

**THE LIVED EXPERIENCES OF PEOPLE WITH CEREBROVASCULAR
ACCIDENTS IN GA-DIKGALE, LIMPOPO PROVINCE**

By

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Submitted in fulfilment of the requirements

For the degree of

MASTER OF ARTS IN PSYCHOLOGY

At the

UNIVERSITY OF LIMPOPO

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2019

DECLARATION

I declare that **THE LIVED EXPERIENCES OF PEOPLE WITH CEREBROVASCULAR ACCIDENTS IN GA-DIKGALE, LIMPOPO PROVINCE**, hereby submitted to the University of Limpopo for the degree of Master of Arts in Psychology, has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

.....

.....

Surname, Initials

(Title) Date

DEDICATION

This is dedicated to my husband (Makhaya), my son (Ophologile) and my daughter (Ontiretse).

ACKNOWLEDGEMENTS

I would like to express my gratitude to:

- My supervisor, Professor Sodi, and co-supervisor, Professor Govender, for the guidance and the continuous training process during the course of completing the research. The experience was invaluable.
- My husband for the continuous support, encouragement and fruitful discussions,
- My son and daughter for giving me the push to work harder even when the times were tough
- The National Research Foundation (NRF) for their financial contribution towards making this study possible.
- I would also like to extend a hand of gratitude to Dr Rammala for his translation services.

This study is a success because of your patience. Thank you!!

ABSTRACT

The CVA patients normally do not know what to expect and often get confused by the change of behaviour that may result. This is because little is done on informing them of the risk factors, the stigma attached to CVAs, and also some strategies on how to deal with all the experiences CVAs bring along with them. The main aim of this study was to inquire more about the lived experiences of people with cerebrovascular accidents in Ga-Dikgale, Limpopo Province. Ten people living with CVAs' in Ga-Dikgale village, in the Capricorn district, were selected and interviewed. The interviews were audio-taped, and later transcribed and translated. The original data was reduced and interrogated to identify some emerging meaning units which further led to emergence of themes.

Phenomenology and the health belief model were chosen as the relevant lenses with which the study could be viewed. Phenomenology helps understand the individual from his or her point of view while the health belief model describes how a person's belief towards his or her health status can affect their healing process, and these are lens with which to view this study. Snowball and purposive sampling methods were used for sampling participants and data was collected through semi-structured face-to-face interviews.

IPA was used for analysing collected data in this study. Most participants in this study were found to still believe that CVAs are a result of witchcraft, while ignoring the main risk factors such as hypertension, high blood pressure and diabetes, to mention a few. The study also study revealed the daily experiences of living with CVAs. It is not an easy thing for others as they have to endure a lot of pain and also the embarrassment of being unable to control their bodies and emotions.

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LIST OF ABBREVIATIONS AND ACRONYMS

NCD- Noncommunicable Diseases

CVA- Cerebrovascular Accident

HBM- Health Belief Model

TIA-Transient Ischemic Attack

SAH- Subarachnoid Haemorrhage

CT- Computerised Tomography

MRI- Magnetic Resonance Imaging

PTSD- Post-Traumatic Stress Disorder

HRQOL-Health Related Quality of Life

QOL- Quality of Life

ABI- Acquired Brain Injury

IPA- Interpretive Phenomenological Analysis

Dikgale DSS- Dikgale Demographic Surveillance System

TREC- Turfloop Research Ethics Committee

VLIR-IUC- Vlaamse Interunirsitaire Raad/Institutional University Cooperation

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CHAPTER 1: INTRODUCTION

1.1 Introduction

The increasing burden of non-communicable diseases (NCD) has been noted globally (Gouri-Devi, 2014) and in South Africa (Maredza, Bertram, & Tollman, 2015). Among the NCDs, neurological disorders form a significant proportion of global burden of diseases (Gouri-Devi, 2014), with some studies estimating neurological disorders to account for 65% of these morbid conditions (Adeloye, 2014; Council for Medical Schemes, 2015). Although there are a variety of neurological disorders such as epilepsy, Parkinson's disease and tremors, cerebrovascular accidents (CVA) or what is commonly known as 'stroke' is the main focus of the present study. Mbatha (2004), defines CVA as a vascular illness where blood supply to the brain is affected, resulting in possible permanent tissue damage. CVAs can cause dysfunctions in one or more domains of human health such as the physical, psychological, social, functional and financial health (Mbatha, 2004).

According to Rhoda (2014), physical impairments associated with CVA include motor, speech and sensory difficulties, whilst functional impairments include reduced ability or inability to conduct activities of daily living, difficulty in mobility and a struggle to maintain previous life roles. The psychological domain includes the cognitive and emotional challenges experienced by CVA patients, while social support by family and others are included in the social health domain (Rhoda, 2014).

The lived experiences of people with cerebrovascular accidents is the topic of the current study where qualitative research method was used and phenomenology and the health belief model were chosen as the relevant lenses with which the study could be viewed. Mbatha (2004) described phenomenological research as a research approach that is intended to study the meanings of human experience in situations, as they spontaneously form in the course of daily life. The emphasis in this type of research is on the study of lived experience, that is, how an individual for example, reads, enacts, and understands his/her life involvement in his/her everyday experiences (Mbatha, 2004).

Mbatha (2004) added that phenomenological thinking has been identified as one way to assist in bringing forth a better understanding of, and access to psychological phenomena as spontaneously lived and that the emphasis of this type of research is

on an attempt to get to the truth of a particular matter, to describe phenomena in the broadest sense as whatever appears, in the manner in which it appears, that is, as it manifests itself to the consciousness of the experiencer.

According to Tanner-Smith (2010), the Health Belief Model posits that people will take action to undergo health prevention behaviour when they are ready; they see it as beneficial; and the difficulty is not greater than what is to be gained, meaning that readiness is determined by the degree to which one believes an illness is likely. The variables of the HBM deal with the subjective world of the behaving individual and not with the objective world of the physician or the physicist and these interpretive approaches clearly place the knowing in the consciousness of the individual and not the external world (Tanner-Smith, 2010). Tanner-Smith (2010) also added that recognizing and evaluating the perceived reality of another was important in understanding their motivation and that people can only act on what they believe to exist.

1.2 Problem statement

There is evidence to suggest that patients in the acute stage who are treated in CVA units have better outcomes (Rhoda, 2014). This is not always possible in developing countries like South Africa, due to a lack of resources **such as MRI and CT scans, physical rehabilitation machines and counselling services** (Mshana, Hampshire, Panter-Brick, & Walker, 2010). Thus according to Rhoda (2014), in developing countries, CVA patients are often referred for rehabilitation to primary level outpatient facilities that might not always be the most appropriate settings. The outcomes of CVAs, including the quality of life of the individuals, could therefore be non-optimal due to this lack of access to services (Ignatowski et al., 2014).

A number of studies have also indicated that CVAs potentially have a profound negative impact on the patient's sense of self (Gillespie et al., 2014; Glass et al., 2000). According to King, Shade-Zeldow, Carlson, Feldman and Phillip (2002), most of the studies related to post-CVA progression have tended to focus on the actual physical and cognitive-communicative impairments. King et al. (2002) further suggest that studies on the other aspects of this neurological condition, such as the experiences of the patient and their coping strategies are less common. Consequently, patients are left without guidelines on how to manage their disability

going forward. The CVA patients normally do not know what to expect and often get confused by the change of behaviour that may result. This is because little is done on informing them of the risk factors, the stigma attached to CVAs, and also some strategies on how to deal with all the experiences CVAs bring along with them. It is these kinds of gaps in the literature on CVA that have motivated the researcher in the present study to explore the lived experiences of CVA patients in the rural community of Ga-Dikgale in Limpopo Province.

1.3 Purpose of the study

1.3.1 Aim of the study

The aim of the present study is to explore the lived experiences of people with cerebrovascular accidents in Ga-Dikgale, Limpopo province.

1.3.2 Objectives of the study

The objectives of the study are:

- To determine subjective notions of cerebrovascular accident by those living with this neurological condition;
- To investigate the patients' understanding of the causes of cerebrovascular accidents
- To describe the patients' coping strategies to deal with their condition.
- To determine the patients' notions of the optimal treatment and rehabilitation methods that could best help them to ameliorate their morbid conditions.

1.4 Motivation of the study

CVA patients worldwide experience a variety of challenging and life threatening issues. Caregivers and health practitioners need more insight on these issues so that they can come up with ways of tackling them. It was therefore of more relevance for the researcher in this study to try and reveal the problems that the CVA patients have to endure throughout their lives.

1.5 Significance of the study

A study of this nature will shed light on the lived experiences of patients living with cerebrovascular accidents in rural settings. It is also hoped that this study could provide useful insights to health care providers on the challenges and coping strategies associated with CVAs. It could also help policy makers to have a deeper understanding of this neurological condition, thus enabling them to develop and implement informed interventions.

1.6 Operational definition of concepts

Lived experience is defined as the reciprocal relationship between the respondent and the environment as he or she sees it. It can also be referred to as an act of consciousness (Fochtman, 2010). In the context of the present study, lived experience will be understood to mean how the person has been living with the CVA since the attack.

Cerebrovascular accident (CVA) is a focal neurological disorder involving decreased blood flow to and within the brain as a consequence of a pathological process in the blood vessels, thus making it vascular in origin (Greenop & Thomas, 2008). In the context of the present study, cerebrovascular accident will be understood as a neurological disorder that results from a damage or disturbance of blood flow in the brain.

Rehabilitation is the process that stimulates activity-driven reorganisation of the brain after stroke and is aimed at restoring function (Tipping, 2008). This, in the context of this study, will be understood to be a way of trying to restore the person's functioning after the attack.

Transient ischemic attack (TIA) is a short-lived episode (less than 24 hours) of impairment to the brain that is caused by a loss of blood supply (Mbatha, 2004). In the context of the current study, this may be understood as a mini-stroke, as it is sometimes referred to, which is sometimes seen as a warning sign for impending stroke.

1.7 Organisation of the thesis

The thesis is organized in a way that chapter 2 addresses the available literature on CVAs, including a detailed explanation of what it is, its pathophysiology, prevalence and risk factors, its causes, treatment and impacts on the person's quality of life, while on the other hand, chapter 3 gives overviews of phenomenology and the health belief model as the two lenses from which the study is viewed. The research methodology employed by the study is covered in chapter 4, including detailed explanations of the research design, the sampling and the methods of data collection and analysis. The results of the study are presented in chapter 5, while the discussion, limitations, recommendations and overall conclusion follow in chapter 6. Following next is chapter 2, which is the literature review.

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

The purpose of the present chapter is to give a review of some international as well as local studies that has sought to demonstrate the lived experiences of people with cerebrovascular accidents. The literature covers what other researchers found to be the experiences of CVA patients worldwide, in Africa and also in South Africa. It outlines a description of the condition, its causes, pathophysiology, and also the effects it comes along with, to mention a few.

2.2. Cerebrovascular accidents

The National Stroke Association (2013) defines a CVA as a condition that results when one of the arteries to the brain are either blocked or burst, therefore making it impossible for oxygenated blood and other nutrients to reach the brain. As a result, part of the brain does not get the blood it needs, so the neurons start to die. There are two broad categories of CVAS, namely: ischemic stroke and haemorrhagic stroke (Corrigan, Escuro, Arlene & Kirby; 2013).

2.2.1. Ischemic stroke

The ischemic stroke or cerebral infarction is the most common type of stroke which occurs as a result of insufficient or interrupted flow of blood to an area of the brain, typically caused by blockage of an artery (Corrigan et al., 2013). This means that the affected brain cells will stop working and their membrane pumps will start to fail. Importantly, the ischemic brain tissue may still be saved if perfusion can be restored at this point. If the hypo-perfusion worsens, the tissue at risk will become irreversibly damaged with cell death proceeding within 4–8 min. Ischemic strokes are categorized into large-vessel atherothrombosis, atheroembolism, cardio-embolism and small-vessel disease, based on the locus and aetiology of the infarct (Powers & Jordan, 2014).

Large-vessel atherothrombosis refers to the formation of lipid-laden atherosclerotic plaques on the inner wall of a large vessel and can affect both extracranial and intracranial arteries. (Corrigan et al., 2013). Corrigan et al. (2013) also added that

atherosclerotic plaques involving the cerebral vasculatures are associated with the same risk factors as those which form elsewhere in the body, such as high blood pressure, diabetes mellitus, and dyslipidaemia among others. Atheroembolism, on the other hand, occurs when a thrombus forms on the wall of a particular vessel and breaks apart and shed pieces of clot, which are swept downstream and lodge in smaller arterial branches, resulting in multiple smaller strokes within the expected territory of the parent vessel (Corrigan et al., 2013). Powers and Jordan (2014) added that in younger patients, dissections of the cervical carotid or vertebral arteries occurring spontaneously or after neck trauma also provide a site for thrombus formation and subsequent brain embolization.

Corrigan et.al. (2013) explain cardio-embolic ischemic stroke as resulting from blood clots forming within the heart, which then break loose, enter the circulation, and lodge downstream in a cerebral artery. This type of ischemic stroke, in simpler terms, results from emboli from the heart. Finally, the small-vessel disease is described as an occlusive disease involving the microcirculation of the brain, which are the unnamed small arteries and arterioles which take off from the named intracerebral parent vessels (Corrigan et al., 2013).

2.2.2 Haemorrhagic strokes

In this type of stroke, the primary pathology is an area of bleeding causing direct damage to brain tissue, resulting in significantly higher morbidity and mortality than do ischemic strokes (Corrigan et al., 2013). As with ischemic strokes, haemorrhagic strokes are also categorized by the aetiology or area of the infarct. The categories in this case are intracerebral haemorrhage and subarachnoid haemorrhage. According to Powers and Jordan (2014), intracerebral haemorrhage refers to the haemorrhage into the basal ganglia, thalamus, pons, and cerebellum and is most common in middle-aged patients with long-standing hypertension.

Subarachnoid haemorrhage (SAH) is defined as bleeding into the subarachnoid space, between the pia mater (the delicate lining directly adherent to the surface of the brain) and the arachnoid membrane which overlies it. This space is usually occupied only by a small quantity of clear, colourless cerebrospinal fluid, which among other functions cushions the brain from injury and plays a key role in

autoregulation of cerebral blood flow at the arteriolar level. When blood is introduced to this space, it causes marked painful irritation of the meninges and may hinder the normal flow of cerebrospinal fluid (Corrigan et al., 2013).

2.3 Transient ischemic attack (TIA)

As their name suggests, transient ischemic attacks (TIAs) are temporary interruptions in cerebral circulation that give rise to neurologic deficits. (Kaufman & Milstein, 2013). Mbatha (2004) adds that (TIAs) are temporary blockages of blood vessels in the brain that can produce mild stroke symptoms that resolve. She also adds that TIAs often occur before a CVA happens and so may serve as warning signs that the person may need CVA preventive therapy. Although some TIAs develop slowly while others develop rapidly, transient ischemic attacks by definition resolve within 24 hours, thus they are also known as “mini strokes” and only 10% last longer than 4 hours and most resolve in 30–60 minutes. During that first hour of a neurologic deficit, neurologists who witness it cannot predict whether the deficit will completely resolve or become permanent. In other words, if the deficit resolves, it constitutes a TIA, but if the deficit persists, it constitutes a stroke and most of the time neurologists diagnose TIAs only in retrospect (Kaufman & Milstein, 2013)

The majority of TIAs result from platelet emboli that have formed on the surface of atherosclerotic plaques that have built up on the inner wall of the extracranial arteries: the carotid and vertebral arteries and the aortic arch. The plaques are usually ulcerated and cause some degree of stenosis. When platelet emboli leave their surface, they progress through a cerebral artery, temporarily interrupt a portion of the cerebral circulation, and induce a brief period of ischemia. Alternatively, cardiac arrhythmias and other causes of hypotension produce TIAs (Kaufman & Milstein, 2013). Not only do TIAs cause temporary neurologic deficits, they also reflect underlying atherosclerotic cerebrovascular disease and represent a risk factor for stroke. TIAs lead to strokes when either an atherosclerotic plaque grows large enough to occlude an extra-cerebral vessel or it throws off an embolus that permanently blocks a “downstream” cerebral artery (Kaufman & Milstein, 2013).

2.4 Causes and pathophysiology of CVAs

The most common cause of CVA is a blockage of an artery in the brain by a clot (thrombosis). The part of the brain that is supplied with blood and oxygen by the clotted vessel is then deprived of blood and oxygen, and the cells belonging to that part of the brain die as a result. Typically, a clot forms in a small blood vessel within the brain that has been previously narrowed due to the long-term damaging effects of high blood pressure (hypertension) or diabetes. Sometimes due to hardening of the arteries (atherosclerosis), a blood clot can obstruct a larger vessel such as the carotid artery in the neck going to the brain (Mbatha, 2004).

Alternatively, bleeding from an artery may occur spontaneously which produces intracerebral or subarachnoid haemorrhaging. An irreversible brain damage commonly occurs as a result of the nervous tissue of the brain being incapable of surviving more than a few minutes of oxygen deprivation. CVA predominantly has one-sided effects, meaning the effects tend to be localised to either the left or right hemisphere of the brain, and these infarcts in turn cause deficits on the opposite or contralateral side of the body (Greenop & Thomas, 2008).

However, electrological studies using Computerized Tomography (CT) and Magnetic Resonance Imaging (MRI) scans have revealed that lasting alterations of functions of the brain may be distant from the actual lesion. Secondary diffuse effects occur during the acute stages, and are thus considered additional symptoms of widespread brain pathology, although symptoms may improve in the primary stages of the illness. These secondary effects, such as swelling, can result in serious bilateral or diffuse damage. As the swelling decreases so the bilateral or diffuse dysfunction gradually improves along with lateralised impairments. The site, as well as the size of the lesion, is associated with level of improvement in functioning (Greenop & Thomas, 2008).

Every human society, according to Sodi and Bojuwoye (2011), has its own cultural system(s) for responding to diseases and restoring health to individuals who are ill and these various cultural realities people have constructed, whether these be in terms of beliefs, values, languages, institutions, customs, labels and laws, all have significant influence in human functioning, and, therefore, in how health, is defined.

As stipulated by Mshana et al. (2010), causal explanations for CVAs range from the 'natural' to the 'supernatural' and more widely attributed to supernatural factors, such as demons and witchcraft. As a result, sufferers try a range of treatments, with traditional medicine being the first resort and hospital treatment the second option. Mshana et al. (2010) also added that hospitals are avoided due to the belief that injections can be fatal to someone who has just had a CVA, which makes prior visit with a traditional healer necessary.

Mshana et al. (2010) states that due to the characteristic CVAs holds of occurring very suddenly, even in a person with no preceding illness or worrying signs, it creates some sense that the victim has been 'struck' by some malevolent power. Sodi and Bojuwoye (2011) also support the above by explaining mental illness in the indigenous African communities in South Africa. They report that it is perceived that the harmony between the individual and the ancestors is critical in maintaining good mental health and this perceived harmonious situation is considered to exist if the individual and his/her family have met their socio-spiritual obligations to the ancestors. Sodi and Bojuwoye (2011) also added that some mental illness conditions are believed to occur when the harmonious relationship between the ancestors and the living is disturbed, resulting in illnesses caused by disharmony, a traditional healer will then aim at restoring the balance between one's family and the ancestors.

2.5 Consequences of CVAs

According to Gillespie et al. (2014), most patients experience some disturbance of cognitive functioning and many have enduring difficulties in specific cognitive domains, such as attention and concentration; memory; spatial awareness; perception; praxis; and executive functioning, after CVA. They added that although it is possible to have a deficit in one cognitive domain only, usually CVA survivors experience deficits across several domains and that cognitive impairment has a significant impact on activities of daily living (ADL) and self-rated quality of life, and it is among the most difficult losses to manage, with high levels of unmet need.

CVAs may result in paralysis of the arm and leg on either the left or right side of the body, twisting of the face, and in some cases other effects which may include loss of balance, disturbance of vision, disturbance of speech, loss of control of the bladder

and bowels, and difficulty in swallowing. In very severe cases, there is a loss of consciousness or confusion of thought and sometime loss of life results (Visser et al., 2015).

Patients with CVAs may well experience a range of impairments that could impact on physical and psychological functioning, lessen the person's ability to participate in work and leisure activities, as well as decreasing their quality of life (Ignatowski et al., 2014). Post-stroke depression, which is multifactorial in origin and commonly associated with excess disability and cognitive impairment may also result. These emotional disturbances may be a direct consequence of the infarct, or depression (post-stroke) may be associated with coping with the challenges of this condition. Patients tend to experience a different relationship with their bodies, their families and society (Greenop & Thomas, 2008).

2.6 The impact of CVAs on the quality of life

According to Rhoda (2014), the majority of individuals who have suffered a CVA report a decline in health-related quality of life following a stroke. He describes health-related quality of life as a broad multidimensional construct that includes physical, functional, psychological and social health. Depression and functional status have been repeatedly found to be factors that predict quality of life in stroke survivors and several factors relating to the stroke such as the severity, cause and side of the lesion in the brain also have an impact on the individual's quality of life (Rhoda, 2014). Mbatha (2004) supports this assertion by stating that impaired cognition such as memory and reasoning deficits have been associated with depression, anxiety, and social isolation among stroke survivors.

Rhoda (2014) further added that personal factors such as the ability of the individual to communicate effectively with others could also impact on their quality of life. Other factors such as the use of mobility assistive devices, adaptations made to the physical home environment and input provided by organizations that support individuals and families could also have an impact on the quality of life of the patients (Rhoda, 2014). Bhatti, Salek and Finlay (2011) state that the continuous long-term impact of chronic disease on patients' lives may influence their decisions about higher education and early career development or having children and patients might

either decide differently or might delay their decision. CVAs can have all sorts of different effects. Many are physical - that can be seen and recognised easily - but there can also be hidden effects, like emotional changes. Although feelings or thoughts cannot be seen, changing emotions often lead to a change in behaviour, which may signify that all is not well (Stroke Association, 2012). These changes are discussed in detail below.

2.6.1 Emotional problems associated with CVAs

Common emotional problems were found by Kneebone and Lincoln (2012) to include depression, emotional lability, catastrophic reaction, anger, aggression, frustration and apathy, and post-traumatic stress disorder (PTSD), to name a few. According to Stroke Association (2012), approximately one third of stroke survivors reported experiencing some emotional problems after their stroke. Some of the emotional changes that arise may be more persistent than others and the person may need coping mechanisms to help deal with them and some usually fade away with time (Stroke Association, 2012).

Depression occurs in approximately 30% of people post stroke and is distressing for the individual. It is associated with longer hospitalisation, institutionalisation, poorer functional outcome, and mortality (Stroke Association, 2012). Morrison, Pollard, Johnson and MacWalter (2005) stated that depression three years after stroke is predicted by earlier levels of handicap, anxiety, exercise, and satisfaction, but not by any clinical variables. They also added that exercising at one month is predictive of lower depression at three years after stroke.

Emotional lability (emotionalism or pathological laughing/crying) refers to inappropriate or uncontrollable crying or laughing. Such reactions occur in 20% - 30% of stroke survivors (Kneebone & Lincoln, 2011). Patients with this emotional problem would laugh or cry for no apparent reason as they are unable to control their emotions or they just become too emotional. Stroke Association (2012) postulated that emotional lability can arise with many conditions that affect the brain and nervous system and often happens after a CVA. People having emotional lability may have intense emotional reactions when talking to people, watching television, carrying out tasks, or even thinking. Although these emotions may reflect how he or

she is feeling, the person will probably express them in a strong way, have outbursts of crying for little or no reason, laugh at inappropriate times and may sometimes swing from crying to laughing quite suddenly (Stroke Association, 2012).

A catastrophic reaction is an intense emotional reaction to the inability to perform tasks after neurological damage and occurs in up to 20% of stroke survivors (Kneebone & Lincoln, 2011). This reaction is said by the Stroke Association (2012) to occur when an individual becomes overloaded. It may be in the form of a verbal outburst, a physical outburst, throwing an item, or simply shutting down emotionally. Catastrophic reactions may be caused by inability to think of a word, problems remembering a task, a problem with a relationship, difficulty with finances, or a reminder of the person's condition (Stroke Association, 2012).

A state in which patients demonstrate a lack of emotion, interest or concern is referred to, by Kneebone & Lincoln (2011) as apathy. This problem manifests in around 27% of people and has been noted as a feature of depression after a CVA (Kneebone & Lincoln, 2011). The American Stroke Association (2006) describes apathy as a lack of motivation or enthusiasm. They argue that someone with apathy may appear listless, passive, lacking spontaneity and motivation, and may not show the variety of expression that they usually display. The American Stroke Association (2006) went on to add that the patients with apathy are often indifferent to everyday occurrences and unmoved by emotional events that would normally arouse strong feelings and, often, there is a loss of interest in things going on around them, such as socialising or previous hobbies.

Ponchel et al. (2015) refers to PTSD as a disease state characterized by a chronic, persistent, excessive lack of energy with an impact on activities of daily living. Besides being frequent, PTSD was judged by between 23% and 59.5% of CVA patients to be one of their worst symptoms. Although fatigue is thought to be less severe and less specific after a CVA than in multiple sclerosis, it seems to have similar functional impacts on psychological functioning and professional, social, and familial activities (Ponchel et al., 2015). Post-traumatic stress disorder (PTSD) reactions appear in between 10% and 30% of patients. Up to 60% of those with a CVA can develop a fear of falling and this has been associated with poorer physical function and a history of falls (Kneebone & Lincoln, 2011).

Furthermore, PTSD has a negative impact on subjective feelings of recovery during rehabilitation and is a major cause of handicap because levels of awareness of this condition among relatives, work colleagues, and even medical staff are low. Fatigue may also lead to misunderstanding of the patient's behaviour by his/her family or friends; excessive demands may exceed the patient's abilities, maintain anxiety or depression, and lead to withdrawal from certain activities and social life (Ponchel et al., 2015).

Anger after stroke ranges from irritability to verbal and physical aggression, and occurs in 17% - 35% in the acute phase post stroke (Kneebone & Lincoln, 2011). It is both a physical and psychological response and usually occurs when one feels intense displeasure, offence or frustration. After a CVA, a person experiences anger more frequently, have less control over his or her outbursts and/or get angry over things that would not normally cause him or her to feel that way, and most often, the anger is directed at family and carers (Stroke Association, 2012).

2.6.2 Behavioural problems

Behavioural problems are described as difficulties that encompass a wide range of behaviours that may be harmful to people or property. The behaviours may be difficult to manage and may limit social access (Kneebone & Lincoln, 2011). Examples of behavioural problems include severe sexual disinhibition, shouting, screaming, and unrealistic demands for attention.

2.6.3 Cognitive Impairments after a CVA

Kneebone and Lincoln (2011) found cognitive impairments as affecting about 80% of CVA patients. They state that these impairments are more common in the acute phase but many problems persist over time and that they are important because they are associated with rehabilitation outcome. They further state that impairments occur in cognitive domains, including attention, memory, language, visuospatial abilities, executive functions and praxis. In addition, there may be loss of awareness of deficits (anosognosia) and some patients have a dementia after a CVA, usually vascular, which produces a progressive decline in cognitive abilities over time (Kneebone & Lincoln, 2011)

2.6.4 Personality changes

The Stroke Association (2012) describes personality as a combination of behaviours, thought patterns and feelings. They state that CVAs can cause changes to a person's personality so that to others, he or she may seem like a different person altogether. Sometimes the person's character traits may be reversed, for example, if he or she was previously mild-mannered, he or she may now be more aggressive, or, if he or she has always been loud and outspoken, he or she may now be more passive. More often, however, existing personality traits are exaggerated. Although family and friends might be more aware of how the person is different, the affected person might be unaware that his or her personality is different and deny that they have changed (Stroke Association, 2012).

2.7 Lived experiences of CVA patients

2.7.1 International studies

Fraas (2011) postulates that most survivors have unmet expectations following the first year of recovery, and these needs often persist for years afterward and as a result, many survivors find that the struggle to integrate back into their communities is insurmountable. The survivors are no longer able to return to their previous occupations, they have difficulties developing and maintaining relationships, and, as a result, most experience depression (Fraas, 2011). They are also reported by Fraas (2011); Sharma, Bulley and van Wijck (2012) and Simeone, Savini, Cohen, Alvaro and Vellone (2014) to experience a high dependence on others, loss of emotional and physical control, and struggle to manage relationships and activities of daily living.

Simeone et al. (2014) reported that patients experienced a deep change in their lives, had a vivid memory of the acute phase of the stroke, felt that their lives had been slowed down, felt relieved for the recovery but also felt they were a burden for their family members; while Sharma et al. (2012) reported the impacts as including reduced independence, low mood, sensorimotor impairment and decreased fitness. Reduced physical fitness is common following stroke, presenting a risk for recurrent stroke, cardiac disease and fall-related fractures, and a barrier to community re-integration (Sharma et al., 2012).

2.7.2 African studies

In a study conducted by Mshana (2008) in Tanzania, it was found that many people abandon biomedical treatment because they do not see themselves being 'cured'. Sometimes the test results are miscommunicated and therefore patients were phrased as 'normal' or 'no problem with the tests', which makes them to think that doctors dismiss their condition as trivial or non-existent. Since this is in conflict with their experiences of serious functional losses, the patients feel demoralized and abandon hospital treatment (Mshana, 2008). Ojagbemi and Owolabi (2013) reported post-CVA disability and depression as other reasons why survivors in the cultural setting of Nigeria report more functional dependency. This is due to a large proportion of patients presenting initially to traditional or faith healers because of sociocultural beliefs about CVA.

Some hospital surveys in sub-Saharan Africa have shown that CT scans are only conducted on less than half of patients presenting with stroke, and this is mainly among those that can afford it. In fact, experts have reported that the unavailability and/or high costs of cranial CT imaging in many parts of Africa have limited information on the pathologic profiles of different stroke types in the continent, with this often affecting the diagnosis, treatment and the overall management of the disease (Adeloye, 2014).

2.7.3 South African studies

Bryer, Connor, and Haug et al., (2010) indicated that most of the population of South Africa is undergoing a rapid epidemiological transition with increased exposure to, and development of, stroke risk factors, which will inevitably result in an increase in the burden of stroke with ageing. Adeloye (2014) argues that the prevalence of stroke in Africa might increase due to substantial changes in major stroke risk factors in the presence of a biased focus on the prevention and control of infectious diseases (such as HIV/AIDS, malaria and tuberculosis), at the expense of many NCDs. In multi-ethnic South Africa, CVA is the major cause of death among white people and South Africans of Indian descent, with incidence rates of 165.3 and 101.2 per 100,000 people, respectively, but only 55.1 per 100,000 among people of mixed descent and 5.3 per 100,000 among black African people (Mbewu & Mbanya, 2006).

Mbatha (2004) in her study conducted in South Africa found the CVA survivor to experience emotional disorders and language disturbances, which result in a lot of frustration for both the patient and the family. It is therefore clear that a stroke affects the ability of individuals to continue doing the activities they had previously been doing, which also highlights the role changes that often occur because of a stroke (Rhoda 2014). Tipping (2008) reported that specific impairments are common in CVA survivors and they contribute to both morbidity and mortality. Extreme cases of loss of hope were expressed as wanting to die, by some survivors, while some felt that they were now going to be a burden to their spouses, children or family and some felt that they are not going to ever recover from the CVA to their usual level of activity (Maleka, Stewart & Hale, 2012).

2.8 Treatment and rehabilitation OF CVAS

In some qualified patients, the use of a clot-busting drug may be used to dissolve the clot and restore blood flow. For many patients, the time span to diagnose and treat such a clot is usually 3 hours (some clinicians suggest a bit longer time). Often, patients do not qualify for this treatment. There are also some risks like bleeding associated with this treatment that may cause problems (Mbatha, 2004).

Rehabilitation begins as soon as the diagnosis of CVA is established. The specific molecular and cellular changes that occur in the brain soon after CVAs suggest that the brain is more amenable to activity-driven reorganisation (Tipping, 2008). Early organised multidisciplinary CVA care in the setting of a dedicated CVA unit allows 5 more patients to achieve independence at home, prevents 4 further deaths and 2 fewer patients requiring institutionalisation per 100 CVA patients managed. In CVA survivors, specific impairments are common, and they contribute to both morbidity and mortality. Early identification is important in minimising the effects of these impairments and also facilitates the implementation of management aimed at maximising rehabilitation and preventing complications (Tipping, 2008).

Different therapies are offered in CVA rehabilitation such as speech therapy, physical therapy, occupational therapy and talk therapy. Speech therapy is used in cases where the CVA has damaged a person's ability to use language and to speak or swallow. This type of rehabilitation, usually performed by speech therapists, can

help a person regain some or most of the abilities they lost initially with the CVA. Rehabilitation can provide methods and skills that can help a person to adapt and compensate for severe damage. On the other hand, physical therapy is designed to improve a person's strength, gross coordination, and balance. This rehabilitation helps people to regain their ability to walk and do other things like using stairs or getting out of a chair after the CVA (Mbatha, 2004).

Patients may develop problems coping with their new disabilities after a CVA. These patients can be helped by a psychologist or other mental health professional to adjust to their new challenges and situations. The adjustment may be done through talk therapy and other methods to help people with reactions such as depression, fear, worries, grief, and anger (Montemagni et al., 2014).

2.9 Coping with CVAs

Coping has been defined as one's cognitive and behavioural effort to manage the internal and external demands of a person's environment transaction that is considered taxing or exceeding one's resources (Pu et al., 2012). It also describes the manner by which people deal with stressful events. It is a complex, multidimensional process determined by environmental conditions, cognitive abilities, and personality dispositions (Bautista, Rundle-Gonzalez, Awad, & Erwin, 2013). Hori et al. (2010) refer to psychological coping as the thoughts and behaviours used to manage the internal and external demands of situations that are appraised as stressful. Coping with stressful situations and adverse life events is both an important personality resource and a measure of one's adaptability (Pu et al., 2012). Pu et al. (2012) further argues that coping style as a mediational factor suggests that cognitive dysfunction leads to depression partially due to its effect on coping style, that is, cognitive deficits may impair individuals' ability to use adaptive coping strategies, leaving them more likely to use maladaptive strategies.

The transactional theory of stress categorized various coping strategies into three main styles: Task-oriented, Emotion oriented, and Avoidance-oriented (Bautista et al., 2013; Montemagni et al., 2014; Pu et al., 2012). Problem-oriented coping is used to actively solve an underlying problem, cognitively conceptualize it, and potentially minimize its adverse effects. Examples of problem-focused coping

strategies include active planning, positive reframing, and information seeking. Emotion-oriented coping strategies are person-oriented and attempt to distance the individual from the source of stress by employing techniques such as denial, avoidance, and wishful thinking, and include emotional responses, e.g., self-preoccupation, self-blame, and fantasizing reactions. Avoidance-oriented coping involves both task and person orientation: one may avoid a stressful situation either by using social diversion, i.e., choosing to be with other people and seeking emotional support, or via self-distraction from stressful situation, e.g., “giving up”, denial, or engaging in a substitute task (Bautista et al., 2013; Montemagni et al., 2014; Pu et al., 2012).

According to Pu et al. (2012), coping style may be associated with a variety of clinical, personal, and biological factors including cognitive function and personality traits. Pu et al. (2012) also states that there is a significant relationship between coping strategies and both severity of symptoms and emotional distress and that less-adaptive coping strategies (i.e., Emotion-oriented coping) were associated with less-adaptive personality traits (i.e., Neuroticism) and with psychological distress (i.e., Depression), whereas the reverse was found regarding adaptive coping strategies (i.e., Task-orientated coping). Bautista et al. (2013) supports this by adding that the main coping reactions employed by patients with epilepsy as a group to be the use of acceptance, religion, and emotional support, while the coping reactions least utilized were substance abuse, denial, and humour.

According to Visser et al. (2015), living with the consequences of CVAs can enormously impact daily life, resulting in diminished health-related quality of life (HRQOL) in most patients. They also reported that problem-oriented coping strategies are positively associated with HRQOL after CVAs. However, patients with CVAs may use fewer active, problem-oriented coping strategies. Depression after CVA has an estimated prevalence of 33% and is also related to other factors such as age, functional limitations, CVA severity, family support, and socioeconomic status. Visser et al. (2015) added that however coping strategies may change during rehabilitation; coping strategies and depression were independently associated with psychological health in patients in the chronic phase after CVA.

2.10 Summary

Visser et al. (2015) explains that living with the consequences of CVAs can enormously impact daily life, resulting in diminished health-related quality of life (HRQOL) in most patients. In order to understand the lived experiences of people with CVAs, it is important to understand the patient's experiences from their own point of view and their belief towards their health. Phenomenology helps understand the individual from his or her point of view while the health belief model describes how a person's belief towards his or her health status can affect their healing process, and these are lens with which to view this study. The next chapter will explore phenomenology and the health belief model and how they can be applied to stroke survivors.

CHAPTER 3: THEORETICAL FRAMEWORK

3.1 Introduction

As introduced earlier on in the first chapter, two theories have been adopted as lenses through which the current study will be viewed. These are phenomenology, which was founded by Husserl in the early 1900 and the health belief model which was developed by Irwin Rosenstock, Godfrey Hochbaum and Stephen Kegels in the 1950s.

3.2 Theories adopted

3.2.1 Phenomenology

In the present study, the researcher adopted phenomenology as a framework through which the lived experiences of people afflicted with the condition of CVA's can be understood and explained. According to Groenewald (2004), phenomenologists are concerned with understanding social and psychological phenomena from the perspectives of people involved. A researcher applying phenomenology is concerned with the lived experiences of the people involved, or who were involved, with the issue that is being researched (Groenewald, 2004). Husserl (1859 – 1938) who is often regarded as the founder of phenomenology rejected the belief that objects in the external world exist independently and that the information about objects is reliable (Groenewald, 2004). He argued that people can be certain about how things appear in, or present themselves to, their consciousness. He elaborated that in order for one to arrive at certainty, anything outside immediate experience must be ignored, and in this way the external world is reduced to the contents of personal consciousness. Husserl further stated that realities are to be treated as pure 'phenomena' and the only absolute data from where to begin. Husserl named his philosophical method 'phenomenology', which is the science of pure 'phenomena' (Groenewald, 2004). Phenomenology was founded in the early 1900s and the word was derived from the Greek for "to bring to light" (Pringle, Hendry & McLafferty; 2011).

Franz Brentano (1838 – 1917), whom Husserl was a student of, provided the basis for phenomenology. Brentano first stressed the 'intentional nature of consciousness'

or the 'internal experience of being conscious of something'. The aim of phenomenology is the return to the concrete, captured by the slogan 'Back to the things themselves'. A student of Husserl, Martin Heidegger (1889 – 1976), introduced the concept of 'Dasein' or 'Being there' and the dialogue between a person and her world. Heidegger and Husserl respectively explored the 'lived-world' and 'Lebenswelt' in terms of an average existence in an ordinary world. A follower, Alfred Schultz (1899 – 1956), furthered the idea that "the human world comprises various provinces of meaning". The existential phenomenology of Heidegger was carried forward by among others Jean-Paul Sartre (1905 – 1980) and Maurice Merleau-Ponty (1908 – 1961). The works of Sartre and Merleau-Ponty extensively expanded the influence of Husserl and Heidegger (Groenewald, 2004).

According to Gavin (2008), human consciousness is separated into two elements which are the act of consciousness and the phenomena we encounter via discovery of the world. Hayes (2000), states that phenomenological research comes from the phenomenological tradition, which argues that meaning occurs through subjective experiences or phenomena. He added that in order to understand human experience we need to explore the personal experience that each individual experiences.

However, by 1970, phenomenology had not yet established itself as a practical alternative to the traditional natural scientific approach in psychological research". The reason was that a phenomenological praxis, a systematic and sustained way, had not yet been developed. Phenomenology was then forgotten for a while after flourishing during the first twenty years after the Second World War this approach was forgotten for a while. However, in the 1970s, phenomenological psychologists established a praxis, which is a methodological realisation of the phenomenological philosophical attitude. The aim of the researcher is to describe as accurately as possible the phenomenon, refraining from any pre-given framework, but remaining true to the facts. Since the present study aims to understand and describe the lived experiences of people living with CVA, the researcher considered phenomenology to be the most appropriate conceptual lens to use.

3.2.1.1 Phenomenology and CVAs

Patients who suffered a disabling stroke described a transformative process resulting in a “disrupted immediacy” between their bodies and their sense of self. In comparison, for most of us who are relatively healthy, our phenomenological perception (or the consciousness of our being in a moment of time) is the unity of the lived body and its opposition to the world – the idea of the embodied self. In the emergent relation of a patient with a stroke and a newly hemi-paretic limb the self and body are related in the way in which the lived body and world were related at the level of primary immediacy. For many of these patients, phenomenologically, the body and self are experienced as acting upon one another. Contemporary phenomenologists observed that significant impairments in body structure and function due to chronic illness such as stroke have a profound effect on patients’ moral understanding of their identity and their expected social roles in society (Greenfield, 2011).

Phenomenological investigation through recorded narrative can help elucidate the issues that are useful to survivors and their families. This approach can provide the reader with a preview into the physical, psychological, social, and economic impact of stroke and how it affects the individual, the family, and the community. The narratives that emerge from phenomenological investigation allow us to conceptualize our lives and identities (Pinker, 2007).

According to Fraas (2011), the stories that emerge from phenomenological research can be used as effective tools to influence treatment decisions, provide motivation and support to survivors and their families, and educate colleagues and the public. Therefore, it seems obligatory to continue Kaufman’s appeal for phenomenological inquiry as a means to further illuminate the perceptions of the medical experience of our patients and their families and, in turn, allow us to better meet their expectations and increase their quality of life (QOL) (Fraas, 2011). He also asserted that the phenomenological approach is an influential tool that can enhance the extent to which medicine’s power both responds to and affects the individual sufferer, and its methods can guide clinicians in their development of more effective, holistic treatments. They can allow clinicians to assist survivors in developing positive, active coping styles that can motivate survivors and inspire and instil hope, finally,

phenomenology can help establish congruent expectations between survivors and their families and clinicians. All of which can improve the medical experience for survivors of stroke and enhance their QOL (Fraas, 2011). A study by Fraas and Calvert (2009) where the narratives of 31 survivors of acquired brain injury (ABI) from trauma and stroke using a phenomenological approach was examined, several major themes that contributed to the perception of successful recovery, productive lifestyle, and an overall positive QOL were identified.

According to Greenfield (2011), we should locate our certainty about patients' experiences of illness within the context of their concrete experiences, we should open up avenues of dialogue, allowing our patients to tell their stories about their experiences, in their own words, from their own perspectives, and without inserting our own biases, values, and points of view to construct meaning for them. He states that although this takes discipline and time, it is only through the unfolding of stories that patients' phenomenological meanings can be understood in the context in which caring and, it is hoped, healing can take place.

A phenomenological approach may result in a deeper understanding of a patient's world and how it has been transformed by living with disability, which in turn could facilitate the development of a mutual plan of action that is embedded in the values and goals of the patient and his or her family members. Most important, the tools of a phenomenological approach are particularly sensitive to the transformative nature of disability (Greenfield, 2011).

Banja (2011) sees the essential task of rehabilitation as becoming one of assisting the stroke survivor to reconstitute his or her self and the experiences that necessarily belong to it: to assist the individual to gain as much functional return as possible; manage his or her limitations skilfully; and integrate this new post-stroke identity in an adaptive and healthy way as it involves the patient learning a profoundly and often disconcertingly new brace of body-world interactions and relationships, rehabilitation is the phenomenological reconstitution of the post-disability self

3.2.1.2 Critique of the theory

As a research method, phenomenology is not without problems, with variations and arguments surrounding its use being well-documented. Some suggested that the

term 'method' is applied incorrectly, arguing that the approach used 'is as much dependent on the way in which the researcher's mind deals with the data, as in the way in which the data were collected' (Pringle, Hendry & McLafferty; 2011). Giorgi's criticism of Crotty, according to Pringle, Hendry and McLafferty (2011), gives the reader a sense of the differences of opinion that surround the subject of phenomenology and suggested that confusions can exist because researchers fail to clarify the type of approach they are using. Similarly, other guidelines appear to offer researchers conflicting advice, as it is suggested that phenomenology is incompatible with the validation of interpretation by participants (Pringle, Hendry and McLafferty; 2011).

Pringle, Drummond, McLafferty and Hendry (2011) stated that in further relation to bracketing, other authors also considered the difficulties of disregarding prior knowledge and understanding, while Pringle, Hendry and McLafferty (2011) discussed it as the real world being 'cut off' and referred to this as the first stage in 'phenomenological reduction'. Rather than just subjective or objective views, there is a third alternative: 'the lived view', while the next stage was described as being to reach the 'essence' – something common to a whole group of phenomena – while not being detached from the original experience and the third step said to involve investigating how these essences are constructed and linked, how these issues are dealt with in practice is rarely made explicit in studies (Pringle, Hendry and McLafferty; 2011).

3.2.2 The Health Belief Model

The Health Belief Model (HBM) is also used as another lens through which the experiences of the CVA survivors can be understood. It is a conceptual framework used to understand health behaviour and possible reasons for non-compliance with recommended health action. It can provide guidelines for program development allowing planners to understand and address reasons for non-compliance (Turner, Hunt, DiBrezza & Jones; 2004). The HBM was developed in the 1950s by Irwin Rosenstock, Godfrey Hochbaum and Stephen Kegels as a way to explain why medical screening programmes offered by the United States Public Health Service, particularly for tuberculosis, were not very successful (Turner, Hunt, DiBrezza & Jones; 2004). The underlying concept of the original HBM is that health behaviour is

determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence. According to Turner *et al.* (2004) the HBM consists of four interrelating variables: perceived susceptibility; perceived seriousness; perceived benefits of taking action and barriers of taking action (Turner *et al.*, 2004).

Perceived susceptibility refers to the belief that one is at risk of an illness is subjective and is one of the more powerful perceptions in encouraging people to adopt healthier behaviours. On one extreme, it is an individual who is in full denial of any risk, while on the other is an individual who feels danger is certain. The one in the middle admits that there is possibilities of contracting an illness, but does not fully believe they will contract it. The greater the perceived risk, the greater the likelihood of engaging in behaviours to decrease it (de Wit, 2005).

Perceived seriousness is the beliefs of an illness causing pain, debilitation, social stigma or death are examples of seriousness perceived. While the perception of seriousness is often based on medical information or knowledge, it may also come from beliefs a person has about the seriousness or severity of a disease and the difficulties a disease would create or the effects it would have on his or her life in general (de Wit, 2005). A perceived benefit is a person's opinion of the value of a new behaviour in decreasing the risk of developing a disease. Deciding on a course of action is shaped by the options accessible to the individual and the belief in their effectiveness. This construct plays an important role in the adoption of secondary prevention behaviours, such as quitting smoking, eating healthy fruit and vegetables, and screening for diseases (de Wit, 2005).

Despite a belief being established that a particular course of action may reduce a health threat, indecision may still take place. If readiness is low and negative aspects of the course of action are viewed as high, barriers are constructed preventing action. Barriers of taking action are the most significant of all the constructs in determining change of behaviour. For a new behaviour to be adopted, a person needs to believe the benefits of the new behaviour outweigh the consequences of continuing the old behaviour (Akey, Rintamati & Kane; 2013). More recently, other constructs have been added to the HBM. Thus the model has been expanded to include (Turner *et al.*, 2004):

Cues to action are stimulus that can trigger appropriate health behaviour, such as people, events, or any other things that can modify a person's behaviour. These may be internal such as physical discomfort, or external such as illness of a family member, media reports, mass media campaigns, advice from others or even health warning labels on a product conveying the seriousness of a disease (de Wit, 2005). Modifying variables are an individual's personal factors that affect whether the new behaviour is adopted. The four major constructs are modified by other variables, such as culture, education level, past experiences, skills, and motivation (Turner et al, 2004). A person living with CVA, for example, will be more cautious with taking his or her high blood pressure medication (if the CVA resulted from high blood pressure) to prevent the same experience again.

Self-efficacy is the belief in one's own ability to do something. People generally do not try to do something new unless they think they can do it (Turner et al., 2004). Turner et al. (2004) also added that if someone believes a new behaviour is useful (perceived benefit), but does not think he or she is capable of doing it (perceived barrier), chances are that it will not be tried. If a CVA patient does not believe that they can learn how to walk again after the attack, probabilities are that they will not go for physical rehabilitation.

3.2.2.1 Critique of the theory

Tanner-Smith (2010) concluded weak support for the HBM's ability to explain and predict perceptions of risk. That is, perceived susceptibility and perceived severity. Perceived susceptibility and severity may be high, but if one is struggling with issues such as poverty, additional stressors may supersede actions to assure health. In other words, if someone is striving to feed the kids, one's concern to seek medical screening may be secondary. The HBM also does not consider repeat behaviour (de Wit, 2005). Tanner-Smith (2010) posits there is a perspective change between those undergoing a pap screening or mammogram for the first time and those who have made these visits routine. Perceived risks may influence the first visit but become less so thereafter (Tanner-Smith, 2010). Issues with perceived severity, as discussed by de Wit (2005), an illness such as cancer has a global perception of being very serious and this would account for little variance when measuring the

perception of severity of those who comply with preventive health care and those who do not.

3.3 Summary

According to Tanner-Smith (2010), a quality of the phenomenological tradition can be discussed when using an example of how what we observe on the surface may not be what is going on internally of another. Our own perceptions get in the way of what lies beneath and this is the tradition of phenomenology that addresses the experience of otherness. Through their leanings toward this concept, the originators of the HBM were drawn toward the ideas of similar thinkers. Behaviour may thus be regarded as a function of a person's motive and of his beliefs about various opportunities for action and these beliefs are important in determining the goals people set. An individual's view on what is important and how they place themselves in context of a situation determines their success or failure of obtaining a goal (de Wit, 2005). Phenomenology forms a good background for this study as more information is needed regarding the lived experiences of CVA patients from their own point of view, and the HBM backs the study up in that the patients' beliefs towards their health status and the medications they use affect their healing process. This shows an interrelation between the two theories that will help in yielding better results from the current study with the use of specific research methods, which are discussed in the chapter that follow, chapter 4.

CHAPTER 4: RESEARCH METHODOLOGY

4.1 Introduction

In this chapter I provide a detailed plan of how the research study was carried out. I start by expanding the types of research which were chosen to be the ones that direct the study which are the qualitative and the phenomenological approach. These two go together as they are similar in their aim and methods of collecting data, thus they were used together in this study. This plan entails the methods used for sampling participants, description of the population from which the sample was derived and the sample itself and also the method used for data collection. I also explain the IPA, which is the method that was used for analysis collected data in this study. Also included in this chapter are the quality criteria for ensuring the quality of the data and also the ethics that were considered throughout the study.

4.2 Qualitative approach

This research is qualitative in nature and seeks to capture in-depth information on the psychological aspect being researched. According to Babbie (2007), qualitative studies are aimed at answering the question of why things are the way they are and how they came to be like that. Tewksbury (2009) explains that because of the differences in the data, how data is collected and analysed, and what the data and analyses are able to tell us about our subjects of study; the knowledge gained through qualitative investigations is more informative, richer and offers enhanced understandings compared to that which can be obtained via quantitative research. Tewksbury (2009) further states that the superiority of qualitative research arises from the core differences in what qualitative and quantitative research are, and what they are able to contribute to bodies of knowledge.

At the core, qualitative research focuses on the meanings, traits and defining characteristics of events, people, interactions, settings/cultures and experience. As one leading proponent of qualitative methods has explained, Quality refers to the what, how, when, and where of a thing– its essence and ambience. Qualitative research thus refers to the meanings, concepts, definitions, characteristics, metaphors, symbols, and descriptions of things (Tewksbury, 2009)

4.3 Research design

The exploratory phenomenological design was used in this study. Exploratory Phenomenology involves trying to understand the essence of a phenomenon by examining the views of people who have experienced it. It is a project of sober reflection on the lived experience of human existence. It is sober in the sense that reflecting on experience must be thoughtful, and as much as possible, free from theoretical, prejudicial and suppositional intoxications. Phenomenology is also a project that is driven by fascination, being swept up in a spell of wonder, a fascination with meaning (van Manen, 2007). The reward phenomenology offers are the moments of seeing-meaning or "in-seeing" into "the heart of things" as van Manen (2007) put it.

According to van Manen (2007), the phenomenologist directs the gaze toward the regions where meaning originates, wells up, percolates through the porous membranes of past sedimentations and then infuses us, permeates us, infects us, touches us, stirs us, exercises a formative affect. In fact, according to the phenomenological approach that guided this study, the meanings that patients attribute to their experiences help create the needs they have and how these needs can best be met. Furthermore, the recovery from a stroke is rooted in patients' lived experience, including patients' perceptions and expectations, which have a deep phenomenological connection (Simeone et al., 2014)

4.4 Location of the study

The Dikgale DSS site is located in the Central Region, Mankweng District, Limpopo Province of South Africa approximately 40km from Polokwane, the capital city of Limpopo Province (Figure 1) and 15 km from the University of Limpopo. It is situated between 23.46⁰-23.48⁰ south latitude and 29.42⁰-29.47⁰ east longitude, and lies on an average altitude of 1400m above mean sea level. Each village has a central residential area comprising demarcated housing stands with communal grazing land some distance away (Mkhonto, Labadarios & Mabaso; 2012).

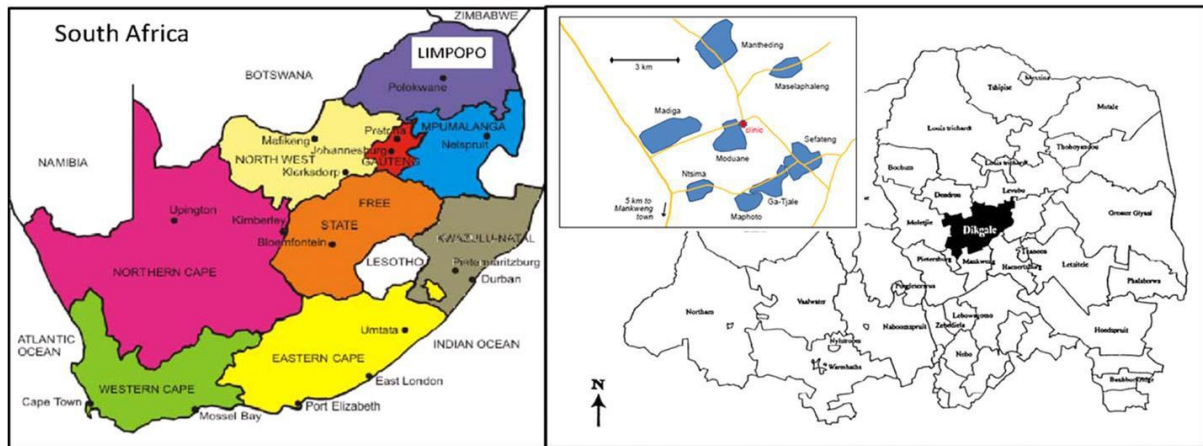


Figure 1: Maps of South Africa and Limpopo showing Dikgale village (shaded in black). The insert is the Dikgale Demographic Surveillance System site (shaded in blue). Image extracted from Mkhonto et al. (2012).

4.5 Population

Ga-Dikgale Village covers an area of 1.63 km² with a population of 430000 (263.15 per km²) and 146000 (89.35 km²) households. The females in this area constitute 54.19% and the males 46.05% of the total population with 100% of them being black Africans (Census, 2011). 98.37% of the people in this area are Sepedi speaking, with 0.47% for English and isiZulu each and 0.23% each for isiXhosa, isiNdebele and those classified under other languages (Census, 2011).

4.6 Sampling and sampling size

The non-probability sampling method, where each unit in a sampling frame does not have an equal chance of being selected, is used in this study. The researcher approached the local clinics in Ga-Dikgale to locate the patients who have been diagnosed with this condition and receiving treatment in the last 12 months (see Appendix 1a: Permission to access clinic records - English version, and Appendix 1b: Permission to access clinic records - Sepedi version). She then targeted any first 10 such participants, five men and five women, and data collections continued till data saturation.

Snowball sampling, (also called chain-referral sampling) existing study subject(s) recruit other participants who meet the eligibility criteria and could potentially contribute to a specific study; CVA patients are the subjects in this research study. It

is useful for building networks and increasing the number of participants. Advantages, it locates hidden populations with specific characteristics the researcher is looking for and it is cheap. Nevertheless, snowball sampling can be biased in the sense that the first participants' will have a strong impact on the sample and you cannot know the actual size of participants and it is time consuming (Babbie, 2007).

Purposive sampling, wherein a particular case is chosen because it illustrates some feature or process that is of interest for a particular study. This type of sample is based entirely on the judgement of the researcher, in that a sample is composed of elements that contain the most characteristic, representative or typical attributes of the population that serve the purpose of the study best. Hence, the most informative respondents were selected to participate in the study (Silverman, 2000).

The targeted population is CVA male and female patients aged from 35 years and above with visible physical impairments. People at this age group are ones at higher risk of suffering CVA attacks and also they are the most affected since they are mostly the breadwinners and heads of households.

4.6.1 Inclusion and exclusion criteria

Participation in this study included CVA patients residing in Ga-Dikgale and receiving outpatient rehabilitation and treatment at the local clinic in the past 12 months. It also included both male and female patients aged 35 and older with visible physical impairments. CVA patients who are able to speak for themselves even with slight difficulty, in either Sepedi or English, were also included. Any race or culture was welcome for participation in the study. The study excluded CVA patients residing at Ga-Dikgale but having intense difficulty speaking, were younger than age 35, and those who fitted the inclusion criteria but were not willing to take part in the project.

4.7 Research instruments

The current study used semi-structured interviews consisting of open-ended questions to collect data from CVA survivors (see Appendix 2a: Interview guide – English version, and Appendix 2b: Interview guide – Sepedi version). **The interview guide contains five open ended questions that seek to find information on the participants' understanding of what CVAs are, the causes and psychological coping**

strategies. The open-ended questions also seek to understand the participants' personal management strategies of the condition and the role of their respective religious beliefs in dealing with the condition. According to Babbie (2007), semi-structured interviews are useful in that they allow the participant to speak for him/herself rather than to provide him/her with a battery of predetermined hypothesis-based questions. The open-ended questions are 'funnel type' in nature, starting with broad questions and moving to more specific, narrow questions as the interview progressed. Flexibility is imperative for this type of study as it provides the opportunity to explore issues working with interviewee responses (Greenop & Thomas, 2008). According to Simeone (2014), the use of an open-ended question is required in phenomenological research because it allows participants complete freedom in reporting their experiences and the participants' 'world' becomes the focus of the investigation.

4.8 Entry negotiation

Choosing the right strategy and proper planning in gaining access to the field is considered to be paramount in ensuring a high response rates and obtain the relevant information for the research. It is also equally important to be flexible and adaptable to the changes which occur at the research site. There are three ways of gaining access, the first being formal access, which refers to achieving an agreement between the organization and the researcher on specific condition in terms of what, when and how empirical data are collected and what might be the return. The second type is personal access, where the researcher knows relevant executives, managers and individuals in the organization and the third type is where the researcher is able to foster individual rapport where a good understanding is developed and there is collaboration between the researcher and the organization (Johl & Renganathan, 2010).

The first type, which is the formal access, was used in the current study. The researcher obtained access by writing formal letters to the organizations involved in the project. Firstly, the research proposal was cleared by the Faculty of Humanities of University of Limpopo (see Appendix 5: Faculty approval of proposal), and then cleared again by the Turfloop Research Ethics Committee (see Appendix 6: TREC ethical clearance certificate). A letter was then written to the Limpopo Department of

Health (see Appendix 2: Permission letter to the Limpopo Department of Health) requesting permission to access clinical records at Ga-Dikgale clinic and also their permission (see Appendix 7: Department of Health Approval letter). Another letter was written to the Kgosi of Ga-Dikgale (see Appendix 3: permission letter addressed to Ga-Dikgale Tribal Authority; 3a- English version and 3b- Sepedi version) asking for permission to conduct the study in his village and interview his people and the response was verbal. With all that done, the participants in the study were given an informed consent letter and form (see Appendix 4a- English version and 4b- Sepedi version) before they could participate and the ethical considerations were read to them.

4.9 Pretesting

Pretesting is highly regarded as an effective technique for improving validity in qualitative data collection procedures and the interpretation of findings (Hurst, Arilogun, Owolabi, Akinyemi, Uvere, Warth, & Ovbiagele; 2015). Casper, Peytcheva, Yan, Lee, Liu and Hu (2016) define a pretest as the collection of the qualitative and quantitative techniques and activities that allow researchers to evaluate survey questions and survey procedures before data collection begins. It involves simulating the formal data collection process on a small scale to identify practical problems with regard to data collection instruments, sessions, and methodology and also provides an opportunity to make revisions to the study materials and data collection procedures to ensure that appropriate questions are being asked and that questions do not make respondents uncomfortable or confused (Hurst et al., 2015).

In the current study, the researcher pretested the interview instrument by interviewing two people first and sending the transcribed responses to the supervisor where the feedback was that more probing has to be made in relation to the semi-structured questions so as to dig as much information as possible about the experiences. In light of that, the researcher went and conducted another interview with one person and sent the transcribed responses and then was given a go-ahead as there was enough and more concrete information.

4.10 Data collection

Data was collected using face-to-face interviews. The researcher conducted semi-structured interviews with each participant to get in-depth information on the experiences of the cerebrovascular accident in their lives. The interviews ranged from 45-75 minutes in length and each participant was interviewed once. The interviews were audio-taped and then transcribed verbatim by the researcher. The accuracy between the digital audio-recordings and the transcripts was checked before the transcriptions were translated from Sepedi to English by a professional translator. The participants were assigned with pseudonyms to maintain confidentiality.

4.11 Data analysis

According to Bless and Higson-Smith (2000), data analysis is conducted so that the researcher can detect consistent patterns within the data, such as the consistent covariance of two or more variables. Data analysis is about the interpretation of collected data for the purpose of drawing conclusions that reflect on the interests, ideas, and theories that initiated the inquiry (Babbie, 2007). In the present study, the researcher followed the four stages of interpretive phenomenological analysis (IPA) as outlined by Gavin (2008). The four stages are:

4.11.1 Bracketing

In this stage of phenomenological analysis, the researcher makes a continuous attempt to suspend their prior knowledge about the phenomenon by attempting to bring that knowledge to the surface. The researcher has to engage in a period of self-reflection so that he or she can be able to recognize and separate their bias from the findings of the present research. This is done so that that prior knowledge does not interfere or influence the research outcomes (Hayes, 2000). However, when researchers perform 'bracketing', which is writing their assumptions and beliefs about the phenomenon, before data collection and analysis, they are more alert to subtle prejudices. Bracketing enhances the credibility of the data and analysis by reducing the chance that researchers will introduce their own biases rather than seeing the data from the participants' perspective (Simeone et.al., 2014).

4.11.2 Analysing

The analysing stage is about bringing the whole experience together and making decisions about which parts of the experience should be included in the study and which should not (Hayes, 2000). When analysing the collected data, the researcher first reads each transcript several times to get a sense of the whole. Then, the researcher re-reads each transcript line by line and starts to uncover a tentative notion of the meaning of an experience and labels passages with theme labels. In doing this the researcher uses a reflective awareness that leads to dialectical examination of parts of the data to better understand the whole. When the whole is understood, different data or the same parts of the data are examined at a deeper level. Passages and themes from an interview are then compared with passages from other interviews (Simeone et.al., 2014).

4.11.3 Intuiting

Intuiting involves the researcher adopting a particular frame of mind or mental approach to the data. The previous assumptions and beliefs which have been identified during the bracketing stage are consciously set aside and the researcher attempts to explore the phenomenon in as open-minded as he or she possibly can. The idea of intuiting is for the researcher to be open-minded to what the participant has to say and to make sure that this is not interfered by the prior assumptions and beliefs. It is about the researcher being able to feel what it would be like to be that person, or rather, to live in that person's world (Hayes, 2000).

4.11.4 Describing

The fourth and final stage, which is describing, involves the researcher trying to pull together the insights which have been obtained from the research. The researcher tries to link together the different experiences gathered through the research project so that they can make intuitive sense to other people. In so doing, the research participants' descriptions of their own experiences are used by the researcher as evidence, and also, as a way of testing whether the researcher's insights are really appropriate (Hayes, 2000).

4.12 Trustworthiness of the study

Trustworthiness is the validity or truthfulness of a qualitative study which serves to generalisability of the study. The following quality criteria applicable to qualitative studies were observed by the researcher when the study was conducted to ensure trustworthiness:

4.12.1 Credibility

This is the alternative to internal validity, in which the goal is to demonstrate that the inquiry was conducted in such a manner as to ensure that the subject was accurately identified and described (De Vos, Strydom, Fouche, & Delport, 2005). In the present study, the researcher ensured credibility of the findings by engaging in an ongoing discussion and review of the findings with the supervisor and co-supervisor at various phases prior to the formal submission of the completed project, therefore adding credibility to the study.

4.12.2 Transferability

Transferability, as proposed by Lincoln and Guba, is an alternative to external validity or generalizability, in which the burden of demonstrating the applicability of one set of findings to another context rests more with the investigator who would make the transfer (De Vos et al., 2005). In the present study, transferability was ensured by selecting participants purposefully, that is, to select participants or cases that are information rich. Although this study comprised members of one South African ethnic group which may make the study results ungeneralizable outside this ethnic group, its scientific nature and all the relevant procedures and methods employed may make the findings useful in other settings.

4.12.3 Dependability

Dependability an alternative to reliability, in which the researcher attempts to account for changing conditions in the phenomenon chosen for study as well as changes in the design created by increasingly refined understanding of setting. This represents the set of assumptions that differ much from those shaping the concept of reliability (De Vos et al., 2005). Different types of data were collected and different conclusions were reached to ensure dependability in this study.

4.12.4 Confirmability

Confirmability, being the final construct, captures the traditional concept of the objectivity. Lincoln and Guba stress the need to ask whether the findings of the study could be confirmed by another (De Vos et al., 2005). To ensure confirmability; data, interpretations, and findings were attached to individuals and contexts apart from the researcher. The paradigm, methodology, and methods employed by the researcher for this study were also elaborated in detail to ensure confirmability of the results.

4.13 Ethical considerations

4.13.1 Permission to conduct the study:

Though this study is part of a larger VLIR-IUC (Vlaamse Interuniversitaire Raad – Institutional University Cooperation) investigation, **which investigates a variety of chronic diseases in rural Ga-Dikgale village with an aim to prevent, manage and them**, the researcher nevertheless obtained ethical clearance from the University of Limpopo's ethics committee, **ethical clearance number TREC/68/2016: PG** (see Appendix 6: Ethical clearance letter). Permission was also sought and obtained from the tribal authority of Kgoshi (Chief) of Ga-Dikgale before the participants could be interviewed (see Appendix 3a: Permission to gain access to the participants – English version, and Appendix 3b: Permission to gain access to the participants – Sepedi version) and also from the Limpopo Department of Health (see Appendix 2).

4.13.2 Voluntary participation

The participants were advised that their participation in the study is voluntary and that they were free to withdraw at any time. The respondents willingly participated with a clear understanding that they were under no obligation to do so and that there were no negative consequences for them if they did not assist in the research.

4.13.3 Informed consent

The researcher obtained informed consent from the participants before the study can commence (see Appendix 4a: Informed consent letter and form – English version, and Appendix 4b: Informed consent letter and form – Sepedi version).

4.13.4 Confidentiality and anonymity

The researcher maintained confidentiality by ensuring that the information given will not be divulged. To ensure anonymity, participant's data were not associated with their names or any other identifier. Pseudo names were used instead of participant's real names if there be a need to identify participants.

4.13.5 Aftercare for participants

Participants who showed psychological problems as a result of their participation in this study were referred to a psychologist or social worker for counselling. **The counselling process was taken by the researcher or the researcher's supervisor.**

4.14 Summary

This chapter shed light on the similarities of the two types of researches that were used, namely; qualitative and phenomenology. As Tewksbury (2009) put it, qualitative research focuses on the meanings, traits and defining characteristics of events, people, interactions, settings/cultures and experience, whilst van Manen (2007) explained phenomenology as a project of sober reflection on the lived experience of human existence. These two both aim to dig for in-depth information about the lived experiences of the CVA patients as they themselves see them. Now that the plan is outlined, the next chapter presents the results of this study and then the discussion section where the results will be discussed in terms of the literature explored in this study.

CHAPTER 5: RESULTS

5.1 Introduction

The primary goal of this study was to provide descriptions on the lived experiences of people with CVAs in Ga-Dikgale. Specifically, it was hoped that this study could provide a broad overview on CVA related experiences and insights on the condition. IPA was used to make sense of the raw data (the transcribed interviews that were conducted with each research participant). In line with phenomenological research and the HBM, my research strategy involved attending closely to the data. This chapter gives an overview of the participants profile, demographic information and emerging themes from the raw data.

5.2 Profile of participants

In all, 10 participants were interviewed of which 5 were males and the other 5 were females. Participants were all Africans, Christians, over age of 35 years and residing in Ga-Dikgale, a rural area in the Capricorn district of Limpopo Province. All participants were given pseudonyms to protect their identity and to maintain confidentiality. The participants' demographic information is laid out in Table 1 below.

Table 1: Participants demographic information

Participant no.	Pseudonym	Gender	Age	Duration of condition (years)
1 ST	Marry	F	53	13
2 ND	Lesiba	M	65	23
3 RD	Mokgadi	F	44	6
4 TH	Rachel	F	51	13
5 TH	Tumelo	F	40	2
6 TH	Noko	M	56	4
7 TH	David	M	68	21
8 TH	Tebogo	M	51	3
9 TH	Kgothatso	F	58	6
10 TH	Pule	M	62	8

5.3 Participants' phenomenological descriptions of experiences

5.3.1 Participants' knowledge of CVAs

Participants in this study, when asked what 'stroke' is, gave different views about it. Only two participants (Mokgadi and Kgothatso) actually gave a much better explanation of what a CVA really is. The term stroke was used during the interview as it is the most common term for this condition, more especially to the elders. The findings from this study show that most CVA patients suffer from ischemic stroke, which is caused by blockage of the artery, while only one had a hemorrhagic stroke which was caused by a car accident. Here is how they explained it:

"...stroke is actually a disease that affects the human mind. It might have been caused by things like high blood pressure and blockage of veins in which case the blood doesn't flow normally. As they explained to us, a disease with which you end up failing to do things." Mokgadi

"...To me stroke is a condition that affects brain veins. It's either they block or burst. And as they burst or block they affect the veins of the brain that should take the blood there. When that part dies it affects the opposite side of the body. Like if it's the left side of the brain, you will be paralysed on the right hand side of the body." Kgothatso

Even though Marry and Lesiba sounded unsure of what a CVA is, they used its causes and what happens during the attack to explain it. They mention that it is actually high blood pressure and it happens when the blood is no longer circulating well in the body. This is how they put it:

"...some say it's high blood pressure, don't they? They say the blood doesn't circulate properly in the body." Marry

"... In my understanding and how I usually hear people saying, stroke is high blood pressure. It is the blood, when they say it has gone high, this blood sometimes blocks in the vein. That's how I had the explanation, they say it boils, it cooks. In our view when they say the blood pressure is high we think there is more blood in the body, and that's not the case, they say it boils. That

implies it forms foam and stops being blood and blocks the veins where blood usually flows then it stops and never flows.” Lesiba

‘Sefolane’ is an African medical term to describe a condition wherein a person just suddenly becomes ill without any clear or foreseen cause. Tebogo below support this statement.

*“...In my view stroke is ‘sefolane’ in Sepedi. It is man-made. I say this because of the way it happens. You should know that stroke does not care whether you are ill or not, you never know what causes it. It seems people just throw something to you which I don’t know and you will be surprised to fall or find yourself in hospital. It is an illness caused by the people of the night. They can let you tread on their things and something changes in the body.”
Tebogo*

Stroke causes paralysis of one side of the body, and that makes other participants to explain it based on that effect.

*“... We just hear that there is stroke. I just think your side just get paralysed.”
Tumelo*

“... in my view it’s just that the blood just started not working. I saw it with me as it was this side that became paralysed, both my arm and leg.” Noko

“...Stroke is...an illness that stretched veins. Yes, stroke stretches. It stretches the veins. If it can drag the mouth to one side, that’s for ever. You can be surprised when you wake up one morning and find your mouth like that. It can hit you while asleep as it does so with others.” David

“... I think stroke is an illness of paralysis of the side...in which case you can’t use your hand and leg from that side.” Pule

The above extracts bear testimony to the medical way of explaining CVAs. They explain that it affects one side of the body and it is highly affected by the blood circulation in the body. Whether man-made or natural, the result is a change in the functioning of the body and mind, and paralysis.

5.3.2 Participants' perceptions on the causes of CVAs

CVAs can be caused by a variety of things, but even so, some participant had no clue at all on what the cause may be. They simply said they do not know, like Marry and Rachel below.

"...Don't know." Marry

"...I don't figure out what it is and what caused it." Rachel

5.3.2.1 Witchcraft

The following participants tried not to explain witchcraft as the cause of the CVA, but they still however spoke about it. This shows that they do believe that it may still be the cause, but they try to dismiss the belief since they cannot prove it.

"...I don't use a witch, that I was bewitched, I don't use that. If the witch is there he will be seen by God, I am not there. He is the one who knows what they want from me...black people always suspect witchcraft when anything happens in your family. You immediately guess who they are. I am not like that. My belief, even my husband when he was still alive, I used to tell him that I am sick but God knows. This many things I don't worry about. I can't say someone bewitched me as I don't want to believe something I don't understand..." Marry

"...we cannot emphasise man-made one as we have no proof. Actually we must accept that it's an illness because if you suspect people you will end up scared of going out thinking that people can harm you. I just take it it's an illness like others and it will also get cured..." Noko

Other patients in this study were convinced that it was witchcraft because of the behaviour they experienced, as they were prophesied at church, or were told by the consulted traditional healers.

"...But there was something that surprised me: what type of stroke is this one? Whether it was witchcraft or what but sometimes when my wife was helping me walk she would be surprised when I suddenly pooled her, when I

actually felt like somebody was dragging be from behind. When she was startled I explained that I felt I was being pulled from the back and I pull you from the other side. We suspected there is witchcraft; a 'tikološi' was grading me to throw me on the ground. ...The traditional healer I consulted in Blood River said it's someone from my employment. He said I got 'sefolane' from my employment. We were driving big trucks exchanging them with AmaZulu and AmaXhosa and I took it were them who brought 'sefolane'. But when I went to church here at home one prophet told me that it is something from here at home, I was trapped just at my gate and it was done by women. When I checked I found that the only women in my home are my mother and my wife and I could not tell who it was... But other forms of stroke come from people of Zimbabwe, they are too many here. They use stroke to snatch animals in the forest, but in this country they use to trap people. They weave a rope using 'muti' and set a snare, once an animal can touch that rope it can't run anymore because one side is dead. When they arrive they kill it and throw away the dead side and eat the other." Lesiba

5.3.2.2 God's will

The following participant explains that it was God's will and believe that God has put her in that position. She believes that it was God's plan for the CVA to attack her at that point in time as He is the one who knows everything even before it can happen. The following is what she said to be the cause:

"...My illness is brought by God and not any person...If I failed to be healed by God as he is the one who knew even the date the stroke will hit me. He knew about it before then so he will heal it on his own. That's what I have in my heart. I will heal and as we speak I am healed as I can do some things. It's just old age...I am old..." Marry

5.3.2.3 Underlying illness and diet

Unhealthy eating habits can also cause CVAs. These include eating too much fatty and spicy food as they can alter the blood circulation in the body. Fat can also block the veins, therefore making it hard or impossible for blood to flow through. The following extracts bear testimony to this.

“... With me my child, when it hit me I did not fall like what many people say. Yes. I never fell. I just said hold me and went down. I said hold me to those who were next to me. They were surprised at what was happening and I told them I just see this playing going like this...going in circles...Even at hospital when I arrived I found myself in a place going in circles. When nurses went up and down I saw them as something very minute. That’s blood pressure.”

Marry

“...This stroke in my view, without witchcraft, is caused by the food we eat. Fatty food as fat can block blood from moving freely in the veins. Even thinking too much about problems causes stress. When you magnify every little thing and make it big. That makes blood to ultimately fail to flow evenly on the body...I had high blood pressure and did not know that it was high as I was on treatment” Lesiba

“...I only have high blood pressure and I was attacked by the stroke it was already there. There are no other illnesses that came thereafter. Even the tablets I take have no problem.” Tumelo

“... According to my understanding, stroke is caused by many different things that we Blacks do not know in most cases. Stroke can be caused by diabetes, high blood pressure or minor accidents.” Kgothatso

Depression, which can be explained as severe mental distress in simpler terms, was also found to be a cause of CVA. Some of the participants experienced depression before the attack.

“...It can be caused by...personal worries. Things like depression, to be worried by listening to people can lead you into problems like those since depression is an illness that affects the mind. Or even not on good terms with people you stay with can also cause some depression which can lead to stroke.” Lesiba

“...they say it’s because of thinking too much. Thinking too much ends up with mental depression. Even the arthritis that we have because when I went to

hospital the doctor said arthritis caused the stroke as it was never diagnosed and it affected some veins. I don't know why.” Tumelo

“...In my view the way I observed is that if you have too many problems and you keep thinking deep, this type of things will ultimately occur as you mind gets damaged. For me to end up this way I also had big problems and thereafter I found myself this way. I had a serious mental depression.” Noko

“Things like stress, depression can cause stroke.” Kgothatso

5.3.2.4 Lack of exercise and accidents

The human body needs exercise to facilitate blood circulation inside the body. Exercise also prevents blood from thickening and clotting in the veins. “All work and no play...”, on the other hand can be problematic. One should not overwork the body without resting. Sometimes accidents can cause veins to rupture, resulting in haemorrhagic stroke. The following extract bear testimony to this.

*“...If you ask some what type of work they did when the stroke hit them, you realise that most men were drivers. Sitting for some time makes veins to be blocked. Such people take time sitting and are troubled by cramps which ultimately cause stroke. Veins need to be straightened so that the blood can flow evenly. Now if you drive a truck you sit for the whole day, Monday to Friday, the veins are squeezed and the heart pumps with difficulty and the blood cannot flow easily throughout the body and that can cause stroke.”
David*

*“...the western doctors told me that one vein burst and I was lucky that I was rushed to hospital. I found a neurosurgeon who was able to drain the blood before damaging my brain. Too much, that's why I recovered early.”
Kgothatso*

“...Sometimes I see other as work...I was working night shift and knocked off in the morning and went home and slept. When I woke up I felt a headache and my left side was numb and could not shift.” Pule

Findings from the above extracts suggest that people have their own perceptions about the events or factors that lead to CVAs. Some of these perceptions appear to be culturally motivated, such as witchcraft, while others see it as God's plan. There are however some who see it in a medical way, such as it being caused by other underlying illnesses like diabetes, high blood pressure, and depression. Some extracts reveal that bad living habits such as lack of exercise or rest, unhealthy diet, and also accidents can cause CVAs.

5.3.3 Perceptions of participants on prevention of CVAs

Prevention is better than cure, so it is best to prevent illnesses before one can even have them. Even with CVAs, one should try preventing them beforehand.

"...you can prevent it by taking treatment for high blood pressure and depression." Mokgadi

"...We can't say it is preventable but we try to prevent it where possible. In cases where it is caused by diabetes or high blood pressure, if one knows about these diseases one take medication and that prevent stroke." Kgothatso

"...No, there I don't know how to put it. The doctor says that if I took the high blood pressure tablets well and did not put my body under a strain at work it could not have happened." Pule

Food also plays a role in keeping the human body healthy for long. As the saying goes "you are what you eat", eating healthy food keeps the body healthy and may also prevent diseases. Marry and Lesiba support the above claim.

"...They are saying we should not eat salty food and shouldn't do this and that...we shouldn't be angry and so on." Marry

"...one should only cut down fatty food and too much acid cool drinks. They say these drinks have caffeine which makes blood to thicken." Lesiba

Years back, Africans did not go to hospitals for treatment, but even so, they knew how to diagnose, prevent and treat certain diseases. Besides medication, healthy food and rest, the Africans also have their own ways. David clarifies this point.

“...People of yore would realise that someone has high blood pressure, and they would take a razor blade to cut you and drain it using a horn. Do you know the cow horn? They prepare it and take a hole in it then inhale and block the hole so that the horn can pull on its own. When they remove it they find it full of blood. In the past there were no things like high blood pressure because they realised it earlier. High blood pressure means more blood but the modern doctors have no way of reducing the amount. With what? They only give tablets to reduce it but if there are older people who know how to ‘lomega’ they can help you faster.” David

The above extracts clarify that CVAs can be prevented by treating underlying illnesses like high blood pressures, diabetes and depression. Treatment may be western, which is by use of over the counter drugs, or by African means, which is by reducing high blood pressure by cutting and draining the blood. CVAs can also be prevented by practicing healthy eating habits, like cutting on salty, fatty and spicy food, reducing the intake of acidic and sugary beverages, and also by excising the body to ensure great blood circulation.

5.3.4 Perceptions of participants on the CVA’s impact on their quality of life

The health status of a person is also affected in the process. With Noko, all aspects of life were affected as he points out.

“...it affects me a lot. Stroke affects many things, actually the whole life. Let me say even the needs you had before diminish. The way you lived before becomes different. When you have stroke everything moves back.” Noko

5.3.4.1 Emotionally

Everyone in life has their own way of dealing with their life events. It was found in this study that even the CVA left people with different emotional reactions towards it. The following themes support this

“...I sometimes get angered but I behave myself. But at times I think of the past and feel very bitter that I just cry...That’s why I say I don’t want anybody to remind me...I feel painful, my heart aches.” Marry

“...My heart just pains that why am I like this even before I reach 60 years. I look at people walking and wish I could still be able to walk. I already limp while I am still young.” Tumelo

“...There are problems in the mind, speaking is a challenge and sometimes I struggle to find some words. I have a mental depression to the extent that I sometimes cry. At home they say I have a mental illness as I sometimes cry and while crying start laughing uncontrollably. Most things I fail to remember and somethings I don't know how to do them...Failure to control my emotions puts me under severe mental depression.” Tebogo

5.3.4.2 Physically

Patients in this study reported paralysis of one side of the body and inability to perform some of their duties as well as they used before the attack. All the participants in this study were physically impaired but some could use the impaired side.

“...Only this side...starting here, from down there up to the head above. I am presently better as I couldn't speak...In the first weeks, I couldn't speak. My tongue was filling my mouth. You know I had some anger but could not say a thing. Even this arm was not working; I thank God that I can even write my name again I couldn't...lately I can...I do things for myself and I can't lie to you. Even though some days may be different, I try as I go to the toilet on my own. I couldn't walk completely...I thank God as I see he loves me and I also love him. I go to the toilet and come back and even my dishes I wash them...when she is gone I do the washing. My under clothing I am not helped by anybody. Yes. I can even stretch this hand, it couldn't stretch.” Marry

“...On the body it's actually only this left side. On this leg, only the big toe is numb. You see when I trap down the toes must move up a bit but it always crumbs, when I am sitting like this the big toe is stretched but when I stand up it crumbs. That means its cartilage is the one that stretches this whole side and is one that makes it difficult to walk properly...With me it was different from what it does with other people whose lips get skewed. Mine was never skewed. My face was just ok and my arm never bent.” Lesiba

“...It troubled me greatly as I ended up not able to walk...The stroke affected the arm and leg on my left and did not deform the face... I am able to bath myself even though this arm does not yet work properly. If you just sit back you won't be able to do a thing.” Mokgadi

“...I felt no pain initially. When time went on now I feel pains. This side is all painful and shivers on its own. Initially I felt no pain and this arm was not numb. Others have numb arms, so numb that they can't do anything. Mine is still alive you see I can control it. I feel such a pain...as if I can cry; if I was a child I would cry.” Rachel

“... It once attacked me very painfully. Thereafter I could not walk. I was always indoors. When I went to toilet I needed two people to support me on either side. I so much needed support. How can one bath using one hand? Can you clothe yourself in one hand?” David

“... As you see me I can't do a thing, can't walk or even wake up on my own. Mine is to sleep in this way, I am bathed, and fed, that is everything is done for me.” Tebogo

“...It paralysed my left side. The leg and hand on that side I try to use but get easily tired. I use crutches to walk and try to exercise so that I can later walk on my own. My face never had any problem” Pule

5.3.4.3 Psychologically/Cognitively

As the medical term cerebrovascular accident, CVAs affects the cerebral arteries, therefore altering the human psyche. This means that CVAs also impact the patient cognitively. The following extracts bear testimony to this.

“...It worries me because you know, you were able to do things for yourself and the next minute you can't even walk, you are somehow affected as you wish only to be able to walk. Even this impatience, When you request someone to help you think they take too long and if it was possible you would stand and do it yourself immediately. But now I feel like am used to it, though when people give me advice I accept that I am this one but I will be fine

someday... The only thing that worries me is why I am not recovering.”

Mokgadi

“...It really worried me and I just ignore it so that I can live well. I have just given up and accept that the way I am I am like other people somewhere. I accept that when it's time you cannot avoid it.” Tumelo

“...it makes me forgetful. I forget easily. Even now when I have to insert airtime I have to think first and those are things I did easily in the past. Even when I have to write I must think that now I am going to write, I am just forgetful. That's how it worries me.” Noko

“...Mentally the problem is forgetfulness. I forget even important things. I depend on my children to remind me when I have forgotten. Mainly days for check-up, physiotherapy or collection of medication. I also forget faces of people I lived with. Sometimes I yearn of going back to work, mainly when my children need something and I am unable to fend for them.” Pule

5.3.4.4 Socially

Every person is a member of a larger society and social support is very crucial in the healing process. Lack of social support may delay the person and this may result in the person having psychological problems that may delay the healing process. The following participants did not have the support and reported that people retreat when you are sick.

“...people have regrouped themselves, they are no more mine. They are no more those friends of mine I knew. Some have left. I don't have a friend anymore; I live here with my children as you see me. My friends are my children, my family is them. Other people like before, no! People just speak to you as if you are now not normal in your mind. But I don't care about it as it's just the same. My illness is brought by God and not any person...people retreat. Maybe they think when they speak to you they will get infected. But never go with a friend because there is no way they can help you. They will only laugh at you and pass.” Marry

“...they desert you, friends and relatives desert you. You don't visit anybody and even if you decide to visit someone you will realise on arrival that this person is no more the one you knew who welcomed you once they saw you coming. No they all move away from you...I take it that the main thing is that they think stroke is also contagious and if you live next to them they will get infected. I have realised that all those I lived with are now aloof since I had the stroke.” Noko

“...How can I explain it? I am living just because God has not yet thought of me. There is no co-operation at home. My mom and sisters see me as a mad person who knows nothing. They speak badly of me while listening and they ill-treat me in front of children. I don't go out of the house so I don't even have friends. My children cry when they see me. I pity them and think I torture them by living on.” Tebogo

On the contrary, those who have the social support reported to have accepted their condition and seem to be at peace with it.

“...Other people who are next to me are already used to me. I am always happy and we are used to calling one another through our praise names. They call me Mokone. We are used to one another I find myself living like them. Now that I don't worry about anything should I keep saying 'where are my children?' No they are grown up and what should worry me?” Lesiba

“...No they live well with me. Let me say at home they give me their full support and generally all the people we live with. Neighbours and church members do come to support me. They preach and pray for me.” Mokgadi

5.3.4.5 Health status

CVAs weaken the human immune system, therefore making it easier for other illnesses to attack the body. The following quotes are a testimony to the above statement.

“...I sometimes have a running stomach, and a peculiar cough...With stroke, you may think you will wake up ok but when you wake up things are

different... you can't live happily with stroke. You may wake up well and do family chores but when the sun sets you are different." Marry

"...it affects my health mostly as I am no more a person who lives well. 123 I have this. I did not have arthritis but now I have it. I always complain of something, you heard me talking about sensitive teeth. Some few days ago I had a sore throat and my left side was too weak and this leg could not move as it was swollen." Mokgadi

"...My throat feels like I am being strangled by someone. It pains me. It needs one to keep checking as the illness never ends... Even flu sometimes" Rachel

"...I take tablets and get better but when the weather is bad the arthritis comes back and I can't walk but the arm is not so painful it's the leg that pains a lot. That time I can't even get out of the house. The whole body pains because of the leg. Sometimes the weather changes and when I try to wake up I feel nothing and can wake up." Tumelo

"...I am just...I am living with illnesses. Every illness that comes to me suppresses me. But what can I say. Even when I have flu it feels like a serious illness." Tebogo

"...Well, I have regular headache but I take medication it's controllable. From there I forget but sometimes it's not very serious." Kgothatso

The above extracts highlight that the quality of life is highly affected by the CVA. They highlight that your dreams diminish; you experience anger problems, bitterness, heart aches, impatience, and hopelessness. CVA patients also state to have mental depression, uncontrollable laughing or crying, and forgetfulness. The extracts also suggest that CVAs result in functional dependency, bodily pains and inability to speak well in some patients. CVAs are also said to result in social problems; such as isolation, lack of co-operation at home, and feeling deserted. Patients experience unstable health state, one moment you are ill, and the next you are well. Any illness, such as flu, a running stomach or a sore throat, is suppressing and you tend to have illnesses you never had before.

5.3.5 Perceptions of participants on treatment strategies

There are different ways of dealing with diseases cross-culturally. Even with CVAs, some patients opt for the western treatment, others for the African, or even both of them. Religious methods also appeared to be helpful in treating CVAs for others. The choice of treatment depends on the patient's personal belief on it and how effective they believe it can work in improving their condition

"...To heal it you need physiotherapy, to work out the side. They also stretch your arms so that blood can flow normally. At the clinic they sometimes come to give us exercises and show us how to do it at home." Lesiba

"... in my view to cure it is to take treatment, i.e. when you have high blood pressure you take its treatment...I trust them and I can see that they help me. The problem is their side effects...some make you sleepy like those for depression. You find yourself asleep and the mind also doesn't work properly. The other one I take, I found out long ago, when I went to the dentist because of sensitive teeth. They cleaned my teeth and said the enamel is eroded and only the sensitive inner part remains bare and that was caused by one tablet that I took...There are herbs that they use and get them from Zimbabweans. It's a good herbal tea that he brought for me free to test it. I lived on it all this time but since it's finished I do not know where to find it but I sent a word to say if he still has it he must bring it or tell me where it can be found so that I buy for myself...this herbal tea it's said can strengthen the body and the immune system...attend physiotherapy sessions. You must try by all means to exercise even at home to remain active." Mokgadi

"...In my condition they had to drain the blood because a vein had burst and spilled blood. But if it's a blockage they can give you some tablets to dissolve the blockage to allow blood to flow normally. If you have high blood pressure you have to take medication to avoid the stroke to come back...used to go to the physiotherapist back then until I was able to walk and do things for myself... I have great hope. I never lost hope and I always believed that for as long as I take my medications I will be ok. Even when I was at the physio trying to stand but failing I knew that one day I am going to make it because

the therapists are trained professionals and they know what they are doing.”
Kgothatso

Even so, Rachel does not have any belief in the medication she is using. She reported that she is getting worse, that the medication is killing her.

“...I only take these tablets from the clinic...If they work I would have recovered. Here I am still shivering and not healed. They keep changing these tablets and there they continue to kill me. They are the ones killing me.”
Rachel

Just as they believe CVAs are caused by witchcraft, Africans also believe in African healing methods. They believe that consulting traditional healers as early as possible after the attack can help with the condition.

“...But other forms of stroke come from people of Zimbabwe...They also claim that they can heal the stroke. If you visit them immediately after having stroke they can heal it. They know what they mixed and they know how to take that out.” *Lesiba*

“...I only used what they call ‘mohlabelo’. Mostly footballers when injured on their legs they prefer to use it. It’s like salt, yes, that’s what I used. I pierce the flesh and rub in that salt.” *Tumelo*

“...Traditional doctors say I made it worse by rushing to the western doctors. According to them I would have recovered if I consulted them first. But I did not realise anything and the hospital is the one that opened my eyes. For now I only take the western treatment.” *Tebogo*

“...In the African way they start you on Monday until Friday steaming you strongly and in the second week they let you lie down on your side affected by stroke then they cut your skin and squeeze the blood into a tennis ball until it’s full. Then when they are full they pour it into a dish. There will come out very stinking blood which makes children to run away and ask me what smells so much, granny. Yes, I am not lying to you. They took blood from this affected stroke. In the third week they left me for the marks to disappear first. The

fourth week they start with steaming and the fifth one they draw blood again until I feel that now I am better my side has eased out.” David

All participants who use the religious methods were found to also use the western methods, while some also tried the African ones. They believe that God will heal them through prayer and others also go for steaming and drinking tea made at church and believed to can heal.

“...I don't take medicine my girl. To tell the truth I am saved, and don't take medicine. I have accepted that I am ill and prayed God that he must help me recover from this illness and it should never get into anyone in my family. If it was possible it should just disappear forever. That's what I pray for in my heart.” Marry

“...When I arrived here, as I am a Zionist, there was a Zionist here healing people in what we call 'diagelo' (steaming). He is good at that even though the Bishop does not approve of them but they took me there. That man was a prophet and he even prepared tea and he had visions. My brother took me to him for him to care for me. He made coffee and when it boiled he poured it into a bath and ordered me to immerse my left foot into the bath. As I was unable to lift it, his helpers helped me put in in the water. It could not even feel the heat but this other one, since its normal I was taking it in and out of the water as it was burning. This other one stayed in the water without feeling the heat and he said he wanted the blood to flow well before he pierced the leg to release the dirty blood. The leg was being burned at that time. Until now some nails are not there and don't grow any longer while others are crooked.” Lesiba

“... At church I steam and drink tea according to instructions...I just go to church as I am an apostle. I go to church and pray. Even if I have not gone to church I can leave my home going for steaming. Let's say when I am done they stretch me and rub me. That's the African physiotherapy. It will not be like that of a doctor.” Rachel

“... I just to the church for the saved and they pray for me...Mine is a prayer, I just pray. When I wake up I cannot go outside without praying I must kneel

down and thank God that I thank him when I am able to wake up. At night when I go to bed I also thank him for having spent the day safely. "God I thank you'. That's how I live in that way...When I pray I see myself living a better life. Sometimes when I pray I see the Holy Spirit coming down you see, and wonder what is happening. I live in prayer and my prayer has a lot of energy. I realised it and I then said 'thank you God'. I believe that God hears me; he listens to me and is still with me." Tumelo

"...I only go to church. The church is the one that helps me as well as the tablets I take from the clinic...I then started going to church and taking my tablets until I was able to use a stick to walk. I go to town, to Mankweng all places I want to go...I trust the church as I saw others coming to church in crutches and ultimately they walk without them. Yes, it is somehow curable but not so easily, it will leave some sign to show that this person once had stroke. It doesn't disappear completely...They make church tea for us and that's what we drink...I have complete trust in it as the way I was struggling I had no hope that I will ever be able to stand and walk with crutches because two people had to support me on each side to enable me to walk. Waking up was also a challenge but now I can wake up by myself. Now I believe that it can be cured anytime." Noko

"...Now, in the church they run a bath and put ice inside and you bath in that. You just persevere when they pour water on the affected side, to try and kill that heat. It's because the blood that is full in this side is heating it up." David

"... As a Christian I believe that God will not give you what you cannot handle. God gave me this condition knowing that I will be able to control it and not the other way around." Kgothatso

In accordance with the above extracts, it is suggested that physiotherapy can help treat the CVA as it facilitates blood circulation in the body and also strengthens the body as a whole. Medication used for treating the underlying illnesses and those for dissolving blood clots are also said to treat CVAs. It is also suggested, in the African perspective, steaming, cutting, and draining the excess blood can also help, while religiously the patients put their faith on prayer and the church tea to help them.

Even though most of the participants have already tried two or more of the treatment strategies, they all however believe in prayer and the western medication.

5.3.6 Participants' psychological coping strategies

It was found that people should accept and shift their focus from their problems by engaging in social groups, keeping their minds busy by reading, or even joining support groups in their area. These strategies were found to help the participants to accept and not magnify and brood about their conditions.

"...My nature is that I accept that I am this way. I tell myself that I will get healed. I don't distress my mind that I am crippled. No. I don't believe in such things. I will recover. Actually I am healed. I can talk to people; I am able to do things for myself. Sick people who are crippled cannot walk with this illness. I see that I am healed as I could not rise from my sleep but now I am able to even carry myself up. I wake myself up, I sleep by myself, I dress myself, I undress myself, I do not fail to do anything. I see myself living like other people." Lesiba

"...I read books to keep my mind busy. Books, magazines and newspapers, even the Bible. Even now I was still reading this one you see on the table for motivation. I read this type of books because in a way they encourage you. You may find that people like you succeed because they used this and that from such books. And then another thing I watch television and listen to gospel." Mokgadi

"... One should just accept and know that it does not start with you because if you worry too much you may not get healed. The illness has long been there. It's just to accept that I have it and does not start with me. It will heal as others are also healed. That is how I take it otherwise you will have a mental depression. And they say if it takes you seriously while you think you are the only one it is possible to have another attack... The way it is you have to accept that I have this illness like when you have any illness because if not it can hit you for the second or third time. You have to believe that it will get healed." Noko

“... Like I said, I was able to accept the situation earlier. When the psychologist spoke to me he found that I already have a positive outlook on life. I was living with people back then even though sometimes I could not speak, just to listen to them joke around. They are able to release the stress. I spent most of my time at work which denies me time to brood about my condition. Even your mind tells you that, that was then and this is now, so that you can accept the new living conditions without looking back. And whenever I feel overwhelmed I go to a psychologist for help... A person should not house-arrest herself and wait for others to feel pity for you because that cannot make you better. One should go out there and interact with others. Find things to make you forget about your condition. There are support group of people like you out there who can serve as good inspiration because walk the same route with you. One can still volunteer at a crèche on a wheelchair and spend the whole day with the kids; they won't judge you and they don't see you having any problem anywhere, while at the same time they move away time.” Kgothatso

The extracts above highlight that to cope with this condition, one should accept it and try to shift focus from the negatives it comes with by reading, joking around with other people, or work if one can. They highlight that one should not worry too much and isolate himself as that can actually be depressing and eventually make the condition worse

5.3.7 Management of CVAs

Living with this condition does not mean that the person should give up on themselves and live a reckless lifestyle. One should try to manage the condition so that he/she can live a better life for longer. Healthy eating habits and exercise were found to be some of the best ways in managing this condition.

“...It's eating recommended food as others you don't have to take. You must respect what you are barred from eating. You see this one I eat because it is written 'low fat'... When you want to live well don't trust anybody, don't care a damn about them. Just look at your family only. It will help you because even the day you become worse you will be seen by them.” Marry

“...Don't sit by yourself and think too much. Taking the whole week without speaking to people is not good. I visit the old-age home and sit with old men there joking and laughing and by so doing time goes. Even at home there is a boy I talk to and we talk until sun set. One should not stay at a lonely place. Laughing is a free therapeutic necessity for mental stress. It is like an exercise, running and sweating sucks the stress out of the body. Even dancing you pass away time.” Lesiba

“...As other say, one day the Bishop said “you stay here and call yourselves Zionists. You can't spend a day without your cell phone but you cannot pray once in a day.’ People should pray as even witches pray and ask God that I want this person, while you are still lost and not praying then God answers them and they get you where they wanted. Yes, even eating one must eat well as advised and take tablets as prescribed.” Lesiba

“...you have to eat good food and you should not be overweight because stroke on its own, as organs are not working, if you gain weight you will ultimately be unable to walk and that can even cause other illness like heart problems.” Mokgadi

“... One must take care of themselves. Persevere this death blocker, I mean tablets that hide for death. If I can leave this tablets I will die, they delay death. I sometimes say God should increase my living days. I ask for it from God.” Rachel

“...It's when you stop taking salt, pepper, and spices because those things make the illness to be severe. You see if your finger is injured and sprinkle salt of pepper how will you feel? Even this illness does that. Even when you don't have this illness you have to reduce their intake as they are not good for the human body. Salt can make your blood thicken and block veins...I simply go to church and attend the prayer sessions or make tea for other people and serve them while we stretch our legs and avoid brooding alone in the house.” David

“...Taking your medication accordingly, exercise, healthy diet and avoiding unhealthy behavior such as smoking and drinking some beverages...Well,

beverages are different. We people tend to assume that its only alcohol that is harmful to your health, while the fizzy and sugary beverages we drink everyday are the dangerous ones. One may develop sugar diabetes which may later, if not treated, lead to stroke. With smoking and alcohol we know that they may lead to hypertensions and high blood pressure which are other risk factors for stroke.” Kgothatso

The above extracts highlight that good management of CVAs include healthy eating habits, taking medication as advised and avoiding unhealthy behaviour such as smoking and alcohol intake. Exercise, laughing and socialising are also suggested to suck the stress out of the body, leaving you with relief from stress.

5.3.8 Perceptions on hospitalisation

As Kgothatso puts it, a hospital is a safer place for patients as there are professionals working round the clock to ensure that their patients get better and are well taken of. At a hospital, one will be given relevant medical attention a lot earlier than when out of the hospital and therefore be saved, while being outside is also good when one is in a better condition as it helps to interact with other people and reduce stress.

“...That will depend on the severity of the condition. If the person is in a critical condition it's obvious that that person needs the nurses' attention at all times. But then if he feels better it's advisable to be outside the hospital for social support because a hospital can be depressing as well. When you see others being worse next to you, you think you are like them because you are all hospitalised. When one is at home with family's support it's much better and makes it easier to heal.” Kgothatso

Even so, some patients still believe that hospitalisation is not good as one does not have all the freedom as when they are outside the hospital. They believe that being in a hospital with more sick people may delay healing as one will be suppressed by the sick person's shadow, and also that when you have children at home you will be stressed about how their lives may be at that time without their parent. The following participants are a testimony to this.

“...Do you know that hospitalisation is not enjoyable? We just go there because of suffering, desperation. But when you are better, it is better to be outside and visit there just for consultations, not to be hospitalised. It’s painful to stay in hospital. Remember every time my children wake up they want to see me. Where is the money? What about food? When there is no food they feel the pinch. It will not be the same when their mother is nearby.” Marry

“...Outside you are able to be on your own. But at hospital you stay there and it’s not good. Life in there is different from outside as you can visit people and they are also able to visit you, but in hospital people visit you and while talking the siren goes and they must leave. You remain lonely after their departure. Out here when I think of someone I take my walking stick and off I go. Now at hospitals you keep brooding about where are they and you are also suppressed by the shadows of other people.” Lesiba

“... A hospital is not a place for people to live. The patient will be attacked by something they call...outside you are able to move about and stretch your arms and legs well not bothered by anybody. You are free. At hospital while you stretch yourself in the morning they will say ‘what’s wrong with you? What’s wrong with you?’ and scold you those nurses. You are not free in hospital, you see.” Tumelo

“...the one at the hospital does not do as they wish but they are controlled then they are different. Everything is done in their time not yours. Even drinking water, you receive at their time. You are just like a cow in the kraal.” David

On the contrary, some believe that being in a hospital is a good thing as one will get all the help they need. This is said because the participants are still stressed, lack social support, and still have emotional problems, as they recorded. They believe that since people don’t care about them and have retreated from them, then it will be better to stay away from them in a place where they will not be seen or see others, and that to them is in hospital.

“...Someone who stays at hospital is rarely angered and may heal faster. When you are outside there so many things that make you angry and if you

are not strong you can fall for the second time. That happens as someone may come and say 'we saw him pounding himself. What did he think he was doing?' There are so many things that you will ask yourself about and never know what is happening. Out here they speak so many things like 'where does he think he will end up?' All those will affect you. But when you are at hospital they cannot take their transports and come to worry you in Mankweng." Noko

"... If I was at hospital I would not see my children even ashamed of looking at me. Maybe I would get the physiotherapy nearer. I would not hear when people gossip about me and my sisters would understand that my position is not mental. I only came back home to be tortured and if I was still in hospital it would be better and I would not be so emaciated... Maybe being admitted would make me admit my condition and live well. Now I look at me as if I can die anytime and I think it would be better if they did not see me...In hospital they give us counselling but when you reach home there is no one to help you. So it's the same as you never received it. When you leave you meet the reality that the counsellor was discussing and it's as if he was just fooling you." Tebogo

"... Living outside is better than at hospital. You have people to while away time with and help you relieve your stress. Inside you stress lot thinking about your children at home. When you are home you struggle with them and it is better that way." Pule

As suggested by the above extracts, hospitalisation depends on the severity of the condition. When one is still in a critical condition it is advisable to stay in hospital to receive thorough medical attention, while the better ones can be outpatients. Some of the participants above do not like the idea of hospitalisation as they see it as limiting one's freedom, social support and time with family, therefore leading to loneliness and depression., while on the other hand, some participants suggest that staying in hospital is good in that one is rarely angered by people's gossips and negativities.

5.3.9 Knowledge of risk factors

When asked who, between men and women and blacks and white, is at higher risk of having CVAs and why, this is how the participants responded:

“...They are women who are domestic workers. They mainly work with electrical appliances...things like irons when used for the whole day they can cause your blood to thicken...Whites eat well and they exercise while we don't look after ourselves.” Rachel

“...In my view we are just the same, male and female. Better people are the whites because they consult their doctors regularly. Black people only consult when they are seriously ill only” Tebogo

“...In my view it's males. Most men don't practice healthy living, they smoke, and they drink while they do not eat healthy diets. Women are better because we mind what we eat and mostly we frequent clinics and are able to know if we have other illnesses we are able to take medication on time. Men only go to clinics when they can't stand it anymore and mostly you find that it's already late for controlling the situation...We black don't care much about our health. Even we women are assisted by the fact that there are many things that take us to the clinic. If it wasn't for that we would also not go like our men. The whites check their health status regularly. Even the way we eat; food for whites are mostly balanced while we on the other hand eat porridge and potatoes Monday to Friday.” Kgothatso

“...Men. Because most have smoke and drink while they do not know their health conditions. While a person has illnesses they even add by smoking. We are better as mostly we know the types of illnesses that we have and it is not common for women to drink and smoke...Blacks. We trust a lot on traditional healers. When the hospital tells that you have high blood pressure you think they are lying and go to the traditional one with their differing prices. When the stroke attacks you, you start saying I should have taken those tablets. I don't understand whether these doctors have specialisations, with others they just can't return the money that you bring.” Pule

From the above extracts, it was found that most male Africans do not practice healthy living and therefore puts them at a higher risk of CVAs than with women. African Women fall pregnant and are therefore forced to do check-ups, which makes it easier for early detection of any underlying condition that may lead to CVAs. Our White counterparts on the other hand are said to frequent consultation rooms just for check-ups to see if everything is still in order. Prolonged use of electric appliances was also found to thicken blood in the body.

5.4 Summary

CVAs affect one side of the body and blood circulation in the body plays a huge role. They cause a change in the functioning of the body and mind. Perceptions on the causes appear to be witchcraft, God's plan, and underlying illnesses like diabetes, high blood pressure, and depression. Lack of exercise or rest, unhealthy diet, and also accidents are also highlighted as causes CVAs. CVAs can be prevented by treating underlying illnesses like high blood pressures, diabetes and depression. CVAs can also be prevented by practicing healthy eating habits, like cutting on salty, fatty and spicy food, reducing the intake of acidic and sugary beverages, and also by exercising the body to ensure great blood circulation. People affected with this condition tend to experience emotional, psychological, social, health and physical problems that interfere with their quality of life. Treatment of CVA is found to be physiotherapy, to facilitate blood circulation in the body and proper intake of prescribed medication used for treating the underlying illnesses and those for dissolving blood clots. CVA patients highlighted that accepting their condition and shifting focus from it help in coping with the condition and that healthy eating habits, taking medication as advised and avoiding unhealthy behaviour such as smoking and alcohol intake are good management strategies for this condition. Exercise, laughing and socialising are also suggested to suck the stress out of the body, leaving you with relief from stress.

**CHAPTER 6: DISCUSSIONs, SUMMARY OF FINDINGS,
CONTRIBUTIONS, LIMITATIONS AND RECOMENDATIONS**

6.1 INTRODUCTION

The following chapter provides a detailed analysis of the results from Chapter 5, incorporating them with phenomenology and the health belief model as the chosen lenses. The emerging themes, an overall summary of the findings, the contributions of this study, its limitations and also its recommendations are also included.

Table 2: Emerging themes

SUPER-ORDINATE THEMES	SUB-ORDINATE THEMES	BRIEF DESCRIPTION
Participants' knowledge of CVAs		Theme emerged to test participants' knowledge on what CVAs are.
Participants perceptions on the cause of CVA	Witchcraft	In this theme, participants expressed their perceptions on the causes of CVA.
	God's will	
	Underlying illness	
	Lack of exercise, diet and accidents	
Perceptions on prevention		This theme records participants views on how CVAs can be prevented
Impact on quality of life	Emotional	CVA was found to have impacted the participants emotionally, physically, psychologically and/or changed their behaviour.
	Physical	
	Psychological/Cognitive	
	Behavioural/social	
	Health	
Perceptions of participants on treatment	Treatment method and Belief on it	Participants said to have tried one or more methods of treatment and also their beliefs on the treatment.
Participants' psychological		This theme emerged to

coping strategies		record participants' coping strategies.
Participants' views on managing CVAs		Participants give their views on how they think CVAs can be managed
Perceptions on hospitalisation		This theme expresses the participants' views on hospitalisation

6.2 Phenomenological discussion of experiences

6.2.1 Participants' knowledge of CVAs

The findings from this study reveal that most people suffer from ischemic stroke or cerebral infarction. This is the type of stroke which occurs as a result of insufficient or interrupted flow of blood to an area of the brain, typically caused by blockage of an artery (Corrigan et al., 2013). Only one participant has suffered a hemorrhagic stroke which was caused by a car accident. Hemorrhagic stroke, according to Corrigan et al. (2013), is the type of stroke where there is bleeding causing direct damage to brain tissue. The meanings attached to CVAs in this study occur through subjective experiences as they were derived from the phenomena in question.

6.2.2 Participants' perceptions on the causes of CVAs

According to the health belief model, people attach meaning to factors or events that lead to their condition based on the seriousness of the condition. Some of these perceptions appear to be culturally motivated, such as witchcraft, while others see it as God's plan. As stipulated by Mshana et al. (2010), causal explanations for CVAs range from the 'natural' to the 'supernatural' and more widely attributed to supernatural factors, such as demons and witchcraft. Mshana et al. (2010) states that due to the characteristic CVAs holds of occurring very suddenly, even in a person with no preceding illness or worrying signs, it creates some sense that the victim has been 'struck' by some malevolent power. This leads to other participants in this study to believe that they have been bewitched, that CVAs are caused by witchcraft, which also tends to affect their perceptions towards the change in behaviour.

Participants who see it as God's will, like Christian and Islamic paradigms who recognise illness (such as CVA) as part of the human being's struggle in life, tend to also stick to a risky behaviour. These people do not see their behaviour as putting them at any risk of any illness as to them it is God who decides when they become ill and with what type of illness. This supports findings by Mshana (2008), that humans should expect to become ill at one point in their lives.

According to Mbatha (2004), a clot may form in a small blood vessel within the brain that has been previously narrowed due to the long-term damaging effects of high blood pressure (hypertension) or diabetes. Sometimes due to hardening of the arteries (atherosclerosis), a blood clot can obstruct a larger vessel such as the carotid artery in the neck going to the brain (Mbatha, 2004). Reeves, Hogan, and Raffertu (2002) and Yoon and Byles (2002), cited in Mshana (2008) found that respondents commonly mentioned stress, diet, high blood pressure, age, physical inactivity and smoking as the risk factors for stroke. In the current study, high blood pressure was found to be one of the leading causes of CVAs. Depression, which can be explained as severe mental distress in simpler terms, was also found to be a cause of CVA. Some of the participants said to have experienced depression before the attack. All these can be subjectively perceived as serious and the change in behavior is also subjective. The CVA patient is the one who chooses whether their behavior is risky and should be changed, or not risky.

Sometimes accidents can cause veins or arteries to rupture, resulting in bleeding. This bleeding may occur spontaneously and produces intracerebral or subarachnoid haemorrhaging (Thomas & Greenop, 2008). It is often not easy for a person to know if they had an intracerebral or subarachnoid haemorrhaging. Corrigan et al. (2013) defines subarachnoid haemorrhage as bleeding into the subarachnoid space, the pia mater and the arachnoid membrane which covers it. Intracerebral haemorrhage, on the other hand, is haemorrhage into the basal ganglia, thalamus, pons, and cerebellum (Corrigan et al., 2013). These are not usually known by the patients, they are just told they have a CVA and most explanations are avoided because of terminology and level of education.

6.2.3 Perceptions of participants on prevention of CVAs

Prevention is better than cure, so it is best to prevent illnesses before one can even have them. Even with CVAs, one should try preventing them beforehand. Treating underlying illnesses and having enough rest were found to be some ways of preventing CVAs. Insufficient fruit and vegetable consumption were found by Kolapo and Vento (2011) to be one of the contributing factors to CVA. CVA is also more strongly related to poverty, and in turn increases it (Kolapo & Vento., 2011). Healthy eating habits keeps the body strong and helps prevent illnesses. It was found in the current study that people should control their fat, salt, and pepper intake, and focus more on eating fruit and vegetables. These subjective notions help the patients to stick to the new behaviour as the belief it will benefit them.

Africans also had a way of diagnosing some illnesses earlier and then try to treat them without a visit to the hospital. One of the participants asserted that in the African tradition, elders were able to see if a person had a lot of blood, and then they made a means to reduce the blood. Just as blood pressure is controlled by medication in hospitals and clinics, the elders used a razor and a horn or a tennis ball to reduce the blood through a process known as “go-lomega”. They believed that their approach benefited them, and they used it as a way of prevention, supporting De Wit (2005) on his statement that the decision on a course of action is shaped by the options accessible to the individual and the belief in their effectiveness.

6.2.4 Perceptions of participants on the CVA’s impact on their quality of life

CVAs impact a person’s quality of life on different aspects. It can either be emotionally, physically, cognitively and/or socially. Patients with CVAs may well experience a range of impairments that could impact on physical and psychological functioning, lessen the person’s ability to participate in work and leisure activities, as well as decreasing their quality of life (Ignatowski et al., 2014). Findings from this study support the above findings as the participants alerted that CVA affects all spheres of life, that is emotionally, physically, psychologically, socially, and also the health status. Common emotional problems include depression and anxiety, anger, aggression, frustration and apathy are also evident (Kneebone & Lincoln, 2011). Participants in the current study confirmed to have anger, depression, and

uncontrollable crying or laughing, which often leave them depressed. CVA patients, as found in this study, were left partially or fully paralysed, therefore reducing their quality of life. All the patients in this study reported physical impairment and inability to perform some of the task they used to perform before they had the CVA. To back up this finding, Visser et al. (2015) reported that CVAs may result in paralysis of the arm and leg on either the left or right side of the body, twisting of the face, and in some cases other effects which may include loss of balance, disturbance of vision, disturbance of speech, loss of control of the bladder and bowels, and difficulty in swallowing. Some of the participants in this study reported that they still cannot walk properly and experience a lot of pain on the affected side. To back these findings, Greenfield (2011) also reported that patients who suffered a disabling stroke described a transformative process resulting in a “disrupted immediacy” between their bodies and their sense of self. He reported that the patients phenomenologically reported that their bodies and selves are experienced as acting upon one another.

Every person is a member of a larger society and social support is very crucial in the healing process. Lack of social support may delay the person and this may result in the person having psychological problems that may delay the healing process. Contemporary phenomenologists observed that significant impairments in body structure and function due to chronic illness such as stroke have a profound effect on patients’ moral understanding of their identity and their expected social roles in society (Greenfield, 2011). Participants who did not have support reported that people retreat when you are sick. On the contrary, those who have the social support reported to have accepted their condition and seem to be at peace with it.

The majority of individuals report a decline in health-related quality of life following a stroke. Health-related quality of life is seen as a broad multidimensional construct which includes physical, functional, psychological and social health (Rhoda, 2014). All these domains are affected after a CVA and the human health is mostly affected as the immune system is now weakened. It was found in this study that the patients suffer a variety of other diseases as their bodies’ are weak. The participants reported illness such as flu, arthritis, headaches, running stomach and sore throat, to mention a few. They complained that even the simplest illnesses will suppress them and make them very weak. The associated illnesses act as perceived benefits as they help

patients to adopt secondary prevention behaviours, such as quitting smoking, eating healthy fruit and vegetables, and screening for diseases (de Wit, 2005) to keep them healthy.

6.2.5 Perceptions of participants on treatment strategies

It was found in this study that there are different ways of dealing with diseases cross-culturally. Some patients opt for the western treatment, others for the African, or even both of them. Religious methods also appeared to be helpful in treating CVAs for others. The choice of treatment depends on the patient's personal belief on it and how effective they believe it can work in improving their condition. To back this assumption up, Turner et al. (2004) posited that an individual's personal factors affect whether the new behaviour is adopted or not. A person living with CVA, for example, will be more cautious with taking his or her high blood pressure medication (if the CVA resulted from high blood pressure) to prevent the same experience again.

Western treatment is the one provided by western doctors and nurses in hospitals and clinics. Most participants take the western treatment and believe it works. They believe that fighting the underlying diseases that led to the stroke will make their condition better and that rehabilitation will help them to get to walk again. Rehabilitation can provide methods and skills that can help a person to adapt and compensate for severe damage. Physical therapy (physiotherapy), as a type of rehabilitation, is designed to improve a person's strength, gross coordination, and balance. This rehabilitation helps people to regain their ability to walk and do other things like using stairs or getting out of a chair after the CVA (Mbatha, 2004). Banja (2011) explains rehabilitation as the phenomenological reconstitution of the post-disability self, as the person affected is the one reconstituting his or her self.

Just as they believe CVAs are caused by witchcraft, Africans also believe in African healing methods. They believe that consulting traditional healers as early as possible after the attack can help with the condition. This supports findings by Mshana et al. (2010) that sufferers try a range of treatments, with traditional medicine being the first resort and hospital treatment the second option. Mshana et al. (2010) also added that hospitals are avoided due to the belief that injections can be fatal to

someone who has just had a CVA, which makes prior visit with a traditional healer necessary. According to the health belief model, this phenomenological notions lead patients to construct barriers to taking actions of treating the condition because they don't see benefits but only further harm from them.

Akey et al. (2013) asserted that for a new behaviour to be adopted, a person needs to believe the benefits of the new behaviour outweigh the consequences of continuing the old behaviour, which is evident in this study. Mixed treatment of local and modern medicine was used in cases whereby the illness was long term or not responding to treatment. Switching of healers and biomedical practitioners was common until recovery, or inability to sustain costs cut it short (Mshana 2008). All participants who use the religious methods were found to also use the western methods, while some also tried the African ones. They believe that God will heal them through prayer and others also go for steaming and drinking tea made at church and believed to can heal. According to Mshana (2008), the religious informed discourse asserts that since God is in control of everything, He has the ability to either protect people from illness or cure any type of illness.

6.2.6 Participants' psychological coping strategies

Hori et al. (2010) refer to psychological coping as the thoughts and behaviours used to manage the internal and external demands of situations that are appraised as stressful. Coping with stressful situations and adverse life events is both an important personality resource and a measure of one's adaptability (Pu et al., 2012). Various ways were found in this study for coping with this condition. It was found that people should accept and shift their focus from their problems by engaging in social groups, keeping their minds busy by reading, or even joining support groups in their area. These strategies were found to help the participants to accept and not magnify and brood about their conditions. These coping strategies, according to the health belief model, can act as cues to action, that is, they can trigger appropriate health behaviour.

6.2.7 Management of CVAs

According to Gillham and Endacott (2010), exercise frequency and fruit and vegetable consumption can be used as ways of managing the CVA. An additional appointment with a health professional can also resolve other overlooked concerns for people with stroke (Gillham & Endacott, 2010). Findings from this study confirmed that eating healthy food, which is avoiding sugary beverages, salty and spicy food and fatty food, can help in managing the CVA. Regular exercises are also good for the body. One should also avoid stressing and try to engage with others to avoid enclosing themselves and worrying about the illness. Prayer and taking medication accordingly were found to be helpful in managing CVAs.

6.2.8 Perceptions on hospitalisation

A study by Mamabolo et al. (2009) concluded that patients with stroke have limited functional independence on discharge from hospital and these patients are sent home where community based rehabilitation services are not adequate and accessible. In SA the community-based rehabilitation services are poorly developed and inadequate, therefore leaving many patients with stroke limited in their participation in family and community activities, and with a poor quality of life post stroke, even after satisfactory levels of independence in daily living activities and mobility have been achieved following minimal rehabilitation in the hospitals (Maleka, Stewart & Hale; 2012). Some CVA patients see hospitalization as a better option for them as they are still struggling with re-integrating into the community and inadequate resources. Those with better social support don't see hospitalisation as good since they want to spend a lot of time with family and friends, while the visiting times in hospitals are too limited. These phenomenological perceptions provide a basis for an approach to treatment and re-integration where patients are facilitated in re-integrating into the society before they are fully discharged from the hospital to ensure that they receive all the support they need to face their condition.

6.2.9 Knowledge of risk factors

A study by Komolafe et al. (2015) concluded that there was inadequate awareness of stroke risk factors and warning signs among the respondents and that there is a need for more stroke education with emphasis on adequate information about stroke

risk factors to prevent occurrence especially among students and warning signs especially among at-risk adults so that they can act promptly and appropriately by seeking immediate medical attention. The current study confirms that very little is known about the risk factors and warning signs of CVAs mostly among our elderly community. It was found that people do not believe that they are at risk of contracting a disease until they are actually affected, and even so, they keep trying different treatment strategies because they struggle to believe they will benefit them.

6.3 Summary of findings

The current study reveals that black people have their different notions on CVAs, what they are, what causes them and the treatment. They still believe that CVAs are a result of witchcraft, while ignoring the main risk factors such as hypertension, high blood pressure and diabetes, to mention a few. Most importantly, this study revealed the daily experiences of living with CVAs. It is not an easy thing for others as they have to endure a lot of pain and also the embarrassment of being unable to control their bodies and emotions. **Some of the participants still perceive that CVAs are contagious, that you can acquire them by simply being in contact with the person, resulting in rejection by family members and possible neglect and nutritional deprivation.** Although the participants in this study seemed to know more about managing their condition, most still do not believe much on the western mode of treatment.

6.4 Contributions

This study sheds light on the experiences of patients living with cerebrovascular accidents in a rural setting to start with. Secondly, it provides insights to health care providers on the challenges faced by CVA patients both as inpatients and outpatients on a daily basis. Thirdly, psychological coping strategies used by the patients are also brought to light in this study. With the findings of this study, policy makers can have a deeper understanding of this neurological condition, and thus to develop and implement informed interventions. The research findings can also be opportunities to intervene and develop programmes for community psycho-education on CVAs (especially early identification, prevention and management).

6.5 Limitations

There are considerable limitations in this study and the researcher is aware of them. Firstly, the translation of the raw data from Sepedi to English may have caused omission of the original rich material provided by the participants. Secondly, this study relied on the perceptions of a few CVA patients from the same rural dwelling and therefore their perceptions cannot represent all CVA patients. Thirdly, demographic information such as education, religion and socio-economic status were not considered when analysing and drawing conclusions in this study. Finally, the results of this study cannot be generalized to a larger population since the study was conducted on a limited sample.

6.6 Recommendations

This study suggests that stroke survivors should be offered individualised rehabilitation programmes that address not only physical activities but also psychological circumstances and existential issues. It is recommended that the interventions offered to the stroke survivor are unfolded through an educational approach, so the individuals do not feel alienated or need to struggle in isolation. It is recommended that future studies cover a larger sample consisting of patients from different areas and also taking into consideration all the other demographic information missed in this study. Home-based counselling sessions should also be provided for CVA patients and also family members who live with them to better understand and know how to deal with their daily experiences. More research is also needed concerning the African notions on treatment and causes of CVAs from the perspective of the person, whether African or western doctor, treating the patient. Religion should also be given priority as to their perceptions on the condition. Lastly, future research should focus on counselling and therapy and how they contribute to the treatment of CVAs.

REFERENCES

- Adeloye, D. (2014). An Estimate of the Incidence and Prevalence of Stroke in Africa: A Systematic Review and Meta-Analysis. *Public Library of Science ONE*, 9(6), 1-14.
- Akey, J. E., Rintamati, L. S & Kane, T. L. (2013). Health Belief Model deterrents of social support seeking among people coping with eating disorders. *Journal of Affective Disorders* 145, 46–252.
- American Heart Association Statistics Committee and Stroke Statistics Subcommittee. (2015). *Heart disease and stroke statistics-2015 update: a report from the American Heart Association* [published online ahead of print December 17, 2014]. Retrieved from https://www.heart.org/idc/groups/ahamah-public/@wcm/@sop/@smd/documents/downloadable/ucm_470704.pdf
- Babbie, E. (2007). *The Practice of Social Science Research* (11th Ed.). Cape Town: Oxford University Press.
- Banja, J. D. (2011). Stroke Rehabilitation and the Phenomenological Reconstitution of the Self. *Topics in Stroke Rehabilitation*, 18 (1), 24-29.
- Bautista R. E. D., Rundle-Gonzalez, V., Anad, R. G., & Erwin, P. A. (2013). Determining the Coping Strategies of Individuals with Epilepsy. *Epilepsy and Behaviour* 27, 286-291.
- Bhatti, Z. U., Salek, M. S., Finalay, A. Y. (2011). Chronic Diseases Influence Major Life Changing Decisions: A New Domain in Quality of Life Research. *Journal of Journal of the Royal Society of Medicine*, 104, 241-250.
- Bless C., & Higson-Smith, C. (2000). *Fundamentals of Social Research Methods*. Cape Town: Juta.
- Bryer, A., Connor, M.D., Haug, P., Cheyip, B., Staub, H., Tipping, B., Duim, W and Pinkney-Atkinson, V. (2010). South African Guideline for Management of Ischaemic Stroke and Transient Ischaemic Attack 2010: A Guideline from the

South African Stroke Society (SASS) and the SASS Writing Committee. *South African Medical Journal*, 100 (11), 750-778.

- Casper, R., Peytcheva, E., Yan, T., Lee, S., Liu, M & Hu, M. (2016). Pretesting. *Cross-cultural survey guidelines*.
- Census. (2011). Extracted from <https://census2011.adrianfrith.com/place/970001>=
- Corrigan, M.L., Escuro, A. A., Arlene, A., & Kirby, D. F. (eds.). (2013). Handbook of Clinical Nutrition and Stroke. *Nutrition and Health*, 28 (1), 15-31.
- Council for Medical Schemes. (2015). *Research Brief: Prevalence of Chronic Diseases in the Population Covered by Medical Aid Schemes in South Africa*. Retrived from: www.medicalschemes.com/Publications.aspx.
- De Vos, A. S., Strydom, H., Fouche, C. B., & Delport, C. S. L. (2005). *Research at Grassroots: For the Social Sciences and Human Service Profession*, (3rd Ed.). Pretoria: Van Schaik Publishers.
- De Wit, J. B. F., Vet, R., Schutten, M & Steenbergen, J. (2005). Social-Cognitive Determinants of Vaccination Behavior Against Hepatitis B: An Assessment Among Men who have Sex with Men. *Preventive Medicine*, 40(6), 795-802.
- Denzin, N., & Lincoln, Y. (2005). *The Sage Handbook of Qualitative Research*. Thousand Oaks, CA: SAGE.
- Fochtman, D. (2010). Understanding the Meaning of the Lived Experience of Adolescents in Treatment for Cancer. Unpublished Phd Thesis, University of Hawai-Retrieved from Uhm_PhD_Fochtman-D_R_Pdfon 08 August 2015.
- Fraas, M. R. (2011). Enhancing Quality of Life for Survivors of Stroke through Phenomenology. *Topics in Stroke Rehabilitation*, 18 (1), 40-46.
- Fraas, M. R., & Calvert, M. (2009). The Use of Narratives to Identify Characteristics Leading to a Productive Life Following Acquired Brain Injury. *American Journal of Speech-Language Pathology*, 18, 315-328.
- Gavin, H. (2008). *Understanding Research Methods and Statistics in Psychology*. London: SAGE.

- Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of Data Collection in Qualitative Research: Interviews and Focus Groups. *British Dental Journal*, 204 (6), 291-295.
- Gillespie, D. C., Bowen, A., Chung, C. S., Cockburn, J., Knapp, P., & Pollock, A. (2014). Rehabilitation for Post-Stroke Cognitive Impairment: An Overview of Recommendations Arising from Systematic Reviews of Current Evidence. *Clinical Rehabilitation*, 29(2), 120–128.
- Gillham, S & Endacott, R. (2010). Impact of Enhanced Secondary Prevention on Health Behaviour in Patients Following Minor Stroke and Transient Ischaemic Attack: a Randomized Controlled Trial. *Clinical Rehabilitation*, 24, 822-830.
- Glass, A., Dym, B., Greenberg, S., Rintell, D., Roesch, C., & Berkam, L. (2000). Psychological Intervention in Stroke: Families in Recovery from Stroke Trial (FIRST). *American Journal of Orthopsychiatry*, 70(2), 169-181.
- Gouri-Devi, M. (2014). Epidemiology of Neurological Disorders in India: A Review of Background, Prevalence and Incidence of Epilepsy, Stroke, Parkinson's Disease and Tremors. *Neurology India*, 62, 588-598.
- Greenfield, B. (2011). Phenomenology as a Philosophical Orientation for Understanding the Transformative Experience of Disabling Illness. *Topics in Stroke Rehabilitation*, 18 (1), 35-39.
- Greenop, K., & Thomas, M. (2008). Caregiver Experiences and Perceptions of Stroke. *Health SA Gesondheid*, 13 (1), 29-40.
- Groenewald, T. (2004). A Phenomenological Research Design Illustrated. *International Journal of Qualitative Methods*, 3(1), 1-26.
- Hayes, N. (2000). *Doing Psychological Research*. Glasgow: Bell & Bain Ltd.
- Hori, H., Ozeki, Y., Teraishi, T., Matsuo, J., Kawamoto, Y., Kinoshita, Y., Suto, S., Terada, S., Higuchi, T., & Kunugi, H. (2010). Relationships between Psychological Distress, Coping Styles and HPA Axis Reactivity in Healthy Adults. *Journal of Psychiatric Research*, 44, 865-875.

- Hurst, S. H., Arulogun, O. S., Owolabi, A. O., Akinyemi, R., Uvere, E., Warth, S & Ovbiagele, B. (2015). Pretesting Qualitative Data Collection Procedures to Facilitate Methodological Adherence and Team Building in Nigeria. *International Journal of Qualitative Methods* 14, 53-64.
- Ignatowski, T., Spengler, R., Dhandapani, K., Folkersma, H., Butterworth, R., & Tobinick, E. (2014). Dysfunction: Scientific Rationale and Current Evidence. *Central Nervous System Drugs*, 28, 679-697.
- Johl, S. K & Renganathan, S. (2010). Strategies for Gaining Access in Doing Fieldwork: Reflection of Two Researchers. *The Electronic Journal of Business Research Methods* 8, 37-46
- Kaufman, D. M., & Milstein, M. J. (2013). *Kaufman's Clinical Neurology for Psychiatrists (7th ed)*. New York: Elsevier INC.
- King, R., Shade-Zeldow, Y., Carlson, C., Feldman, J., & Phillip, M. (2002). Adaptation of Stroke: A Longitudinal Study of Depressive Symptoms, Physical Health, and Coping Process. *Topics in Stroke Rehabilitation*, 9(1), 40-66.
- Kneebone, I. I., & Lincoln, N. B. (2011). Psychological Problems after Stroke and their Management: State of Knowledge. *Neuroscience and Medicine*, 3, 83-89
- Kolapo, K. O & Vento, S. (2011). Stroke: a Realistic Approach to a Growing Problem in Sub-Saharan Africa is urgently needed. *Tropical Medicine and International Health*, 16(6), 707-710.
- Komolafe, M. A., Obembe, A. O., Olaogun, M. O., Adebisi, A. M., Ugalahi, T., Dada, O., Kanu, A., Adebisi, O. C., Akilo, F., Ogunkoya, B & Fawale, B. (2015). Awareness of Stroke Risk Factors and Warning Signs in Nigerian Adolescents Compared with Adults. *Journal of Stroke and Cerebrovascular Diseases*, 24(3): 687-693
- Maleka, M., Stewart, A. S., & Hale, I. (2012). The Experience of Living with Stroke in Low Urban and Rural Socioeconomic Areas of South Africa. *South African Journal of Physiotherapy*, 68 (3),25-29.

- Mamabolo, M. V., Mudzi, W. M., Stewart, A. S, Olurunji, S & Singh, A. (2001). A Study to Determine Post Discharge Functional Improvements in Patients with Stroke. *South African Journal of Occupational Therapy*, 39(1), 15-18.
- Maredza, M., Betram, M. Y., & Tollman, S. M. (2015). Disease Burden of Stroke in Rural South Africa: An Estimate of Incidence, Mortality and Disability Adjusted life Years. *Bio-Medical Central Neurology*, 15 (54), 1-12.
- Mbatha, F. P. (2004). *Patient and Family Experience of a Cerebrovascular Accident: A Phenomenological Inquiry*. Unpublished Dissertation, University of South Africa, Department of Psychology.
- Mbewu, A & Mbanya, J.C. (2006). *Chapter 21 Cardiovascular Disease*. Extracted from www.ncbi.nlm.nih.gov/books/NBIC2294
- Mkhonto, S. S., Labadarios, D & Mabaso, M. L. H. (2012). Association of Body Weight and Physical Activity with High Blood Pressure in a Rural Population in the Ga-Dikgale Village of Limpopo Province in South Africa. *Bio-Medical Central Research Notes*, 5, 118-125.
- Montemagni, C., Castagna, F., Crivelli, B., de Marzi, G., Frieri, T., Maori, A., & Rocca, P. (2014). Relative Contributions of Negative Symptoms, Insight, and Coping Strategies to Quality of Life in Stable Schizophrenia. *Psychiatry Research*, 220, 102-111.
- Morrison, V., Pollard, B., Johnston, M & MacWalter, R. (2005). Anxiety and Depression Three Years Following Stroke: Demographic, Clinical and Psychological Predictors. *Journal of Psychosomatic Research* 59,209-213.
- Mshana ,G. (2008). *Stroke Discourses and Remedies in Urban and Rural Tanzania*. Durham Theses, Durham University. Available at Durham E-Theses Online: <https://ethee.dur.ac.uk/1949>.
- Mshana, G., Hampshire, K., Panter-Brick, C., & Walker, R. (2010). Urban- Rural Contrasts in Explanatory Models and Treatment-Seeking Behaviors for Stroke in Tanzania, *Journal of Biosocial Science*, 40 (1), 35-52.

- National Stroke Association. (2006). *Recovery after Stroke: Coping with Emotions*. IPO 2/06.
- National Stroke Association. (2013). Explaining Stroke. BG7, 09/13.
- Ojagbemi, A., & Owolabi, M. (2013). Predictors of Functional Dependency after Stroke in Nigeria. *Journal of Stroke and Cerebrovascular Diseases*, 22 (8), e381-e387.
- Pinker, S. (2007). *The Stuff of Thought: Language as a Window into Human Nature*. New York, NY: Viking.
- Ponchel, A., Bombois, S., Bordet, R., & Henon, H. (2015). Factors Associated with Poststroke Fatigue: A Systematic Review. *Stroke Research and Treatment*, 15,1-12.
- Powers, W. J., & Jordan, J. D. (2014). Stroke, Overview. *Encyclopedia of the Neurological Sciences*, 4, 323-325.
- Pringle, J., Drummond, J., McLafferty, E., & Hendry, C. (2011). Interpretive Phenomenological Analysis: A Discussion and Critique. *Nurse researcher*, 11 (3), 20-24.
- Pringle, J., Hendry, C., & McLafferty, E. (2011). Phenomenological Approaches: Challenges and Choices. *Nurse researcher*, 18 (2): 7-18.
- Pu, S., Nakagome, K., Yamada, T., Yokohama, K., Matsumura, H., Mitani, H., Adachi, A., Nagata, I., & Kaneko, K. (2012). The Relationship between the Prefrontal Activation during Verbal Fluency Task and Stress-Coping Style in Major Depressive Disorder: A Near-Infrared Spectroscopy Study. *Journal of Psychiatric Research*, 46, 1427-1434.
- Rhoda, A. (2014). Health-Related Quality of Life of Patients Six Months Post-Stroke Living in the Western Cape, South Africa. *African Journal of Disability*, 3(1), 126-132.
- Sharma, H., Bulley, C., & van Wijck, F. M. J. (2012). Experiences of an Exercise Referral Scheme from the Perspective of People with Chronic Stroke: A Qualitative Study. *Physiotherapy*, 98, 336-343.

- Silverman, A. (2000). *Doing Qualitative Research: A Practical Handbook*. London: SAGE.
- Simeone, S., Savini, S., Cohen, M. Z., Alvaro, R., & Vellone, E. (2014). The Experience of Stroke Survivors Three Months after Being Discharged Home: A Phenomenological Investigation. *European Journal of Cardiovascular Nursing*, 14(2), 162-169.
- Sodi, T., & Bojuwoye, O. (2011). Cultural Embeddedness of Health, Illness and Healing: Prospects for Integrating Indigenous and Western Healing Practices. *Journal of Psychology in Africa*, 21(3), 349-356.
- Stroke association. (2012). *Emotional Changes after Stroke*. Factsheet 32 version 02
- Stroke association. (2012). *What is a stroke?* Leaflet 2 version 1, 1-16.
- Tanner-Smith, E. (2010). Evaluating the Health Belief Model: A Critical Review of Studies Predicting Mammographic and Pap Screening. *Social Theory and Health*, 8 (1), 95-125.
- Tewksbury, R. (2009). Qualitative Versus Quantitative Methods: Understanding Why Qualitative Methods are Superior for Criminology and Criminal Justice. *Journal of Theoretical and Philosophical Criminology*, 1, 38-58.
- The Stroke Association. (2006). *Psychological Effects of Stroke*. Factsheet 10, 1-10.
- Tipping, B. (2008). Issues in Long-Term Management of Stroke. *CME*, 26(2), 70-72.
- Turner, L. W., Hunt, S. B., DiBrezzo, R., & Jones, C. (2004). Design and Implementation of an Osteoporosis Prevention Program Using the Health Belief Model. *American Journal of Health Studies*, 19 (2), 115-121.
- Van Manen, M. (2007). Phenomenology of Practice. *Phenomenology and Practice*, 1(1), 11-30.
- Visser, M. M., Heijenbrok-Kal, M. H., Van't Spijker, A., Oostra, K. M., Busschbach, J. J. & Ribbres, G. M. (2015). Coping, Problem Solving, Depression and Health-Related Quality of Life in Patients Receiving Outpatient Stroke Rehabilitation. *Archives of Physical Medicine* 96, 1492-1498.

APPENDICES

Appendix 1a: Semi-structured interview guide (English version)

1. As a person living with cerebrovascular accidents, may you explain to me your own understanding of what a cerebrovascular accident is.
2. Living with cerebrovascular accidents yourself, may you share with me what your understanding is regarding the causes of this condition?
3. Kindly share with me your own psychological strategies that you use to cope with a cerebrovascular accident.
4. Kindly share with me what you consider to be the role of your religious beliefs in dealing with your condition.
5. Looking at your own experience of cerebrovascular accidents, what would you consider to be the best way or ways to manage these cerebrovascular accidents?

Appendix 1b: Semi-structured interview guide (Sepedi version)

1. Bjale ka motho yo a phelago ka bolwetši bja seterouku, le ka ntlhalosetša ka kwišišo ya lena gore ke eng seterouku?
2. Kage le phela ka bolwetši bja seterouku, le ka ntlhalosetša go ya ka maitemogelo a lena gore ke eng sehlodi sa seterouku seo?
3. Ntlhalosetšeng mekgwa ya lena ya kgopolong goba moyeng ye le e šomišago go phela le seterouku.
4. Oka nhlalosetša ka mekgwa yeo o e šomišago goya le katumelo ya gago ya semoya go phela le bolwetši bjo?
5. Ge le lebeletše seemo se sa seterouku, keeng seo le bonago e le tsela goba ditsela dife tša maleba tša go sepidiša bolwetši bjo bja seterouku ka tshwanelo?

Appendix 2: Letter of permission to the Limpopo Department of Health

Department of Psychology
University of Limpopo
Private Bag X1106
Sovenga
0727
04 April 2016

The Head of Department
Department of Health, Limpopo Province
18 College Street
0700, Polokwane

Dear Sir/ Madam

Request for permission to access clinic records at Ga-Dikgale

I am Molomo Linah Maimo, a master's student at the University of Limpopo (Turfloop campus). The research that I wish to conduct for my master's thesis is about the lived experiences of people with cerebrovascular accidents in Ga-Dikgale, Limpopo province. I hereby seek your permission to access the clinic records for people with cerebrovascular accidents who have been receiving treatment in the last 12 months.

Thank you for your time and consideration.

Regards

Molomo Linah Maimo (Student)

Date

Prof. T Sodi (Supervisor)

Date

Appendix 3a: Permission to gain access to the participants (English version)

Department of Psychology

University of Limpopo (Turfloop Campus)

Private Bag X1106

Sovenga,

0727

Date: _____

The secretary

Ga-Dikgale Tribal Authority

PO Box 3734

Sovenga

0727

Dear Sir/ Madam

Request for permission to interview members of the Ga-Dikgale community

I am Molomo Linah Maimo, a master's student at the University of Limpopo (Turfloop campus). The research that I wish to conduct for my master's thesis is about the lived experiences of people with cerebrovascular accidents in Ga-Dikgale, Limpopo province. I hereby seek your permission to interview the members of your community.

Thank you for your time and consideration

Regards

Molomo Linah Maimo

Appendix 3b: Permission to gain access to the participants (Sepedi version)

Depatemente ya Psychology

Unibesithi ya Limpopo (Turfloop campus)

Private Bag X1106

Sovenga

0727

Letšatšikgwedi _____

The secretary

Ga-Dikgale Tribal Authority

PO Box 3734

Sovenga

0727

Thobela

Kgopelo ya tumelelo ya go nyakišiša go badudi ba Ga-Dikgale.

Kenna Molomo Linah Maimo, morutwana wa masetase Unibesithing ya Limpopo (Turfloop campus). Nyakišišo yaka e mabapi le maitemogelo a go phela le bolwetši bja seterouku go badudi ba Ga-Dikgale, Porofentsheng ya Limpopo. Ke kgopela tumelelo yalena go nyakišiša go badudi ba naga yalena.

Ke leboga nako le maitapišo a lena

Ka hlomphe

Molomo Linah Maimo

Appendix 4a: Informed consent letter and form (English version).

Department of Psychology
University of Limpopo (Turfloop Campus)
Private Bag X1106
Sovenga
0727
Date_____

Dear Participant

Thank you for showing interest in this study that focuses on the lived experiences of people with cerebrovascular accidents at Ga-Dikgale. Your responses to the interview will remain strictly confidential. The researcher will attempt not to identify you with the responses you give during the interview or disclose your name as a participant in the study.

Please note that your participation in this study is voluntary and you have the right to withdraw from participating at any time should you wish to do so. Kindly answer all the questions as honestly as possible. Your participation in this study is very important.

Thank you for your time and cooperation.

Kind regards

Molomo L. M. (Masters Student)

Date

Prof. Sodi (Supervisor)

Date

Consent form

I _____ hereby agree to participate in a Masters Research project (which is a part of a larger VLIR research project) that focuses on the lived experiences of people with cerebrovascular accidents at Ga-Dikgale, Limpopo Province. The purpose of the study has been fully explained to me.

I further understand that I am participating freely and without being forced in any way to do so. I also understand that I can withdraw my participation in this study at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project, whose purpose is not necessarily to benefit me personally. I understand that my details as they appear in this consent form will not be linked to the interview schedule, and that my answers will remain confidential.

Signature: _____

Date: _____

Appendix 4b: Informed consent letter and form (Sepedi version)

Depatemente ya Psychology

Unibesithi ya Limpopo (Turfloop campus)

Private Bag X1106

Sovenga

0727

Letšatšikgwedi _____

Dumela motšeakarolo nyakišišong

Ke leboga ge o bontšhitše kgahlego go tšea karolo nyakišišong ye e lego mabapi le maitemogelo a go phela le bolwetši bja seterouku go badudi ba Ga-Dikgale, Porofentsheng ya Limpopo.

Diphetolo tša gago mo go nyakišišo ye di bolokegile. Monyakišiši a ka se leke go go lebanya le diphetolo tša gago le dipotšišo tša nyakišišo goba a tšwetša leina la gago nyanyeng bjalo ka motšeakaralo mo nyakišišong ye. Le lemošwa gore go tšea karolo mo nyakišišong e ke boikgethelo ebile le na letokelo ya go tlogela go tšea karolo nako efe goba efe.

Le kgopelwa go araba dipotšišo kannete yeo e phatlaletšego. Dikarabo tša gago di bohlokwa ebile di bolokegile.

Ke leboga nako ya gago

Wa gago kamehla

Molomo Linah Maimo (Morutwana wa masetase)

Prof. T. Sodi (Mohlahlhi)

Letšatšikgwedi

Letšatšikgwedi

Letlakala la tumelelano

Nna _____ kedumela go tšea karolo Porojekeng ya nyakišišo ya Mastase (ye e lego ye nngwe ya di Projeke tša VLIR) ka ga nyakišišo ya maitemogelo a go phela le bolwetši bja seterouku go badudi ba Ga-Dikgale, Porofentsheng ya Limpopo.

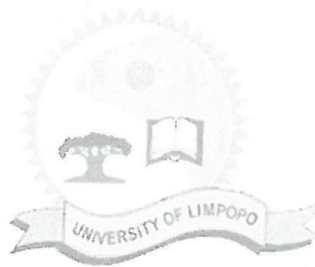
Ke hlaloseditšwe go tlala seatla ka ga maikemišetšo magolo a nyakišišo ye. Go tšea karolo ga ka ke boithaopo nyakišišong ye, ka fao nka tlogela nako efe kapa efe. Ke kwešiša gore se ke nyakišišo dithutong, ebile gago seo ke se humanago go tšea karolo nyakišišong ye.

Ke kwešiša gape gore seo ke se bolelago mo, se tla šomišwa fela ke bao ba dirago nyakišišo ye fela, ebile tsebo yaka e bohlokwa. Nyakišišo ye e tloga e bolokegile.

Mosaeno: _____

Letšatšikgwedi: _____

APPENDIX 5: FACULTY APPROVAL OF PROPOSAL



University of Limpopo
 Faculty of Humanities
 Executive Dean

Private Bag X1106, Sovenga, 0727, South Africa
 Tel: (015) 268 4895, Fax: (015) 268 3425, Email: richard.madadzhe@ul.ac.za

DATE: 4 April 2016

NAME OF STUDENT: SIDJIE, LM
 STUDENT NUMBER: [201013571]
 DEPARTMENT: Psychology
 SCHOOL: Social Sciences
 QUALIFICATION – MA

Dear Student

FACULTY APPROVAL OF PROPOSAL (PROPOSAL NO. FHDC2015/2606)

I have pleasure in informing you that your MA proposal served at the Faculty Executive meeting on 28 October 2015 and your title was approved as follows:

TITLE: THE LIVED EXPERIENCES OF PEOPLE WITH CEREBROVASCULAR ACCIDENTS IN GADIKGALE, LIMPOPO PROVINCE

Note the following:

Ethical Clearance	Tick One
Requires no ethical clearance Proceed with the study	
Requires ethical clearance (Human) (TREC) (apply online) Proceed with the study only after receipt of ethical clearance certificate	√
Requires ethical clearance (Animal) (AREC) Proceed with the study only after receipt of ethical clearance certificate	

Yours faithfully

Prof RN Madadzhe

Executive Dean: Faculty of Humanities

CC: Prof S Sithole

Supervisor: Prof T Sodi

Co-supervisor: Dr S Govender

Finding solutions for Africa

APPENDIX 6: TREC ETHICAL CLEARANCE CERTIFICATE



University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 2212, Fax: (015) 268 2306, Email:noko.monene@ul.ac.za

**TURFLOOP RESEARCH ETHICS
COMMITTEE CLEARANCE CERTIFICATE**

MEETING: 05 July 2016
PROJECT NUMBER: TREC/68/2016: PG

PROJECT:

Title: The lived experiences of people with cerebrovascular Accidents in Ga-Dikgale, Limpopo Province
Researcher: Ms LM Sidjie
Supervisor: Prof T Sodi
Co-Supervisor: Dr S Govender
School: Social Sciences
Degree: Masters in Psychology


PROF. TAB MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: REC-0310111-031

Note:

- i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
- ii) The budget for the research will be considered separately from the protocol.
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

APPENDIX 7: DEPARTMENT OF HEALTH APPROVAL LETTER



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila (015 293 6650)

Ref:4/2/2

Sidjie LM
University of Limpopo
Private Bag X1106
Sovenga
0727

Greetings,

RE: The lived experiences of people with cerebrovascular accidents in Ga-Dikgale, Limpopo Province

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
 - Research must be loaded on the NHRD site (<http://nhrd.hst.org.za>) by the researcher.
 - Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
 - In the course of your study there should be no action that disrupts the services.
 - After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
 - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
 - The above approval is valid for a 3 year period.
 - If the proposal has been amended, a new approval should be sought from the Department of Health.
 - Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.



Head of Department

06/10/2016

Date