at the Nelson Mandela University.

I cannot guarantee that the changes that I have suggested have been implemented nor do I take responsibility for any other changes or additions that may have been made subsequently.

Any other queries related to the language and technical editing of this dissertation may be directed to me at 076 481 8341.

Signed at Port Elizabeth on 22 July 2019

……………………………………

N.J. Stear